Adolescent Medical Transition is Ethical: An Analogy with Reproductive Health

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ABSTRACT. In this article, I argue that adolescent medical transition is ethical by analogizing it to abortion and birth control. The interventions are similar insofar as they intervene on healthy physiological states by reason of the person's fundamental self-conception and desired life, and their effectiveness is defined by their ability to achieve patients' embodiment goals. Since the evidence of mental health benefits is comparable between adolescent medical transition, abortion, and birth control, disallowing transition-related interventions would betray an unacceptable double standard. While great enough risks can override autonomy over fundamental aspects of personal identity, I demonstrate that the available scientific evidence does not corroborate the view that adolescent medical transition is dangerous. Consequently, adolescent medical transition should be recognized as ethical and remain available.

Transgender adolescents, whose gender identity does not correspond to the gender they were assigned at birth, may pursue transition-related medical interventions including puberty blockers, hormone therapy, and, more rarely, surgical interventions. Adolescent medical transition aims at preventing or altering the development of sexual characteristics to achieve the individual's gender embodiment goals. Given its purpose, the effectiveness of adolescent medical transition is defined by its ability to achieve the sought physiological outcomes—a standard undisputedly met. Offering transition-related medical care to adolescents is ethically justified regardless of proven mental health benefits, that is,

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regardless of whether it is proven that adolescent medical transition causes an improvement in mental health such as by reducing distress. However, associating effectiveness with mental health benefits, some authors have argued that adolescent medical transition's effectiveness is unproven and that, therefore, offering transition-related medical care to adolescents is unethical (SEGM 2021; Richards, Maxwell, and McCune 2019).

In this paper, I defend adolescent medical transition by analogy. Birth control, abortion, and adolescent medical transition are analogous insofar as they intervene on healthy physiological states such as puberty, sexual traits, fertility, and pregnancy, by reason of the person's fundamental self-conception and desired life. Scientific evidence of mental health benefits associated with birth control and abortion is also of relatively low quality under the standards of evidence-based medicine. However, birth control and abortion remain commonly understood as ethical and allowed on account of their effectiveness at preventing or terminating pregnancy. Tacitly acknowledging the importance of autonomy, debates on abortion and birth control's relationship to mental health have focused not on whether they are beneficial to mental health but on whether they cause substantial psychological harm—with leading professional bodies agreeing that they do not (Academy of Medical Royal Colleges 2011). Given the analogy of purpose between adolescent medical transition and reproductive health interventions and given their comparable evidentiary standing both in terms of mental health benefits and adverse effects, adolescent medical transition should be also considered effective and ethically justified. The limited evidence base surrounding the mental health benefits of adolescent medical transition does not make it unethical. Given the recognized importance of access to birth control and abortion, disallowing adolescent medical transition violates the ethical norm against double standards. While governments may impose specific requirements for accessing adolescent medical transition without creating a double standard, these conditions must be no more burdensome than those on minors' access to reproductive health. Furthermore, the suggestion that autonomy shifts the burden of evidence onto those wishing to restrict access is ethically meaningful beyond the proposed analogy.

This paper contributes to an emerging bioethical literature on trans youth care that recognizes the centrality of autonomy and defends access to care regardless of proven mental health benefits, thereby displacing the burden of proof onto opponents of gender-affirming care (Wenner and George 2021; Rowland 2021). I aim to convince readers who agree that

birth control and abortion are ethical and should be widely accessible to adolescents who desire them. One of my main intended audiences are feminists who express a commitment to reproductive rights, but who are undecided or opposed to adolescent medical transition. I proceed from the intuition that readers will and should more readily accept adolescent medical transition than abandon their views on reproductive health. Readers who disagree with the premise that birth control and abortion are ethical are unlikely to find my argument convincing.

The paper is divided into three sections. First, I introduce recent debates around adolescent medical transition, review the law and ethics of reproductive healthcare, and discuss the ethical norm against double standards. Second, I argue that adolescent medical transition serves an analogous purpose to birth control and abortion. Third, I survey the evidentiary similarities between adolescent medical transition and reproductive healthcare, and consider whether there are overriding risks that would justify withholding adolescent medical transition.

1. POLITICO-ETHICAL BACKGROUND

In this section, I briefly introduce contemporary ethical debates on the effectiveness of adolescent medical transition, explore the ethical and juridical bases of access to reproductive healthcare, and discuss the role of double standards in bioethics and law.

1.1 Adolescent medical transition

Transition-related medical care has long been offered to adolescents—youths who have begun puberty but not yet reached the age of majority—and is currently the object of consensus in trans health (E. Coleman et al. 2012; Hembree et al. 2017; Lopez et al. 2017; Telfer et al. 2018; The Lancet 2018; Murchison 2016; Oliphant et al. 2018; Rafferty 2018; St. Amand and Ehrensaft 2018; The Lancet Child & Adolescent Health 2021; Dwyer and Greenspan 2021; Moral-Martos et al. 2022). Despite disagreements over timing and approaches to assessment, authors in the trans heath literature agree that transition-related interventions should be offered to help trans adolescents achieve their gender embodiment goals and mitigate negative mental health outcomes. However, a stark opposition to adolescent medical transition has erupted in recent years, claiming that it is experimental and harmful, that its mental health benefits are unproven, and that we are in the midst of an epidemic of youths falsely believing that they are trans. Although many authors have vigorously rebutted

these arguments, access to adolescent medical transition has declined as a result (Restar 2019; Ashley 2020; 2019b; 2019d; Arnoldussen et al. 2020; Kennedy 2020; Clark and Virani 2021; Giordano and Holm 2020; de Vries et al. 2021). In the United States, Arkansas has passed a law criminalizing adolescent medical transition and many states are considering laws to the same effect (Demillo and Crary 2021; McGuire 2021). The Arkansas law was since blocked by a federal judge pending a final determination on the merits (Yurcaba 2021). In Sweden, the Astrid Lindgren Children's Hospital has discontinued all transition-related medical care for those under 16 years old, a decision that other clinics soon followed (Gauffin and Norgren 2021). The Swedish policy change came in the wake of the *Bell v. Tavistock* judgment of the High Court of England and Wales, which questioned the effectiveness of puberty blockers due to conflicting evidence of whether they confer a mental health benefit.[1] The judgment, which restricted adolescents' capacity to consent to puberty blockers, was decried by trans health associations and overturned on appeal (WPATH et al. 2020; Surat Knan 2020).[2] The effectiveness of adolescent medical transition was subsequently questioned in evidence reviews of puberty blockers and hormone therapy published by the National Institute for Health and Care Excellence (NICE 2020b; 2020a). The reports were prepared in support of the England-wide review of gender identity services for minors led by Dr. Hilary Cass. Both reviews looked at mental health benefits and concluded that evidence of effectiveness was of very low quality under the GRADE framework for summarizing evidence (Guyatt et al. 2008). As I argue in this paper, understanding effectiveness in terms of psychological benefits mischaracterizes the purpose of adolescent medical transition.

1.2 Reproductive healthcare

Despite significant attempts to curtail birth control and abortion in recent years, their importance for adolescents remains relatively well accepted. For the purposes of this paper, I group birth control and abortion under the term 'reproductive healthcare'. Birth control and abortion have long been accessible in many countries, and are constitutionally protected in some due to their relationship to individual autonomy. In the United States, courts recognize that reproductive healthcare belongs to a zone of privacy within which individuals may exercise their autonomy.[3] These rights apply to adolescents as well, who are entitled to constitutional rights despite their age.[4] More burdensome conditions of access to reproductive health may be applied to minors, however, and many states require parental

consent or notice (Guttmacher Institute 2021). Since states cannot create an absolute bar on abortion through parents, a process must be in place to obtain an abortion notwithstanding parental objection, including the possibility of arguing that it is in the adolescent's best interests.[5] While decisions mention the potential distress, social problems, and physical risks associated with undesired pregnancies, the Supreme Court has not required evidence of mental health benefits. Fundamentally, it is autonomy that justifies access to reproductive health.

Various jurisdictions also protect access to reproductive health based on autonomy.[6] Many other jurisdictions allow reproductive health but disclaim any right to it (Scott 2016). Yet other countries prohibit birth control or abortion altogether. In 2017, 34% of countries allowed abortion upon request, 37% allowed it for economic or social reasons, and 69% allowed it to preserve the pregnant person's mental health (United Nations Department of Economic and Social Affairs 2020). Access often extends to minors, such as in the United Kingdom.[7] Requiring a risk to mental health has rightly been criticized on feminist grounds (Leslie 2010). However, the scientific literature does not offer guidance on how to accurately assess who would be benefitted from abortion, and assessments must inevitably rely on the pregnant person's reported feelings and self-concept (Cook et al. 2006). Relatively few are denied an abortion, suggesting that autonomy remains central despite mental health notionally serving as a justification for access (Leslie 2010; Douglas, Black, and de Costa 2013). Testifying before New Zealand's 1977 Royal Commission on reproductive health, prominent psychiatry professor John Scott Werry explained that there was "little doubt that most abortions are performed 'on compassionate grounds masquerading as psychiatric'" (Leslie 2010). While conditions of access for minors vary, the *Convention on the Rights of the Child* establishes that "the views of the child being given due weight in accordance with the age and maturity of the child" even if they may not consent on their own (United Nations 1989).

1.3 Justice, equality, and double standards

Double standards are unethical. Applying different standards to comparable situations is a paradigmatic form of injustice, violating the formal principle of justice that likes must be treated alike (Gosepath 2021). The ethical norm against double standards is recognized in the bioethical principle of justice (Beauchamp and Childress 2013). The dominant approach to bioethics, known as principlism, involves balancing

four principles: autonomy, nonmaleficence, beneficence, and justice. Throughout the bioethics literature, authors point out double standards as an ethical wrong to be avoided (Flanigan 2016; Barclay 2008; Tangwa 2001; Kottow 2003; Ashley 2019a). Double standards are also relevant to anti-discrimination law. Proving discrimination typically involves showing that a person or group was disadvantaged because of irrelevant characteristics, that similarly-situated persons weren't treated alike.[8] While double standards do not exhaust the breadth of inequality, they are one of its paradigmatic forms. Identifying double standards can reveal the hypocrisy of governments who try to hide their discrimination behind the difficulty of balancing competing ethical considerations.

If adolescent medical transition is analogous to reproductive healthcare, requiring evidence of mental health benefits for only one of them would be a double standard. Because of autonomy, evidence of mental health benefits are not required of birth control and abortion and it is unclear whether such evidence could be mustered—as discussed in the section on scientific evidence below. Autonomy outweighs concerns regarding beneficence and non-maleficence surrounding reproductive health. By demonstrating a double standard, I circumvent potential disputes around how to best balance autonomy against other bioethical principles. If a balance is acceptable for reproductive health, so should it be for adolescent medical transition.

2. ANALOGOUS PURPOSES

In this section, I argue that the purpose of adolescent medical transition lies in preventing or bringing about changes to sexual characteristics. I analogize it to birth control and abortion, which have for purpose the prevention or termination of pregnancy. Reproductive health and adolescent medical transition share three important features. First, they are not predicated on illness. Second, they are legitimated by autonomy over fundamental aspects of personal identity. And third, they are closely tied to considerations of social equality. After discussing these three features, I consider and rebut the counterarguments that transition-related interventions differ from reproductive health care because they are irreversible, more analogous to elective surgical sterilization, or because being trans or having gender dysphoria is a mental disorder. Since adolescent medical transition is analogous to reproductive healthcare, it is defined by how well it brings about changes that are aligned with the adolescent's gender embodiment goals. While impacts on mental health

are relevant to the ethical analysis—for instance, overwhelming risk could outweigh autonomy—these impacts do not pertain to effectiveness, which regards the purpose of an intervention.

2.1 No illness to fix

In conventional medical care, patients go to healthcare professionals to have their illness diagnosed. While they may have opinions on treatment, their ultimate goal is not to obtain a particular intervention but rather to have the underlying condition and its symptoms treated.[9] A rather different picture arises in reproductive and trans health. Someone who is fertile and does not wish to become pregnant or is pregnant and does not wish to carry a pregnancy to term asks a doctor for birth control or abortion. Someone whose current or developing body conflicts with their gendered self-image, which may or may not correspond to conventional understandings of their gender (Ashley 2019c; Bradford and Syed 2019; Vipond 2015), asks a doctor for puberty blockers, hormone therapy, or surgical care. These patients are typically uninterested in the diagnostic process, instead wanting a specific intervention (Ashley 2019a; MacKinnon et al. 2020; Frohard-Dourlent, Coronel Villalobos, and Sacwyc 2017; Fraser, Brady, and Wilson 2021). Although the person may be distressed, suicidal, or traumatized, they may also not be. Negative emotions are understandable, since their embodiment conflicts with how they understand themselves and the life they wish to lead. However, these emotions are not the *raison d'être* of intervention—few who ask whether birth control is effective are asking about its mental health benefits.

Contrasting with conventional medical care, we might call interventions integral to self-definition 'definitional medical care'. Conventional medical care is pursued as a treatment for an underlying illness or injury. Definitional medical care refers to interventions that are pursued as a means of defining or actualizing fundamental aspects of personal identity. This picture of birth control, abortion, and adolescent medical transition as definitional medical care places them at the margin of medicine, eschewing the conventional understanding of medical care as a treatment for an illness or injury. While relying on medical professionals to dispense desired interventions, definitional medical care resists the conceptual medicalization of patients as having a medical condition (Conrad 1992). There is nothing intrinsically unhealthy about being fertile, pregnant, trans, undergoing puberty, or having certain sexual characteristics. While birth control, abortion, and medical transition can involve conditions such as

preeclampsia or breast cancer, they are routinely pursued regardless of any identifiable condition (Horncastle 2018). The fact that they 'mess with' natural processes and healthy bodies is a major cause of opposition to reproductive healthcare and medical transition—with the latter sometimes being framed as mutilation (Koyama 2003; Fernández Romero 2021; Ashley 2019e; 2019a).

Distress does not entail illness, and health does not offer a guarantee against profound dissatisfaction. Most of life's suffering is unrelated to illness and injury, with unwanted pregnancies providing clear evidence that distress can be found in nature's ways. As disability studies has long emphasized, societal conceptions of the natural tell us little about wellbeing. Bodies cast as unnatural, such as disabled bodies, may be a source of happiness and pride (Clare 2017; Johnson 2006). And just the same, bodies may 'naturally' develop in worrisome and even traumatic ways, in ways that fundamentally clash with people's self-understanding and desired life. Among trans people, this often manifests in a visceral feeling of disconnect or alienation from one's body, as though certain parts of their body do not belong to them (Ramachandran and McGeoch 2008; Straayer 2020). Trans people also report phantom sensations of body parts that 'feel' present despite not being there or being there under a different morphology (Pulice-Farrow, Cusack, and Galupo 2020; Ramachandran and McGeoch 2008; Straayer 2020). Bodies that are unwanted or disconnected from someone's gendered self-image can be alienating and deeply traumatic (Travers 2018). These experiences offer parallels to the trauma some experience during unwanted pregnancies. Birth control, abortion, and transition-related interventions similarly privilege individuals' sense of self over the purported naturalness of the healthy body.

2.2 Autonomy over oneself

Decisions regarding gender and the family fall within individuals' sphere of autonomy. Within the spectrum of autonomy, decisions regarding core aspects of personal identity deserve the utmost respect, going to the heart of how we live in and relate to the world. To deny people's autonomy over such matters is to deny their ability to define who they are and live out this self-understanding. In addition to undermining sovereignty over oneself, refusing to give uptake to someone's self-understanding at these critical junctures risks impairing their self-respect and self-trust (Mackenzie

2017; Kukla 2021; Lindemann 2009; Wallace and Russell 2013). Few routine medical decisions have such weighty implications for the patient.

Gender is a pivotal component of personal identity. One of the most pervasive social categorizations, it seeps through the totality of our social experiences. As philosopher Catriona Mackenzie points out in the context of pregnancy, gender embodiment "affects a woman's mode of being-in-the-world both physically and morally and, as a consequence, re-shapes her sense of self" (Mackenzie 1992). Gender governs the bathrooms we use, the sports teams we play on. It determines whether we are boyfriend, wife, mother, or nibling. It frames the social norms applied to us and shapes our experiences of sexism. Gender is so significant that trans people are willing to experience brutal forms of oppression to live in a way that feels authentic. The psychosocial significance of gender is difficult to overstate. Parenthood, the province of birth control and abortion, is also of great significance, standing as one of the most meaningful social relations we can create. Giving birth, an experience inextricable from the social apparatus of gender, involves creating new life and assuming moral responsibility for its existence (Mackenzie 1992). Gender, like pregnancy, is an embodied identity. Bodily form is one of the manifold ways gender is expressed and actualized, and it is through our body that we interact with the world as gendered beings.

In *Planned Parenthood v. Casey* (1992), the U.S. Supreme Court offered a compelling defense of the right to abortion, explaining that some decisions are so integral to personal identity that they must be afforded constitutional protection:

> These matters [*i.e.* marriage, procreation, contraception, family relationships, child rearing, and education], involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Courts have recognized the importance of gender identity in equally strong terms. The European Court of Human Rights has described gender identity as "one of the most intimate areas of a person's private life" (*Van Kück v. Germany* 2003) whereas the High Court of England and Wales described medical transition as going "to the heart of an individual's identity" (*Bell*

v. Tavistock 2020). While *Casey*'s legal authoritativeness is imperiled by courts chipping away at *Roe v. Wade*, its articulation of the relationship between access to abortion and autonomy over fundamental aspects of personal identity remains poignant.

Puberty, fertility, pregnancy, and sexual characteristics are not merely biological processes, but also "an active process of shaping for oneself a bodily and a moral perspective" (Mackenzie 1992). The decision to undergo medical transition, like the decision to undergo an abortion, fundamentally shapes what life you lead and what kind of person you get to be. Replaced in this context, the decision becomes far more understandable. Wanting to 'be yourself' is a legitimate desire, one that deserves respect and support even if it comes at the cost of marginalization. Better sad as yourself than happy as someone else. Though not all think that way, many do (Turban et al. 2021). Given the deep social and psychological significance of gender, why wouldn't trans people want their body to reflect their gendered self-understanding? Why wouldn't they want others to see a body that reflects this self-understanding? Given the deep social and psychological significance of parenthood, why wouldn't people with unwanted pregnancies seek an abortion? Prohibiting access to reproductive or medical transition is tantamount to rejecting someone's self-understanding, imposing an embodied identity onto them, and denying their right to self-define.

Gender and parenthood are no less significant in adolescence and carry the full stake of self-definition through it. Although judicial treatment of medical decision-making varies by age, autonomy does not evaporate below the age of majority.[10] Pursuant to the *Convention on the Rights of the Child*, adolescents have a right to their identity and to having their views granted due weight in accordance to their age and maturity (United Nations 1989; UN Committee on the Rights of the Child 2016; 2013; Tobin and Todres 2019). Youths matter in the present; they are not merely adults-in-waiting (Kukla 2020; Valentine 2011; Mühlbacher and Sutterlüty 2019). Preventing adolescents from self-defining and living out their personal identity poses unique risks to their self-trust and socio-moral development, as well as having the potential to generate shame and attachment dysfunction (Mackenzie 2017; Kukla 2021; Wallace and Russell 2013; Mullin 2014; Turban, Beckwith, et al. 2020; McLean and Pasupathi 2012; Wiley and Berman 2013).

2.3 Social equality

Reproductive health and transition-related interventions are rife with implications for social equality. Each contributes to the full and equal access to civil society of women and trans people. Some men and non-binary people give birth; nonetheless, pregnancy is overwhelmingly experienced by women (Riggs et al. 2021; Moseson et al. 2021; Charlton et al. 2021). The social burden of parenthood lies disproportionately on birthing parents, contributing to gender inequality. Caregiving responsibilities are associated with wage and employment disparities (A. Earle and Heymann 2012; Felfe 2012). Despite legal protections, pregnancy is a major site of employment discrimination (Byron and Roscigno 2014). For adolescents, pregnancy can mean being deprived of education, which severely hinders future life prospects (Lall 2007). Teenage pregnancy and parenthood are heavily stigmatized (Ellis-Sloan 2014; Yardley 2008). Ensuring access to birth control and abortion is crucial to gender equality (Sherwin 1991).

Access to adolescent medical transition also carries deep consequences for equality. Trans communities are deeply marginalized (James et al. 2016). Discrimination towards trans people is common and impacts access to education, employment, and services. In Canada, more than half of trans people have avoided public spaces out of fear of harassment, being perceived as trans, or being outed (Bauer and Scheim 2015; Trans PULSE Canada 2020). Trans adolescents typically want to be recognized as their gender, and may struggle to take their place in society without recognition. Trans youths often avoid school or drop out because of marginalization, including due to misgendering and gender misrecognition (Scheim, Bauer, and Pyne 2014; Greytak, Kosciw, and Diaz 2009; Ashley 2017). Gender misrecognition can also impair social relationships by causing resentment towards peers, doctors, parents, and society for their role in the adolescent's socially discordant experience of gender. Because social gendering is often based on appearances, access to transition-related medical care facilitates gender recognition. Many jurisdictions require medical transition to change birth certificates or participate in sports in one's gender. While these requirements are unjust, lack of access to medical transition compounds their injustice. Of course, not all trans adolescents seek transition-related interventions that will help them blend into society; trans adolescents' gender embodiment goals often belie predominant conceptions of male and female bodies (Ashley 2019c; Bradford and Syed 2019; Vipond 2015). Access to medical transition is crucial for those adolescents as well, due to its role in self-recognition. Feeling at home in your body enhances

confidence and self-respect, setting the stage for full and equal participation in civil society. Like reproductive health, adolescent medical transition is not solely a matter of medical autonomy but also one of socio-political agency and group equality.

2.4 Counterarguments

At this point, some may argue that despite similarities, reproductive healthcare and transition-related interventions are nonetheless different because the latter is irreversible, because transition-related surgeries are more analogous to elective surgical sterilization, or because being trans or having gender dysphoria is a mental disorder. However, neither argument sets medical transition apart from reproductive health.

2.4.1 'Transition-related healthcare is irreversible'

Reversibility alone does not offer a sufficient reason to distinguish between reproductive healthcare and medical transition as a matter of purpose and effectiveness. If no one ever regretted an irreversible intervention, irreversibility would hardly count against offering it. An irreversible good is of no moral concern. Reversibility matters because of the possibility of regret, which relates to the balance of risk and benefits—something I discuss in the last section of the paper. The irreversibility of transition-related interventions is often overstated, whereas the irreversibility of withholding them is routinely understated. Endogenous puberty is difficult to reverse, and many trans individuals undergo lengthy and expensive interventions to alter the sexual characteristics they developed during puberty. By contrast, puberty blockers are far more reversible, whereas hormone therapy is of comparable reversibility—essentially inducing puberty (Ashley 2019c; George and Wenner 2019). Nonetheless, few would claim that youths should be disallowed from undergoing endogenous puberty on account of irreversibility. While surgeries are more difficult to reverse, surgical transition and re-transition—a reversal of transition that may or may not be accompanied by regret or a shift in gender identity—are largely symmetrical. Reversing surgical transition is of the same order of difficulty as surgically transitioning in the first place (Djordjevic et al. 2016). People who wish to medically re-transition are in a similar position as people who wish to medically transition. Centring the needs of those who would re-transition while downplaying those trans people seeking transition manifests a problematic preference for cisnormative lives (Ashley 2019c; George and Wenner 2019). What makes surgical scars on

a cisgender person's body more undesirable than a trans person having a body that clashes with their self-understanding?

Like adolescent medical transition, reproductive healthcare lies on a spectrum of reversibility. Birth control can be reversed relatively easily, fertility returning within a few months. Abortions, by contrast, are not as easily reversed. You can become pregnant again but, as with re-transition, the earlier intervention cannot be un-experienced. From a social, religious, and psychological standpoint, you will always have had an abortion. Abortion is socially stigmatized in many places (Kimport 2012). In some religious sects, abortions are compared to murder. Individuals who regret their abortion may experience it as affectively and psychologically irreversible—a fact often weaponized by anti-abortion movements (Kimport 2012; Watson 2014). This perception of irreversibility is not unlike the dissatisfaction that individuals who medically re-transition can have with their resulting body—though that dissatisfaction should not be overstated, since bodies that have not transitioned also often fall short of what we would wish for. Despite irreversible aspects, regretting abortion is rare (Rocca et al. 2015). As is regretting medical transition (Bustos et al. 2021; Olson et al. 2022; Davies et al. 2019; Blasdel et al. 2018; Wiepjes et al. 2018; Deutsch 2012; van de Grift et al. 2018; Brik et al. 2020; Pfäfflin 1993; Dhejne et al. 2014; Vujovic et al. 2009; Judge et al. 2014; Narayan et al. 2021; Ashley 2020)retransition. This is not to say that the difficulty of reversing medical transition is immaterial. However, it does not set transition-related healthcare apart from abortion and responses to it must therefore be justified based on the same standard. Reproductive healthcare and transition-related healthcare cannot be distinguished on account of (ir)reversibility; both are partly irreversible, and both are rarely regretted.

2.4.2 'Transition-related surgeries are analogous to elective surgical sterilization'

At this juncture, critics could concede that puberty blockers and/or hormone therapy are analogous to birth control and abortion but suggest that elective surgical sterilization is a more appropriate analogy for transition-related surgeries. While part of reproductive healthcare, elective sterilization is typically unavailable until later in adulthood. Elective sterilization is less reversible and time-sensitive than abortion, much like transition-related surgeries. "You can always wait until you are older," goes the argument. Accordingly, puberty blockers and/or hormone therapy should remain available in adolescence but there would be no double

standard in delaying surgeries since elective sterilization is also unavailable until adulthood. In my view, this counter-analogy does not hold water.

The counterargument is easily rebutted for non-genital surgeries such as mastectomies, breast augmentation surgery, and facial feminization surgery. For those surgeries, surgical interventions for gynecomastia offer an even closer analogy than elective surgical sterilization. Mastectomy, which is sought by many transmasculine individuals, is often performed for gynecomastia. We do not ask cisgender boys who develop breasts to wait until adulthood for surgeries (Nuzzi et al. 2018). Asking it of trans adolescents would betray a double standard and engage my central argument. It is therefore unnecessary to determine whether non-genital surgeries are closer to elective sterilization than to birth control or abortion.

Turning to genital surgeries, a few preliminary observations are in order. Metoidioplasty, orchiectomy, vaginoplasty, hysterectomy, and phalloplasty are typically not offered until the age of majority (E. Coleman et al. 2012). While they are occasionally offered to a few older adolescents, adolescent genital surgeries remain rare (Milrod and Karasic 2017). Accepting this limited counterargument would not radically challenge current practices. It is also open to question whether delaying elective surgical sterilization until later in adulthood is justified. I share the view that elective sterilization should be more readily available and that barriers to access reflect much of the same paternalistic and patriarchal animus that plagues birth control and abortion (Denbow 2014; Campbell 2003). Ongoing sterilization of disabled minors without their consent suggests that autonomy may not be the primary reason for gatekeeping and delaying elective sterilization (Pyne 2017). The counter-analogy will likely not be compelling to those who favour greater access to elective sterilization, since delaying elective sterilization until adulthood may itself be a double standard. Moreover, elective sterilization might be disallowed until later in adulthood due to overriding risks rather than lack of proven benefits, given the social context I discuss below. In other words, it may be subject to the same burden of justification as birth control and abortion and simply have discharged it. If that is the case, my argument would still hold.

We have good reasons to reject the counter-analogy. Elective surgical sterilization differs from transition-related surgeries in important regards. Elective sterilization is less time-sensitive than abortion because alternatives exist for those who do not want to become pregnant while being sexually active. Elective sterilization, while also an expression of commitment to one's childfree identity, is often typically because of concerns over the

reliability and side-effects of alternative forms of birth control (Campbell 2003). Condoms, hormonal birth control, and intrauterine devices all prevent intercourse from resulting in pregnancy, with varying effectiveness and side-effect profiles. Delaying elective sterilization does not prevent someone from living a childfree life while sexually active. Denying someone their preferred form of birth control, while undesirable, is not equivalent to denying reproductive choice altogether—whether in terms of autonomy or equality. If alternative forms of birth control did not exist, the ethics of delaying elective sterilization would be vastly different.

By contrast, no alternatives exist to transition-related surgeries. No pills that temporarily grow penises or vaginas, or otherwise achieve results comparable to surgeries. Even chest binding only serves so long as the person is clothed. Delaying transition-related surgeries, whether genital or non-genital, goes beyond imposing a choice of side-effects and prevents the adolescent from feeling at home in their own body and fully living out their gender. This imposition has significant implications for safety and comfort in public washrooms and changing rooms, sexual and romantic relationships, sexual satisfaction, and gender self-understanding. The everyday significance of delays is even starker in the case of non-genital surgeries, since they involve traits that are typically visible in daily interactions. Saying transition-related surgeries aren't time-sensitive because you can always have them in adulthood makes little more sense than saying birth control and abortion aren't time-sensitive because you can always give the child up for adoption. In this regard, the analogy between elective sterilization and transition-related surgeries falls apart.

Another significant difference between elective sterilization and transition-related surgeries lies in social context. Doctors have long been reluctant to perform surgeries requested by trans people, and access to medical transition remains difficult today (Meyerowitz 2004; Vipond 2015; MacKinnon et al. 2020). By contrast, there is a long and ongoing history of doctors coercing, misleading, and forcing Black, Indigenous, immigrant, and disabled women to undergo sterilization for eugenic purposes (Hansen and King 2013). The Senate of Canada reports that hundreds of Indigenous women were sterilized without their free and informed consent, and many immigrant women may have been sterilized without consent at a facility overseen by U.S. Immigration and Customs Enforcement—all in recent years (Standing Senate Committee on Human Rights 2021; Olivares and Washington 2020). Sterilization's disturbing role in white supremacy, cultural genocide, and ableist violence cannot

be forgotten. Elective sterilization sits at the uneasy juncture between eugenic ideologies that favour sterilization of those deemed undesirable and patriarchal attitudes that see motherhood as women's nature and duty. This social context has led some feminists who are favourable to elective sterilization to accept procedural safeguards such as waiting periods as burdensome but necessary protections against the severe risk of coerced sterilization (Denbow 2014). Current barriers may be unjustified, but having some safeguards seems wise. Such stark tensions do not arise with regards to transition-related care. Despite occasional claims to the contrary, there is no compelling evidence that adolescents are being coerced or forced into medical transition. While social pressures have been alleged, they are not comparable to the systematic and violent imposition of sterilization on marginalized groups, often with the knowledge and support of governments and the scientific community. If anything, the historical trend has been rather uniformly against access to medical transition. With regards to time-sensitivity and social context, transition-related surgeries differ in important respects from elective sterilization.

2.4.3 'Being trans is a mental disorder'

According to another argument, adolescent medical transition would be disanalogous to birth control and abortion because being trans or having gender dysphoria is a mental disorder. However, we have reasons to doubt whether trans subjectivities are disordered. According to the International Classification of Diseases (ICD-11, 2019), Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) and Standards of Care of the World Professional Association for Transgender Health (SOC7, 2012), being trans is a desirable part of human diversity and not a mental disorder (World Health Organisation 2018; American Psychiatric Association 2013; E. Coleman et al. 2012). Most people have a gender identity. That identity does not always correspond to the gender the person was assigned at birth—making them trans. Many trans people experience bodily gender dysphoria, a form of distress or discomfort due to the non-correspondence between someone's gendered self-image and bodily traits (Pulice-Farrow, Cusack, and Galupo 2020; Ashley 2021). Gender dysphoria was preserved as a mental disorder in the DSM-5, but all trans-related diagnoses were removed from the chapter on mental disorders in the more recent ICD-11. Preserving the DSM-5 category of gender dysphoria may have been partly motivated by a desire to ensure continued insurance coverage for transition-related medical care (Ehrbar 2010; Knudson, De Cuypere,

and Bockting 2010; Davy 2015). Under the SOC7, gender dysphoria is conceptualized more broadly as a psychological phenomenon rather than as a diagnostic category (Ashley 2021).

The classification of mental disorders does not reflect natural categories that exist beyond the reach of social influence. Many realities have been classified as disordered out of prejudice, homosexuality being the best-known example (Conrad and Schneider 1992). Categorizations as mental disorders are inextricable from judgments of naturalness and desirability (Szasz 1974; Foucault 2007). Before the DSM-5, bereavement precluded a diagnosis of depression unless it was considered disproportionate or too long (Sabin and Daniels 2017). Bereavement was mutually exclusive with depression because sadness is considered a 'normal' reaction to distressing circumstances (Iglewicz et al. 2013). The exception's removal from the DSM-5 was criticized as medicalizing normal sorrow (Iglewicz et al. 2013; Pies 2014; Horwitz and Wakefield 2012). The history of the bereavement exception reveals how judgments of normalcy and naturalness underpin mental disorder classifications.

Whether gender dysphoria is a mental disorder depends on whether we consider being trans and having a corresponding gendered self-image normal. Many scholars and advocates argue that gender dysphoria should not be considered a mental disorder (Suess, Espineira, and Walters 2014; Gherovici 2017; Davy, Sørlie, and Schwend 2018). Gender dysphoria is an understandable reaction to the unusual circumstance of having bodily traits that conflict with your gendered self-image (Ashley 2021). Imagine a cis man waking up in the body of a cis woman, *Freaky Friday*-style (Waters 2003). Wouldn't they be distressed or traumatized? Wouldn't negative emotional reactions be understandable? It is not clear why gender dysphoria should be pathologized when other forms of situational distress aren't, unless we think there is something inherently abnormal or disordered about being trans. Gender dysphoria does not have to be a mental disorder and, if it is, it is one akin to depressive bereavement.

In any case, the psychopathologization of gender dysphoria does not set adolescent medical transition apart from reproductive healthcare. The desire not to have a child has long been psychopathologized. Psychoanalysts have interpreted adolescent abortion as self-hatred, hatred of the mother, divestment from Oedipal guilt, and maladjustment to adulthood (Grill 1985; Henker 1973; Remeikis 2001). Following in Freud's footsteps, anti-abortion movements have framed abortion as infanticide, accusing those who pursue them of being sociopathic or psychopathic (Davis

1990). The historical diagnosis of hysteria is intimately intertwined with an understanding of penile intercourse and pregnancy as the purpose of womanhood, serving as a pathway to psychopathologize seeking abortion (Maines 2001; Beisel and Kay 2004; Traister 2019). In an ambitious crossover, hysterical psychosis was once also posited as a source of gender dysphoria (shuster 2021). In the 1970s, the notion of 'post-abortion syndrome' was developed by anti-abortion advocates to pathologize reproductive health as a violation of women's nature (Ntontis 2020; Kelly 2014). Birth control is similarly taxed of contravening the 'feminine mystique' (Osberg 2020). The psychopathologization of adolescent medical transition is in good company.

To be clear, I am not arguing that people living with mental disorders do not deserve autonomy. On the contrary, I believe they deserve far greater autonomy than is usually afforded them. Rather, my argument is that bioethical balancing applies differently when interventions are pursued for their own sake rather than as a treatment for an underlying condition. If a medication did not appear to alleviate depression, routinely prescribing it for that purpose would be ethically questionable. Reproductive healthcare and transition-related interventions, however, do not operate under the same analytical frame. They are not pursued as psychiatric treatments for gender dysphoria or distress towards pregnancy, but to terminate pregnancy or alter sexual characteristics for their own sake.

3. SCIENTIFIC EVIDENCE

Adolescent medical transition is analogous to reproductive health and is effective by virtue of its effects on sexual characteristics. In this section, I argue that strong evidence of mental health benefits is not needed to justify transition-related care because such an evidentiary threshold is not applied to birth control and abortion. If stronger evidence of mental health benefits was required of definitional medical care, reproductive health would be disallowed. While overriding risk could outweigh autonomy, I review the available evidence and conclude that adolescent medical transition is not associated with substantial harm. Accordingly, adolescent medical transition is ethical and should remain available.

3.1 Mental health benefits

Evidence of mental health benefits from transition-related interventions falls short of the gold standard of evidence-based medicine, namely randomized controlled trials. The observational nature of available

evidence has been conflated with unproven effectiveness and marshalled against access to adolescent medical transition. Equating effectiveness with mental health benefits, the English National Institute for Health and Care Excellence (NICE) recently published reviews that described the evidence of mental health benefits from puberty blockers and hormone therapy as having 'very low certainty' (NICE 2020b; 2020a). The reviews, which did not include all relevant studies showing positive outcomes (van der Miesen et al. 2020; Turban, King, et al. 2020; Carmichael et al. 2021; Moore 2018; Grannis et al. 2021), employed the GRADE framework for summarizing evidence (Guyatt et al. 2008). As I explain in this subsection, the available observational evidence of mental health benefits is sufficiently strong to justify access to adolescent medical transition. However, more importantly, high-quality experimental evidence should not be required of adolescent medical transition since it is not required of other definitional medical interventions such as birth control and abortion. Autonomy suffices to create a *prima facie* right to adolescent medical transition, which can only be curtailed by proof of overriding risk.

The studies reviewed by NICE reported statistically significant improvements across various measures of mental health after initiating puberty blockers or hormone therapy. Puberty blockers improved depression by up to 40.4%, but did not significantly reduce anxiety, gender dysphoria, or body image issues (de Vries et al. 2011; Costa et al. 2015). The psychological benefits of puberty blockers should be framed in light of their function, which is to prevent or pause the development of undesired secondary sexual characteristics. Accordingly, we would expect them to prevent the degradation of mental health rather than directly improve it. For hormone therapy, studies found significant improvements across a wider range of mental health measures. After initiating hormone therapy, gender dysphoria scores were 74.3% lower; depression was 38.8% to 49.7% lower, anxiety was 49.5% lower, and quality of life scores increased by 13.8% (López de Lara et al. 2020; Kuper et al. 2020; Kaltiala et al. 2020; Achille et al. 2020; Allen et al. 2019). Among results that fell below statistical significance, none suggested a worsening of mental health. While NICE did not review surgical outcomes, the few available studies report mental health improvements (Mahfouda et al. 2019). In one study, chest gender dysphoria was 88.8% lower among trans adolescents who received a mastectomy (Olson-Kennedy et al. 2018). A study of young adults (mean age 19.2 years old) found slight improvements in psychosocial functioning and a 70.9% reduction of gender dysphoria after genital surgery (de Vries

et al. 2014). These studies echo studies on adult surgical outcomes, which overwhelmingly show improvements in mental health (Center for the Study of Inequality 2018).

According to NICE, these studies are of very low quality. They are not randomized controlled trials, meaning that they do not randomly allocate youths to either receive transition-related interventions or not. Instead, the studies look at how those who pursue medical transition improve over time or compare to others who did not receive them. Because of their methodology, it is possible that improvements are due to selection bias or regression to the mean. Regression to the mean would occur if youths initiated medical transition at their worst mental health; in that case, improvements could be due to naturally returning to baseline mental health. Given the extreme waitlists at many gender identity clinics—over 26 months in England—it is unlikely that initiating treatment happens to coincide with mental health fluctuations (Smith, Van Goozen, and Cohen-Kettenis 2001).[11] Sensitivity analyses conducted by new studies further suggest that unmeasured confounders are unlikely (Tordoff et al. 2022). Studies are also rated poorly because mental health measures are predominantly self-reported, which the GRADE framework looks unfavourably upon despite it being the norm in psychology.

Upholding randomized controlled trials as an evidentiary norm regardless of context underestimates the value of other methodologies. Evidence-based medicine and its focus on randomized controlled trials has been extensively criticized in the literature (Grossman and Mackenzie 2005; Deaton and Cartwright 2018; Kennedy-Martin et al. 2015; shuster 2016; Mykhalovskiy and Weir 2004). Evidence reviews should account for the pragmatic and ethical realities of science. If randomized controlled trials were required, many existing treatments would be ruled out. When studying highly desired interventions or measuring psychological outcomes, randomized controlled trials are often impractical or unethical (Grossman and Mackenzie 2005). Randomized controlled trials must hide whether the participant is receiving the intervention or not to avoid reporting bias, which is impossible for transition-related interventions due to their obvious physiological effects. Adolescents who more strongly wish to undergo a medical transition are less likely to accept randomization and more likely to leave the study if assigned to the control group, gravely undermining randomization. It would also be difficult or impossible to obtain ethics approval for a randomized controlled trial since one of the criteria for approval is genuine uncertainty in the scientific community

about whether an intervention is beneficial (Deutsch, Radix, and Reisner 2016; Freedman 1987; Emanuel 2000). Despite marginal disagreements, adolescent medical transition is subject to consensus (E. Coleman et al. 2012; Hembree et al. 2017; Lopez et al. 2017; Telfer et al. 2018; The Lancet 2018; Murchison 2016; Oliphant et al. 2018; Rafferty 2018; St. Amand and Ehrensaft 2018; The Lancet Child & Adolescent Health 2021; Dwyer and Greenspan 2021; Moral-Martos et al. 2022).

Under frameworks tailored to non-randomized studies, such as the Newcastle-Ottawa Quality Assessment Scale, evidence of mental health benefits would likely be assessed as moderate to high (Karalexi et al. 2020). While the methodologies of existing studies limit our ability to distinguish causation from correlation, other scientific evidence provides contextual clues. Gender affirmation is consistently correlated with improved mental health across a wide range of contexts, suggesting a causal relationship. Misgendering is associated with poor mental health (McLemore 2018; 2015; Restar et al. 2020; Bauer et al. 2015; Fontanari et al. 2020; Durwood, McLaughlin, and Olson 2017; Olson et al. 2016). Attempts to alter or discourage gender identity or expression are associated with psychological distress and suicidality (Turban, Beckwith, et al. 2020; Green et al. 2020). Inferring causation also agrees with prevailing scientific understandings of gender diversity as part of human diversity. Replaced in their full context, the mental health benefits of adolescent medical transition are adequately proven.

Yet even if mental health benefits were insufficiently evidenced, we should not conclude that adolescent medical transition should be curtailed. The decision to initiate transition-related interventions is a matter of self-definitional autonomy and deserves respect, just like reproductive decisions. Debates on access to birth control and abortion have implicitly acknowledged that autonomy provides sufficient justification. Instead of debating whether the interventions provide mental health benefits, anti-choice advocates have instead sought to prove that they are so harmful that autonomy must be overridden. If randomized controlled trials were required to justify definitional medical care, birth control and abortion would be disallowed. As with adolescent medical transition, randomized controlled trials of birth control and abortion are impractical and unethical and have, therefore, not been conducted (American Psychological Association 2008; Academy of Medical Royal Colleges 2011). As a result, the same methodological limitations arise.

In 2011, the Academy of Medical Royal Colleges (2011) published a systematic review of the impact of abortion on mental health. The review surveyed studies comparing the mental health of individuals who had an abortion with that of individuals who delivered an unwanted pregnancy and concluded that they were of very poor to poor quality. Studies largely showed that those who received an abortion had poorer mental health—not better, as is the case for adolescent medical transition—but the correlation was no longer significant after controlling for previous mental health problems and other risk factors. Looking to contextual evidence, the review concluded that "rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth" (Academy of Medical Royal Colleges 2011). Earlier reviews by the American Psychological Association (2008) and American Psychiatric Association (2009) came to similar conclusions. The evidentiary basis for adolescent abortion is far worse; in the Academy of Medical Royal Colleges review, all but one study on adolescents were excluded on account of inappropriate methodologies. The sole study reviewed showed no significant correlation between abortion and mental health (Warren, Harvey, and Henderson 2010). Studies on adolescent birth control come to similar conclusions (Lewandowski, Duttge, and Meyer 2020; McKetta and Keyes 2019).

Despite no evidence of mental health benefits, the results of the Academy of Medical Royal Colleges were treated as vindicating access to abortion (Orr 2011). Continued access to birth control and abortion would perhaps be surprising if the conventional picture of medical care applied and reproductive healthcare served as treatment for an underlying psychological condition (Reardon 2018). Once we understand them as definitional medical care, however, asking for proof of mental health benefits—or, worse, proof by randomized controlled trial—seems unreasonable. The effectiveness of adolescent medical transition, birth control, and abortion is not defined by their mental health benefits, but by their ability to induce physiological changes intimately connected to the patient's personal identity. Autonomy prevailing, definitional medical care is presumptively allowed regardless of psychological benefits. Asking for randomized controlled trials of adolescent medical transition's mental health outcomes constitutes an unacceptable double standard.

3.2 No overriding risk

Autonomy has its limits. I accept that sufficient harm could justify restricting access to adolescent medical transition. *Ex hypothesi*, immediate and certain death would preclude offering any intervention outside of palliative care and medical aid in dying. In such a case, the bioethical principles of beneficence and non-maleficence would outweigh respect for autonomy for conventional and definitional medical care alike. When assessing whether risks associated with adolescent medical transition justify withholding access, the threshold cannot be set too low. Autonomy over fundamental aspects of personal identity is a weighty value. Moreover, we tolerate a host of risks in definitional medical care. We do not ban fertility counselling because of the risk of post-partum depression, nor hormonal birth control because it has greater side effects than condoms. The probability and magnitude of harm must be such that individuals must be deprived of their self-definitional capacities. Given the low risks associated with adolescent medical transition, this threshold is not met.

Risks associated with adolescent medical transition may be psychological or physiological. There is no evidence that adolescent medical transition causes overall psychological harm. While some individuals experience regret, the available evidence points to significant overall mental health benefits (Ashley 2020; NICE 2020b; 2020a; McQueen 2017; Mahfouda et al. 2019; 2017). At the physiological level, systematic reviews have concluded that puberty blockers and hormone therapy are reasonably safe (Mahfouda et al. 2017; Chew et al. 2018; Rew et al. 2021; Mahfouda et al. 2019; NICE 2020b; 2020a). Puberty blockers are associated with poorer age-matched bone density, and bone health improves upon initiating or resuming puberty and the risks of fracture are minor. According to one estimate, long-term pubertal suppression would increase the absolute risk of hip fracture over the next 5 to 10 years by 0.3% and the risk of other fractures by up to 1% (Pang et al. 2020). Hormone therapy is associated with a range of metabolic changes, in large part due to gender-based differences. Testosterone increases hemoglobin and hematocrit concentrations. While these may place individuals at risk of clinical complications, the resulting metabolic range is comparable to cisgender men—yet we do not ask cis men to reduce their testosterone levels. Estrogen is associated with an elevated risk of cardiovascular events, but the risk remains small and existing studies do not adequately control for the impact of lifestyle and mental health on cardiovascular health (Khan et al. 2019). Estrogenic hormonal therapy is associated with 2.3 to 4.3

venous thromboses per 1,000 person-years (PTPY) compared to 1.0 to 1.8 PTPY in the general population and 3.5 PTPY among cis women taking combined oral contraceptives (Khan et al. 2019; Kotamarti et al. 2021). Risk can be reduced to around 1.1 PTPY with transdermal estrogen (Kotamarti et al. 2021). A large-scale study from the Netherlands found that the increased mortality among trans adults was largely explained by causes unrelated to hormone therapy (de Blok et al. 2021). I am unaware of systematic reviews of the safety of transition-related surgeries, but it seems fair to assume that risks are comparable to similar surgeries such as prophylactic mastectomies, which are widely tolerated.

Regulatory approval confirms the relative safety of puberty blockers and hormone therapy. Leuprorelin, the most common puberty blocker, is an approved treatment for central precocious puberty. Its use for central precocious puberty and in adolescent medical transition is similar. It is prescribed in similar dosages and serves to delay the onset of puberty by up to several years in both cases. It is considered reasonably safe (Bangalore Krishna et al. 2019). Estrogen is considered safe as birth control and for menopause. Testosterone is considered safe for cisgender men who have low testosterone. Studies on the safety of puberty blockers and hormones for approved and off-label indications provide confirmatory evidence of the safety of adolescent medical transition. While there may be some effects we do not know yet, the side effects are sufficiently rare and small not to have been picked up over decades of diverse uses and are not considered reason enough to discontinue interventions for central precocious puberty, birth control, menopause, and low testosterone.

Reproductive health offers a strong basis of comparison for the risks of adolescent medical transition. Hormonal birth control is allowed despite having a similar risk profile to hormone therapy. Like hormone therapy, oral birth control is associated with elevated risks of venous thrombosis, myocardial infarction, and ischemic stroke (de Bastos et al. 2014; Roach et al. 2015; Dragoman et al. 2018; Stegeman et al. 2013). Like trans people, adolescents on oral birth control are prone to other risk factors such as smoking and high cholesterol, which can lead to overestimating risk (Paulus, Saint-Remy, and Jeanjean 2000). In both cases, harms have been overemphasized by opponents, a tendency also observed with abortion (Ashley 2020; Osberg 2020; Academy of Medical Royal Colleges 2011; P. K. Coleman 2011; Reardon 2018). Nonetheless, birth control and abortion are considered reasonably safe and allowed despite their side effects (Dragoman 2014).

In sum, transition-related interventions are reasonably safe. Their risk profile is comparable to common interventions, including birth control and abortion. Furthermore, adolescent medical transition shows a significant correlation with improved mental health. Opponents of adolescent medical transition bear the onus of showing that its harms outweigh autonomy. Based on the available evidence, it is unlikely that they will be able to discharge this burden of proof. The side effects of puberty blockers, hormone therapy, and transition-related surgeries fall well within the range allowed in medicine.

4. CONCLUSION

Adolescent medical transition is effective, fulfilling the physiological purpose of bringing the person's sexual characteristics and gendered self-image into closer alignment. Like abortion and birth control, transition-related interventions do not seek to cure an illness but instead reflect autonomy over fundamental aspects of personal identity. Transition-related interventions are forms of definitional medical care. Proof of mental health benefits is not required of reproductive healthcare, another form of definitional medical care. Asking such proof for adolescent medical transition is an unacceptable double standard. Since abortion and birth control are ethically justified, so is adolescent medical transition. Since abortion and birth control remain available, adolescent medical transition must remain available. The structure of my argument suggests that, from an ethical standpoint, those proposing restrictions on access to definitional medical care bear the burden of demonstrating that overriding harm would arise absent such restrictions. Requiring proof that withholding abortion would threaten the person's mental health or requiring a diagnosis ahead of transition-related interventions must be justified. Given the analogy between reproductive healthcare and adolescent medical transition, constitutional protections should extend to the latter. The U.S. Supreme Court's reasoning in *Planned Parenthood v. Casey* and other cases applies, *mutatis mutandis*, to transition-related interventions. Treating trans adolescents differently under due process would belie the very double standard that lies at the heart of my argument. In countries without constitutional protections of reproductive health, this double standard may provide additional evidence of discrimination and bolster claims under anti-discrimination statutes. Tolerating restrictions on adolescent medical transition may pave the way for curtailing access to birth control and abortion, an undesirable outcome (Ashley 2020; Giordano and

Holm 2020; Koyama 2003; Ntontis 2020; Osberg 2020; Reardon 2018). Requiring randomized controlled evidence of mental health benefits is a weapon easily turned against birth control and abortion. How decisional authority should be allocated in law is beyond the scope of this paper. However, the deeply intimate nature of medical transition suggests that great weight should be afforded to the adolescent's views even when they are not the ultimate decisionmaker as a matter of law (Ashley 2019a). Privileging adolescents' understanding of their own gender and gendered embodiment goals accords with the right to identity enshrined in the UN *Convention on the Rights of the Child* (United Nations 1989; UN Committee on the Rights of the Child 2016; 2013; Tobin and Todres 2019). Burdens on the exercise of trans adolescents' autonomy may violate legal protections and could create a double standard with how access to birth control and abortion is managed.

For researchers, my argument suggests that studies should move beyond whether transition-related interventions confer mental health benefits and place greater focus on how to best meet individual embodiment goals. Effectiveness is a function of gendered embodiment goals, and trans adolescents deserve interventions that are tailored to their unique experiences of gender. While research on mental health benefits is valuable, it is not the *sine qua non* of clinical ethics. Unfortunately, the politically controversial nature of trans youth care has meant that studies of mental health benefits tend to be privileged over studies that aim to individualize and improve hormonal and surgical regimens.

NOTES

1. *Bell v. Tavistock*, [2020] EWHC 3274 (High Court of England and Wales).
2. *Bell v. Tavistock*, [2021] EWCA Civ 1363 (Court of Appeal of England and Wales).
3. *Griswold v. State of Connecticut*, 381 U.S. 479 (1965) (Supreme Court of the United States); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (Supreme Court of the United States); *Roe v. Wade*, 410 U.S. 113 (1973) (Supreme Court of the United States); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (Supreme Court of the United States).
4. *Carey v. Population Services International*, 431 U.S. 678 (1977) (Supreme Court of the United States); *Bellotti v. Baird*, 443 U.S. 622 (1979) (Supreme Court of the United States).
5. *Bellotti v. Baird*, 443 U.S. 622 (1979) (Supreme Court of the United States); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (Supreme Court of the United States).

6. For example, *R v. Morgentaler*, [1988] 1 SCR 30 (Supreme Court of Canada).
7. *Abortion Act 1967*, c. 87 (United Kingdom); *Gillick v. West Norfolk and Wisbech AHA*, [1985] UKHL 7 (United Kingdom House of Lords); *R (Axon) v. Secretary of State for Health*, [2006] EWHC 37 (Admin) (High Court of England and Wales);
8. *Plyler v. Doe*, 457 U.S. 202 (1982) (Supreme Court of the United States); *Bostock v. Clayton County*, 590 U.S. ___ (2020) (Supreme Court of the United States); *Andrews v. Law Society of British Columbia*, [1989] 1 SCR 143 (Supreme Court of Canada); *Withler v. Canada*, 2011 SCC 12 (Supreme Court of Canada).
9. This picture of conventional medical care is an aspirational one that is widely shared in medicine. Reality often falls short of that aspiration. Marginalized communities' experiences of the medical system vastly differ from clinicians' perceptions of their own practices. Prejudices, bias, and ignorance among healthcare professionals often lead patients to research and diagnose their own conditions and seek out specific interventions. Self-diagnosis and treatment often do not reflect a fundamental disagreement with this picture of conventional medical care—as happens with definitional care—but rather result from doctors' ongoing failure to dispense care in a patient-centre manner. Conventional medical care also includes preventive interventions, which seek to prevent illness and disease. However, I do not discuss them in this paper since they are not relevant to my analogy.
10. *Carey v. Population Services International*, 431 U.S. 678 (1977) (Supreme Court of the United States); *Bellotti v. Baird*, 443 U.S. 622 (1979) (Supreme Court of the United States).
11. *Bell v. Tavistock*, [2020] EWHC 3274 (High Court of England and Wales).

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