Response to: This Wasn't a Split-Second Decision: An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy

February 20, 2021
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In January 2021, the research article This Wasn't a Split-Second Decision: An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy was published in the Journal of Bioethical Inquiry.
https://link.springer.com/article/10.1007/s11673-020-10086-9

The stated aims of the authors are "to provide empirical analysis of minor trans youth capacity to consent to hormone therapy and to address the normative question of whether there is ethical justification for granting trans youth the authority to consent to care." The authors explain that their research was conducted in British Columbia where mature minor legislation applies to healthcare decision making. It's also notable that they selected interview participants from gender-affirming organizations and treatment facilities, thus making this a biased sample. The authors admittedly follow "a gender-affirmative clinical orientation" and therefore aren't applying ethical analysis to that model itself. They concluded that yes, minors are capable of consenting to hormone therapy.

The second line of the ethics abstract reads:

"Transgender (trans) youth experience barriers to needed gender-affirming care"

There's a lot to unpack right there.

Transgender versus gender dysphoria

The authors begin their whole argument with an assumption that we all know and agree upon what a "transgender youth" is. Do we? Is it like a racial group, or a third biological sex? Is it a newly discovered phenotype? Is it a nationality or religious affiliation? I can tell you that, even within the trans-identified population, there is no consensus on what constitutes "trans". Deep ideological divides exist within the trans community just as much as anywhere else.

Classifying "trans" as a definable group of people has been politically effective and lends itself well to advocacy, especially when piggy-backed onto LGB and intersex issues (which, I might add, has ticked off many LGB and intersex people). The ideas of "human rights" and "access to care" easily roll off of the designation of a marginalized group. We want justice for those who are oppressed, so well-meaning people get on board without question. But, the reality is, "trans" is a mere declaration of identity, not a measurable entity. Anyone can be "trans".

Identity is subjective. Sound medical practice on the other hand, requires evidence-based objectivity. What is the diagnosis? How do we reliably determine the diagnosis? Are there biomarkers? How do we determine who will most likely benefit from treatment? Such questions are now considered taboo, even among clinicians. Let that sink in. Clinicians within the system are not allowed to openly discuss among themselves and debate what this condition is. It's now considered wrong to "pathologize" something which has been studied and named as a condition in peer-reviewed journals and the DSM. We're to eliminate all barriers to medical interventions for something we're not allowed to name as anything other than natural variations of "gender identity" (a term that has never been scientifically substantiated). Any barriers (like taking the time to explore identity development with a client) are considered oppressive ("gatekeeping"), even though transition regret happens. Valid clinical research is being suppressed whenever it doesn't align with this narrative. (Link 1 and 2) If there's no pathology, then why is treatment needed and paid for by the public health system? If treatment is so desperately needed, then there is pathology.

The truth is, there is no such thing as a "trans person" outside of political utility and sociality constructed identity. There is a range of ways in which any person can express their femininity or masculinity, within the bounds of their biological sex. There are tomboys and feminine men. There are gender roles, and many people take up roles which are not traditionally aligned to their sex. Nothing pathological about that. No need for a doctor.

There are people who experience Gender Dysphoria (GD), or what used to be called Gender Identity Disorder (GID). Many gay and lesbian people feel GD. Some intersex people experience it. There are correlations between GD and schizophrenia, autism spectrum disorders and personality disorders. (Links 3-5) In some cases GD goes away, and for others it doesn't. Some people feel it but still embrace their biological sex. Others dissociate entirely from their sexed body. There are many reasons why people dissociate from their bodies or hate their sex, like sexual trauma or social inequities. And, I've heard many trans-identified people say that they never felt GD at all and lied to their clinicians in order to get hormones. I've heard others say they transitioned for "political reasons". Some heterosexual men are turned on by the idea of having a female body. So there's our motley crew. I may be missing some. Some of these pathways have been well studied and articulated by psychologists like Dr Blanchard. As far as clinical or social need, does a gay kid have the same needs as someone with autism? Is a woman who's experienced sexual trauma the same as a man who's sexually aroused by the thought of having a female body? (Link 6)

Many people don't realize that approximately 84% of children with GD resolve it by the time they're through puberty. (Link 7) Most of those kids end up being gay or lesbian adults. So, why is it considered ethical to capture children with GD into a trans identity and present medicalization as the only treatment pathway when we know that most of those kids would desist if left alone? What does the gay and lesbian community think about transitioning kids who most likely would have turned out to be gay or lesbian?

“Trans” is an identity that masks all of these separate and often unrelated pathways. When children experience GD, or are otherwise distressed by their bodies, they are being taught a trans narrative, rather than being helped to find themselves within a complex array of GD presentations and social pressures. No one can provide informed consent if they’re not being truthfully well-informed.

Gender-affirming care

Gender-affirming healthcare is an extension of the trans ideological narrative. As such, it’s a significant departure from medical conventions. For any other healthcare issue, whether a medical condition like diabetes or a mental health condition like anorexia nervosa, a qualified clinician employs a standardized process for examining and diagnosing the condition. Once reasonably certain of a diagnosis, treatment options are presented to the patient (and family, if applicable), risks and benefits are discussed, and then the patient may either consent to treatment or decline treatment.

This is not the current pathway to gender medicine, where principles of safekeeping and evidence-based discernment by qualified specialists are being reframed as oppressive “barriers”. Patients present to clinics stating that they are “trans”, having made a self-diagnosis by obtaining trans-cultural information from places such as the internet, social media and peer groups, and then tell the clinician that they want hormones and surgeries. Gender-affirming clinicians don’t question that self-diagnosis or conduct careful, exploratory, diagnostic assessments. In a co-operative trans-cultural effort, they presume that “people know who they are and what they need” and initiate treatment, as long as the client seems capable of consenting to the treatment they’ve said they want. While affirming someone’s identity may be socially polite, it is a grossly irresponsible departure from science-based medical practice, regardless of the age of the patient. Clinicians are willfully ignoring a wealth of research about the different types, pathways and therapeutic options for GD, choosing instead to collude with gender ideology. This sudden, dramatic shift to affirmation was the result of activism, not new scientific evidence. The “old” science stands, but is rejected.

Finland, Denmark, Australia, Ireland, and the UK have completed or started systematic reviews of gender-affirmative treatment for children. Finland and Denmark concluded that there is insufficient evidence to support this approach. There’s still a great deal unknown about the long-term health outcomes, and it hasn’t yet been determined why gender clinics are seeing sudden, exponential growth in young people (mostly girls) seeking treatment. Finland has released their own guidelines of care, emphasizing psychological interventions and cautious assessment. Gender politics didn’t hold up to clinical scrutiny in the landmark 2020 case in the UK between the Tavistock clinic and Keira Bell. The judge concluded that children are not legally capable of consenting to puberty blockers - the first step in medically transitioning children. The judge’s ruling outlines many key points of debate in detail. (Link 8) Some highlights include:

The Dutch Protocol, on which this intervention is based, was designed for the use of puberty blockers on children who had severe early childhood onset GD. It was not intended for use on children with later onset GD or other presentations.

Puberty blockers may generate persistence of GD and prevent desistance, since virtually all kids who start puberty blockers move on to hormone therapy.

There is insufficient data about the long-term health risks. Possible risks include: weakening of bones, incomplete development of sex organs, body shape and height, memory and concentration deficits, and infertility.

The clinic's claim that puberty blockers are "fully reversible" is misleading

It was noted that "there was no overall improvement in mood or psychological wellbeing using standardized psychological measures"

This is experimental treatment which should only be used in research settings

Authorization of the court will be required to receive puberty blockers

GD as a condition was not contested

A similar legal challenge or systematic review has not taken place in Canada, but I expect similar outcomes when that happens.

I am not proposing that we roll back civil rights for trans people, nor am I proposing a roll back to coercive and punitive measures to treat it. (Most people aren't.) I would like to see an approach that is integrative of all that is currently known about these conditions, which requires that we take the lid off the box and look at these issues with honesty as well as compassion. Medicalization should be a last resort, not first-line treatment for such complex psychological, social and political phenomena. Children are not developmentally mature enough to fully understand these complexities, especially when they are also struggling with other mental health symptoms or developmental disabilities. The lack of mature, balanced, clinical oversight and community leadership places all of the decision-making responsibility onto the shoulders of these misinformed children.

I would like to see the authors of this ethics paper back up, set aside their own political bias, and provide analysis on the glaring ethical problems within the very foundations of gender-affirming care. Our children require this of us, as their parents, teachers, researchers, and clinicians.

Links:

https://www.independent.co.uk/news/uk/home-news/psychotherapist-gender-assignment-surgery-reverse-research-stop-trans-bath-spa-university-james-caspian-a7965281.html

https://www.nydailynews.com/news/national/ny-news-brown-university-removal-gender-dysphoria-study-reaps-backlash-20180905-story.html

https://www.hindawi.com/journals/schizort/2014/463757/?fbclid=IwAR28sAg5ilHYpGYjQmOiy7jH1AuEFJYjDViigAoVlL9Qp8agRAYI82gPrQg

https://www.autism.org/gender-dysphoria-autism/

https://www.hindawi.com/journals/tswj/2014/809058/

https://www.researchgate.net/publication/5893630_What_Many_Transgender_Activists_Don't_Want_You_to_Know_and_why_you_should_know_it_anyway

https://jaacap.org/article/S0890-8567(13)00187-1/fulltext

https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf