Flawed reasoning on two dilemmas: a commentary on Baron and Dierckxsens (2021)

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ABSTRACT

A recent paper by Teresa Baron and Geoffrey Dierckxsens (2021) argues that puberty blockers and hormone therapy should be disallowed before adulthood on prudential and consent-related grounds. This response contends that their argument fails because it is predicated on unsupported premises and misinterpretations of the available evidence. There is no evidence that a large proportion of pubertal and postpubertal youths later discontinue medical transition. Meaningful assent is a viable and commonly accepted alternative to meaningful consent in paediatric bioethics. And finally, the primary purpose of transition-related interventions is to actualise youths' gendered self-image, not treat an underlying mental illness.

In their recent paper, 'Two dilemmas for medical ethics in the treatment of gender dysphoria in youth', Teresa Baron and Geoffrey Dierckxsens[1] suggest that puberty blockers and hormone therapy for transgender individuals should not be allowed before adulthood.[1] The authors support their position by arguing that gender dysphoria 'often' remits, because treatments should not be undertaken without meaningful consent, which trans youths allegedly cannot provide, and because it is uncertain whether physiological interventions are the best response to gender dysphoria. Their arguments are deeply flawed, relying on unsupported premises and misunderstandings of the evidence, which severely undermines their conclusion.

'DESISTANCE'

The authors argue that many if not most youths will grow up into cisgender adults, and should accordingly be disallowed from undergoing hormonal interventions. The claim that most trans youths eventually 'desist' from their gender identity has been strongly criticised in the literature for including youths who never expressed a gender identity that differs from the gender they were assigned at birth, for including a large number of youths lost to follow-up in the denominator, and for classifying trans people who are non-binary or do not want to medically transition as having 'desisted'.[2 3] While Baron and Dierckxsens acknowledge criticisms of the 80% figure for drastically overestimating the number of gender dysphoric youths who grow up not to be transgender, they suggest that another study by Steensma *et al* does not suffer from the same pitfalls.[4] However, the study never purported to assess the developmental pathways of gender dysphoric youths; the prospective study looked at gender non-conformity in a large cohort using parental reports of two items on the Child Behaviour Checklist. Youths were considered gender variant if parents answered that their child sometimes wished to be 'of opposite sex' or behaved 'like opposite sex'. The study deliberately cast a very broad net, labelling 5.7% of all youths as gender variant. Relying on the study to draw conclusions about trans youths reproduces in an even worse form of of the core problems with 'desistance' studies, namely conflating gender conformity, gender dysphoria and desire for hormonal transition. Moreover, childhood gender non-conformity was evaluated at a mean age of 7.48 years old, years before puberty blockers become available. Since we know that most youths who allegedly 'desist' do so before puberty, the study is wholly immaterial to the question of how many youths offered hormonal interventions will or would grow up cisgender.[5 6] The authors' core claim that gender dysphoria is likely to remit after puberty without endocrine treatment is wholly unsupported by evidence.

MEANINGFUL CONSENT

Baron and Dierckxsens argue that only serious medical indications can justify interventions in the absence of meaningful consent, and that meaningful consent cannot be given due to loss of fertility. The argument relies on an absolutist and binary view of consent that belies paediatric practices. Paediatric bioethics does not end with consent but must also accord due weight to the views of minors who lack capacity up to and including assent.[7] The UN Convention on the Rights of the Child expressly provides that even when they cannot provide meaningful consent, 'the views of the child (must be) given due weight in accordance with the age and maturity of the child.' This stance is enshrined in Canadian law, the notion of best interests of the child operating 'as a sliding scale of scrutiny, with the child's views becoming increasingly determinative depending on (their) maturity.'[8] Moreover, an absolute bar on hormonal interventions may well violate article 8 of the Convention, which protects 'the right of the child to preserve (their) identity.' This right to identity is not voided just because a child can re-establish their cultural ties on reaching adulthood, and similarly should not be dismissed just because trans adolescents could medically transition on reaching majority. Childhood studies have long cautioned against dismissing youths' current views and needs by treating them as adults-in-waiting.[9 10]

If a stringent criterion of meaningful consent is required, I wonder what the authors would think of minors who seek abortion or birth control before reaching Gillick competence. In those cases, many including myself would argue that requests followed by a careful assent process are enough to justify the procedure or medication, despite negligible evidence of psychological benefit.[11] Youths should be afforded the autonomy to, if not decide, at least share in decision making over what kind of parental or gendered life they will inhabit every single day for the foreseeable future.

Still on the matter of consent, Baron and Dierckxsens claim that 'good faith' requires us to include impacts on hormone therapy of fertility when considering the balance of risks and benefits of pubertal suppression. Rather than argue the point, they refer to Bell v. Tavistock as their sole support for the normative aspect of their claim. However, whether hormone therapy's impact on fertility is relevant to initiating puberty blockers, which typically occurs years before hormone therapy is offered, is at best deeply contentious. Youths who want genetically related children could simply decline to initiate hormone therapy later in adolescence or early adulthood, or discontinue it later on. The authors themselves suggest that the possibility of initiating hormonal therapy in adulthood sufficiently safeguards

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children's right to an open future. Why do they not extend the same reasoning to fertility? The fact that trans adolescents and adults do not end up wanting to delay or discontinue hormone therapy to recover their fertility is hardly a tar on consent; they simply chose an option that Baron and Dierckxsens disagree with.

TREATMENT GOALS AND DISTRESS

The authors conclude by questioning whether there are serious medical indications for gender-affirming care, pointing out that no reliable evidence shows that hormonal interventions are the best response to distress associated with gender dysphoria. In the absence of meaningful consent, the authors suggest that only such evidence would justify gender-affirming care. This view exemplifies the unspoken premise that gender dysphoria is a mental illness and that hormonal interventions serve to treat the psychiatric symptoms of the condition. The premise is a loaded one. Trans people have long argued against the psychopathologisation of trans identity, pointing out that distress is a normal reaction to the atypical situation of having a body that does not correspond to your gendered self-image.[12] Parallels may be drawn with unwanted pregnancies, which also are also sites of distress despite the 'naturalness' of pregnancy.

As pointed out earlier, evidence of mental health benefits associated with birth control and abortion is weak. Yet birth control and abortion remain allowed because their point is not to treat an underlying mental illness but rather give effect to people's deeply personal desire to have or not have children.[13] Like gender embodiment, having children is a hugely consequential matter that impacts all facets of our lives. The present needs and desires of teens preclude forcing them to carry a pregnancy to term, even if the child were later given to adoption. Similarly, I would argue that the present needs and desires of teens preclude forcing them to live a gendered life that fundamentally clashes with the one they wish to lead. The primary purpose of transition-related interventions is gender actualisation, a valuable end. My hope here is not to set out my argument in full detail—I am working on a manuscript to that effect—but to emphasise the contentious and unsupported nature of some of the authors' core premises.

CONCLUSION

Teresa Baron and Geoffrey Dierckxsens' lofty argument against access to adolescent medical transition is gravely undermined by their unsupported premises and misappreciation of the scientific literature. A point-by-point criticism of their claims, including the use of sources claiming trans youths arise from social contagion, would unfortunately be longer than the response format allows. Clinicians and bioethicists working in trans health should be wary of relying on the paper's conclusions, as they would be led astray. The best path forward is to acknowledge trans youths' autonomy and self-knowledge, and follow their lead.

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