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Not just a tragic compromise: The positive case for adolescent access to puberty-blocking treatment

Danielle M. Wenner | **B. R. George**

Center for Ethics & Policy, Carnegie Mellon University, Pittsburgh, Pennsylvania, USA

Correspondence
Danielle M. Wenner, Department of Philosophy, Carnegie Mellon University, 5000 Forbes Ave., Baker Hall 155C, Pittsburgh, PA 15213, USA.
Email: danielle.wenner@gmail.com

Abstract

Within bioethics as well as in broader clinical practice, support for transgender and gender-questioning adolescent access to pubertal suppression has often relied heavily on the desire to prevent risky, self-destructive, and suicidal behavior. We argue that framing justifications for access to puberty suppression in this way can actually be harmful to both individual patients as well as to the broader trans population. This justification for access to care makes such access precarious, limits its scope, and introduces perverse incentives to the patient population that is being served. We go on to offer an alternative, positive defense of access to puberty-blocking treatment for transgender youth grounded in the child's right to an open future. We argue that decisions related to pubertal suppression are both importantly weighty and potentially irreversible, and show why this justification is preferable to so-called "informed consent" approaches.

KEYWORDS

adolescent, puberty suppression, puberty-blocking treatment, right to an open future, transgender

1 | INTRODUCTION

Questions about the appropriate treatment of transgender, nonbinary, and gender questioning (hereafter TGQ) youth have recently begun to garner wider attention from the bioethics community. One important question regards whether and when to provide access to reversible puberty-blocking treatment (PBT).[1]

In determining the appropriateness of an intervention, one important consideration relates to the magnitude and types of harms that may result from intervening versus not. In the case of PBT, potential harms (such as hot flashes and reduced bone mineral density during puberty suppression) are considered as compared to the harms of allowing natural puberty to continue uninterrupted, including psychological impacts as well as the potential need for more expensive and more invasive interventions later in life. Several studies have shown that TGQ youth experience higher rates of depression, self-harm, eating disorders, and suicidality,[2] and discussions of the question of access to gender affirming care broadly, and PBT specifically, have frequently focused primarily on how such interventions prevent these kinds of material harms. In particular, the claim is often made that providing access to puberty suppression is

[1]Panagiotakopoulos reports that the first-line option for puberty suppression is treatment with a GnRH agonist like Leuprolide and Histrelin, while GnRH antagonists represent a possible alternative. Hembree et al. likewise focus on GnRH agonists as preferred treatment, while noting that long-acting GnRH antagonists may be considered once evidence on their safety and efficacy in adolescents becomes available. The 2011 WPATH Standards of Care likewise focus on GnRH analogs. All note the high cost of these medications, and mention progestins as a possible, less effective, alternative. Panagiotakopoulos, L. (2018). Transgender medicine - Puberty suppression. *Reviews in Endocrine and Metabolic Disorders*, *19*, 221–225; Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L. J., Hannema, S. E., Meyer, W. J. I., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology & Metabolism*, *102*(11), 3869–3903; World Professional Association for Transgender Health (WPATH). (2011). *Standards of care for the health of transsexual, transgender, and gender nonconforming people, 7th version*. WPATH.

[2]See, for example, the recent systematic review by Connolly, M. D., Zervos, M. J., Barone, C. J. I., Johnson, C. C., & Joseph, C. L. M. (2016). The mental health of transgender youth: Advances in understanding. *Journal of Adolescent Health*, *59*(5), 489–495.

the best way to prevent TGQ youth from engaging in suicidal, self-harming, or risky behaviors (hereafter "SSR behaviors").

In this paper, we highlight the prominence of this focus among bioethicists, practitioners, and guidance documents, and go on to demonstrate why a heavy emphasis on the prevention of SSR behaviors in these discussions places a harmful onus on this patient population. We go on to explore autonomy-based approaches to gender-affirming care, including the "informed consent model" and the right to an open future, and make a case for emphasizing the latter in clinical decision-making related to PBT. While our discussion centers on access to PBT specifically, we also discuss how some of our arguments generalize to other forms of gender-affirming care such as cross-sex hormones and surgical procedures.

2 | TRAGIC COMPROMISE

In a well-known paper Simona Giordano argues that, "transgender children who are not treated for their condition are at high risk of violence and suicide" and that consequently, puberty suppression may in fact be lifesaving treatment.[3] Similarly, the most prominent recent bioethical defense of access to PBT for trans adolescents explicitly relies on the claim that absent access, TGQ youth are at "high risk of psychological harm leading to suicidal tendencies."[4] Similar framing can be found in papers from other well-known theorists.[5]

This framing is also pervasive among medical discussions related to the treatment and care of TGQ youth. For example, Daphna Stroumsa cites social and medical barriers to accessing gender-affirming care as being associated with increased risk of violence, suicide, and sexually transmitted infections.[6] A recent qualitative study sought to understand medical professionals' reasons for either supporting or opposing the provision of PBT to TGQ adolescents, and found that among proponents a frequently cited justification was that "many young gender dysphoric people will harm themselves without intervention or at least the promise of future treatment options."[7] And Norman Spack, co-director of the Gender Management Service at Boston Children's Hospital, has argued that the reason we ought to encourage trans youth and young adults to seek treatment is that "forty-five percent of transgender 16- to 25-year olds who don't have any support attempt suicide."[8]

Finally, while we are focused specifically on TGQ youth, similar framing can also be found in international guidelines related to the treatment of the trans population as a whole. The World Health Organization (WHO)'s 2015 report on "Sexual Health, Human Rights, and the Law" states that "withholding or denying access to information and quality transition-related services may have multiple health-related ramifications, including anxiety, depression, substance abuse and suicidal thoughts or behaviors."[9] And the Standards of Care published by the World Professional Association for Transgender Health (WPATH) cites worries both of transgender persons seeking hormones via black-market channels and using them unsupervised,[10] as well as concerns that denying access to care may cause increased risk of "surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality."[11]

This prevailing framing presents medical interventions for TGQ youth as something of a tragic compromise, necessitated by the intractability of dysphoria and the risk of self-harm resulting from lack of access to clinical interventions. While there is significant evidence that gender-affirming care does promote psychological well-being in transgender persons,[12] in the next section we argue that centering the prevention of SSR behaviors in the ethics of transgender care is problematic for a number of reasons.

Before we proceed to our criticism, however, we want to emphasize that this problematic framing draws on real and urgent concerns. We are mindful of the reality that, at the time of this writing, the High Court of Justice in England has recently ruled to drastically curtail access to puberty blockers for youth under the age of 16,[13] and there is an active movement within the United States and elsewhere to deny TGQ youth access to PBT and similar interventions, sometimes by legislation that would impose criminal penalties on health providers.[14] The potential loss of human life from SSR behaviors is one important impact of such restrictions, and it is

[3]Giordano, S. (2008). Lives in a Chiaroscuro. Should we suspend the puberty of children with gender identity disorder? *Journal of Medical Ethics, 34*(8), 580–584.

[4]Priest, M. (2019). Transgender children and the right to transition: Medical ethics when parents mean well but cause harm. *American Journal of Bioethics, 19*(2), 45–59.

[5]See, for instance, Horowicz, E. (2019). Transgender adolescents and genital-alignment surgery: Is age restriction justified? *Clinical Ethics, 14*(2), 94–103. While Horowicz stops short of making the further claim that delaying access to gender-affirming care will increase the risk of suicide, they nevertheless suggest that if distress is intrinsically related to "genital discomfort" then the alleviation of psychopathologies may provide an argument in favor of earlier access, even to gender-affirming surgery.

[6]Stroumsa, D. (2014). The state of transgender health care: Policy, law, and medical frameworks. *American Journal of Public Health, 104*(3), e31–e38.

[7]Vrouenraets, L. J. J. J., Fredriks, A. M., Hannema, S. E., Cohen-Kettenis, P. T., & de Vries, M. C. (2015). Early medical treatment of children and adolescents with gender dysphoria: An empirical ethical study. *Journal of Adolescent Health, 57*, 367–373, p. 371.

[8]Fernandez, J. (2015, April 24). Norman Spack: Saving transgender lives. *Thriving: Boston Children's Hospital's Pediatric Health Blog*. https://thriving.childrenshospital.org/norman-spack-saving-transgender-lives/

[9]World Health Organization. (2015). *Sexual health, human rights and the law*. World Health Organization.

[10]WPATH, op. cit. note 1, pp. 34–35. Worries about unsupervised use of medical interventions are likewise pervasive in the medical literature. See, for example, Waldman, R. A., Waldman, S. D., & Grant-Kels, J. M. (2017). The ethics of performing non-invasive, reversible gender affirming procedures on transgender adolescents. *Journal of the American Academy of Dermatology, 79*(6), 1166–1168.

[11]WPATH, op. cit. note 1, p. 67. Appeals to worries about psychopathology and self-harm are also ubiquitous in the popular press. See, for example, Garel, C. (2019, July 5). Hormone coverage 'Pocket Change' for governments, but life-saving for trans people. *Huffington Post*. https://www.huffingtonpost.ca/entry/trans-hormone-coverage-health-canada_ca_5d1e4551e4b04c481410c698

[12]See, for example, Nobili, A., Glazebrook, C., & Arcelus, J. (2018). Quality of life of treatment-seeking transgender adults: A systematic review and meta-analysis. *Reviews in Endocrine and Metabolic Disorders, 19*, 199–220.

[13]Quincy Bell and Mrs A v. Tavistock and Portman NHS Foundation Trust, [2020] EWHC 3274, No. [2020] EWHC 3274 (Royal Court of Justice 2020).

[14]For references to some recent and current legislative efforts, see World Professional Association for Transgender Health (WPATH), & United States Professional Association for Transgender Health (USPATH). (2020). *WPATH and USPATH joint statement in response to proposed legislation denying evidence-based care for transgender people under 18 years of age*. https://listloop.com/wpath/mail.cgi/archive/adhoc/20200128125839/

one that contributes a special sense of urgency to this topic. If prevention of SSR behaviors were the only reason to support access to PBT for TGQ youth, that would presumably be sufficient reason to ensure access in many cases. Our concern, however, is that by centering this motivation in debates about the ethics of access to gender-affirming care, often while ignoring others, the medical and ethical communities leave themselves ill-prepared to recognize the full range of positive claims of TGQ youth.

3 | A HARMFUL FRAMING

The fundamental problem with this framing is that if the justification of access to gender-affirming care is oriented toward prevention of SSR behaviors, that justification will be both precarious and limited in scope. If PBT and similar interventions depend on this risk for their justification, then TGQ youth who are perceived as unlikely to engage in SSR behaviors will lack an adequate claim to receive PBT and other gender-affirming care. This can put TGQ youth and their advocates in the position of having to prove that their dysphoria is severe enough to increase the risk of SSR behaviors if they can't access PBT, which is worrisome for several related reasons.

First, grounding access to gender-affirming care in worries about self-harm suggests that TGQ youth who are otherwise in good mental health do not have sufficient claim to interventions known to be beneficial to this population, and is especially likely to deny treatment to questioning youth. SSR behaviors are, plausibly, a product of palpable distress at the experienced or anticipated effects of endogenous puberty. However, it need not be the case that TGQ youth experience their trans identity as a source of distress.[15] Perhaps more importantly, puberty suppression is valuable to questioning youth precisely because, in the absence of clarity about their gender identity, it gives them time to figure out how they feel about their bodies and about possible paths forward, without having a decision made for them by the partially- or fully-irreversible changes brought on by endogenous puberty. PBT—by itself or coupled with social transition—is reversible: a patient on PBT who ultimately comes to the conclusion that allowing puberty to progress as assigned at birth is the desired outcome can cease its use and continue natal puberty. These considerations suggest that its availability should not be limited only to those who are already certain of their discomfort with their assigned sex or who are already experiencing extreme distress about it.[16]

Second, and following from the above, this approach is likely to result in further mental health declines among trans youth, insofar as it may be used to deny treatment to those who are not yet suffering extreme dysphoria and could be spared such via earlier access to pharmaceutical intervention. Especially as regards access to PBT, the postponement of access may not only allow for greater mental health decline, but also increase the severity of later dysphoria as further partially- or fully-irreversible physical changes are undergone during endogenous puberty. This approach to gender-affirming care is in tension with the therapeutic goals of medicine. Compare, for instance, the suggestion that patients ought not to have access to known effective treatments for diagnosed coronary artery disease until or unless they have experienced myocardial infarction, or that nobody should have access to oral contraception until after they've experienced an unwanted pregnancy.

Finally, grounding access to care in worries about SSR behaviors introduces perverse incentives for those who desire access to such care to engage in, threaten, or falsely claim self-harm behavior. Schulz reports that trans individuals often research the narratives that physicians look for before giving a green-light for gender-affirming care and approach medical contact fully prepared to "say what is expected."[17] And evidence suggests that such threats are effective in gaining access to care even for adolescents. For example, in a 2019 case seen before the Supreme Court of British Columbia, a 14-year-old trans boy was granted access to hormonal therapies over the objections of his parents in part due to a history of suicide attempt and the testimony of a pediatric endocrinologist that delay in such access would place the patient at risk of additional such attempts.[18] Our point in raising this example is not to object to the outcome in this case, but to note that a system in which this is the primary rationale for such outcomes is a system in which TGQ youth are left with the credible threat of suicide as the primary effective means of advocating for themselves.

Not only does this represent the imposition of further harms on adolescent patients, it also functions to undermine patient-physician relationships, which should be grounded in openness and trust.[19] Such relationships may be particularly important for TGQ youth, who face disproportionately high social stigma from their communities, peers, and often even their families. Distrust of the medical community may also undermine the goal of preventing SSR behaviors by, for example, driving TGQ youth to seek gender-affirming treatment outside of the clinic and without the supervision of a medical professional.[20]

Of course, some of the discussions we've cited do not explicitly demand that individual patients demonstrate imminent SSR risk in order to access PBT. Rather, some seem to suggest that the statistical

[15]Schulz, S. L. (2018). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *Journal of Humanist Psychology, 58*(1), 72–92.

[16]Ashley makes the case that there is intrinsic value in the exploration of gender independently of what patients ultimately decide. Ashley, F. (2019). Thinking an ethics of gender exploration: Against delaying transition for transgender and gender creative youth. *Clinical Child Psychology and Psychiatry, 24*(2), 223–236.

[17]Schulz, op. cit. note 15, p. 79.

[18]A.B. v. C.D. and E.F., 2019 BCSC 254, No. E190334 (Supreme Court of British Columbia 2019).

[19]Cavanaugh, T., Hopwood, R., & Lambert, C. (2016). Informed consent in the medical care of transgender and gender-nonconforming patients. *AMA Journal of Ethics, 18*(11), 1147–1155; Schulz, op. cit. note 15.

[20]Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health, 91*(6), 915–921; Grossman, A. H., & D'Augelli, A. R. (2006). Transgender youth: Invisible and vulnerable. *Journal of Homosexuality, 51*(1), 111–128; Sanchez, N. F., Sanchez, J. P., & Danoff, A. (2009). Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *American Journal of Public Health, 99*(4), 713–719.

prevalence of such behaviors among TGQ youth who lack access to supportive care functions as a prima facie justification for providing access to this patient population across the board. For instance, when Norman Spack argues that "Forty-five percent of transgender 16- to 25-year-olds who don't have any support attempt suicide" and that therefore providing access to puberty suppressants "is an opportunity… to save lives,"[21] he seems to take the population-level 45% risk of suicide attempt as a justification for providing access to TGQ youth generally. This is analogous to reasoning used in other prevention contexts, when we can't identify prospectively which members of a high-risk group will experience a bad outcome absent a prevention modality, but know that bad outcomes are statistically likely within that group absent the preventive intervention.

Yet even if population-level increased risk of SSR behaviors is the primary justification for ensuring access to gender-affirming care for TGQ youth, this provides precarious ground for access to treatment. In this framing, access to care depends on membership in a recognizable population understood to be at risk, not on a patient's expressed goals or doubts regarding the timing or direction of their pubertal development. This plausibly invites gatekeepers to focus on defining a more limited population as eligible for PBT: one characterized by relatively pronounced distress and relative certainty regarding trans status. This in turns brings us back to concerns that the SSR risk framing underserves questioning youth and under-values the self-determination and flourishing of TGQ youth not experiencing pronounced distress. When the emphasis is on population-level risk, many of our other concerns re-emerge as group-level concerns: for example, the TGQ community as a whole is placed in the awkward position of needing to maintain a credible collective threat of self-harm.

Justifications in terms of population-level risk also allow the wrong kinds of hypothetical future innovations in diagnosis and treatment to justify the reinstatement of gatekeeping measures or the adoption of troubling therapeutic alternatives. For example: if access to PBT and other gender-affirming care is justified only by the need to prevent SSR behaviors, and not by concerns about the foreclosure of possible life choices, respect for personal identity, or the broader psychological harms of gender dysphoria, then other interventions that prevent SSR behaviors but do not respect these sorts of autonomy interests should be competitive alternatives. In the extreme case, consider a "conversion therapy" approach with the explicit goal of turning patients cisgender: in the prevailing framework, the problem with this approach is not that it constitutes a profound personal violation but only that, regrettably, it does not work. More generally, any imaginable method of selectively discouraging SSR behavior without addressing the underlying detrimental effects of gender dysphoria would, if effective, satisfy the goal of SSR prevention, leaving the prevailing framework ill-equipped to explain why a policy of open access to gender-affirming care was preferable.

These considerations suggest that centering the risk of SSR behaviors in discussions of access to gender-affirming care may have a number of undesirable consequences. Moreover, this approach to grounding TGQ healthcare detracts from what should be the central goal in the care of TGQ adolescents: respect for, and promotion of, the future autonomy and well-being of adolescent patients. In the next section, we consider two approaches to adolescent trans healthcare that seek to re-center this focus.

4 | THE CENTRALITY OF GENDER IDENTITY AND THE RIGHT TO AN OPEN FUTURE

In a recent commentary, Robin Dembroff asks, "Why is psychological distress the lone gatekeeper for accessing PBT? What if PBT simply increases an adolescent's flourishing, without their having previous psychological distress?"[22] As it happens, there is a growing body of evidence that gender-affirming care does just that. In addition to having a positive impact on symptoms of depression,[23] access to gender-affirming treatments generates significant improvements in quality of life.[24]

Recognizing these impacts provides prima facie support for an approach to gender-affirming care for TGQ youth that is less dependent on SSR risk in both its rationale and its application. We suggest an autonomy-based approach as a natural alternative. In the general context of adult and adolescent trans care, such approaches are often discussed under the rubric of the "informed consent model" of trans care.[25] The term "informed consent model" refers to a family of clinical practices, but its name also suggests an approach to justifying access to care, and we consider both below. Such approaches ground the legitimacy of patients' claims to gender-affirming care not in the distress caused by gender dysphoria, but in their decision-making capacity, which may be understood as: (a) the ability to understand the nature of the medical intervention, (b) an appreciation of attendant risks and benefits, (c) expression of a preference for one particular course of action over others, (d) demonstration of a correspondence between desired outcomes and the intervention in question, and (e) correspondence between expected outcomes and a stable set of values.[26] On this model, the possibility of psychiatric comorbidities is recognized, and interface with a therapist is still considered an option. However, the need for a background narrative of distress, and at the limits, threats of SSR behaviors, is removed. In practice, clinical approaches associated with this model show

[21]Fernandez, op. cit. note 8.

[22]Dembroff, R. (2019). Moving beyond mismatch. *American Journal of Bioethics*, *19*(2), 60–63, p. 62.

[23]Tucker, R. P., Testa, R. J., Simpson, T. L., Shipherd, J. C., Blosnich, J. R., & Lehavot, K. (2018). Hormone therapy, gender affirmation surgery, and their association with recent suicidal ideation and depression symptoms in transgender veterans. *Psychological Medicine*, *48*(14), 2329–2336.

[24]White Hughto, J. M., & Reisner, S. L. (2016). A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgender Health*, *1*(1), 21–31; Nobili et al., op. cit. note 12.

[25]Cavanaugh et al., op. cit. note 19; Schulz, op. cit. note 15.

[26]Murphy, T. F. (2019). Adolescents and body modification for gender identity expression. *Medical Law Review*, *27*(4), 623–639.

considerable variation,[27] and do not necessarily involve "on demand" access to treatment.[28] They may also involve seeking the *assent* of patients not legally able to consent to treatment.[29]

If the legitimacy of access to treatments like PBT and cross-sex hormones hinges on the patient's decision-making capacity, then it becomes necessary to engage with the reality that this capacity, including the capacity to comprehend the risks and benefits of such interventions, is not all-or-nothing, but rather is developed over time. The question of when TGQ youth are competent to consent to an intervention will depend both on the specific capacities of the patient, and the nature of the intervention. A systematic exploration of possible cases is beyond the scope of this paper, but we note that cisgender youth are implicitly presumed competent to consent to the irreversible or incompletely-reversible effects of endogenous puberty from an early age, and we suggest that accounts of (in)capacity to consent will need to justify any departures from an analogous presumption of competence in the case of TGQ youth.

Here, however, we are primarily concerned with the specific case of PBT, for which we believe a stronger justification is available. While adolescents are not being coerced into seeking PBT (on the contrary, the very issue at hand is the many and varied roadblocks that are erected in their attempts to gain access), the youngest patients seeking access to this intervention may not have sufficiently developed decision-making capacity to meet the standards of an approach that justifies treatment entirely in terms of informed consent (or informed assent). Moreover, we believe the positive case for granting TGQ youth access to PBT can and should go farther than the claim that they have decision-making capacity in this context.

While adolescents are not yet fully autonomous, they are well on their way to full agency, and one obligation shared by parents and medical professionals is to foster the development of autonomy within adolescents and to respect the autonomous persons that they will become. One specific way to signal respect for the future autonomy of TGQ adolescents is to recognize what has come to be known as their right to an open future.

First defended by Joel Fienberg, the right to an open future is a set of claims that children have that are derived from the autonomy rights they will have as adults. Specifically, it signals a claim to not have future options closed off to them before they become full agents with the capacity to understand and choose which life paths to value and pursue.[30] Feinberg seemed to defend a rather expansive view of the right to an open future, on which each autonomy right attributed to adults has a corresponding right that ought to be protected for children. This expansive view is problematic because it is simply not possible to prevent the foreclosure of every future option a child might encounter. Every decision made by a parent or close associate, or even a child themselves, is likely to have implications for the options that are available to them further down the road.[31]

However, a more moderate understanding of this right—one focused on protecting a subset of very important options—is both more plausible and more defensible. On this more moderate view, the right to an open future functions as a constraint to protect the interests of children by keeping certain vital options, opportunities, and advantages open to them when they reach maturity. The defense of the right to an open future is fundamentally grounded in the values of self-determination and self-fulfillment—or the ideals of autonomy and personal well-being—which are particularly implicated in choices that are deeply impactful on the future adult's self-determination with respect to crucial and irrevocable decisions that will determine the course of their life.[32]

This view of the right to an open future—what Jeremy Garrett has called the "vital quality" interpretation—is both more practical and more flexible than the maximal interpretation that Feinberg seemed to defend. While a fully-specified version of this view would need to unpack which choices are indeed those that are most vital, the case for the importance of keeping options related to gender identity open seems rather straightforward. Physical characteristics attendant on endogenous puberty are only partially reversible, and frequently only with expensive, time-consuming, and invasive procedures. Allowing puberty to progress unimpeded thus represents a partially irrevocable decision. Moreover, the foreclosure of this particularly weighty future option is readily avoidable given the availability of PBT, making the case for maintaining its future viability as a choice particularly strong.

Our reasoning assumes that PBT in fact serves primarily as a low-risk, reversible intervention to keep options open, and that patients who do not respond well to the intervention for whatever reason, or who decide that they want to go forward with endogenous puberty, can cease its use and allow puberty to recommence. Available evidence and clinical consensus bear this out: in the specific case of PBT, long-term risks and irreversible effects do not appear to present a major concern. Although available long-term follow-up data on PBT for trans youth are limited, early findings suggest that risks of negative impacts of PBT on bone development and bone density are low[33] and that impacts on bone density are short-lived.[34] Absent subsequent cross-sex hormones or surgery, the impacts of PBT on fertility are reversible.[35] Although critics sometimes dismiss PBT as a suspect or experimental intervention, it is at this point a well-established and long-studied technology: PBT has been

[27]Deutsch, M. B. (2012). Use of the informed consent model in the provision of cross-sex hormone therapy: A survey of the practices of selected clinics. *International Journal of Transgenderism, 13*(3), 140–146.

[28]Cavanaugh et al., op. cit. note 19.

[29]Ibid.

[30]Feinberg, J. (1992). The child's right to an open future. In *Freedom and fulfillment: Philosophical essays* (pp. 76–97). Princeton University Press.

[31]Mills, C. (2003). The child's right to an open future? *Journal of Social Philosophy, 34*(4), 499–509; Millum, J. (2014). The foundation of the child's right to an open future. *Journal of Social Philosophy, 45*(4), 522–538.

[32]Garrett, J. R. (2018). *Rethinking "Open Future" arguments in pediatric bioethics* [Unpublished manuscript].

[33]Wylie, K., & Wylie, R. (2016). Supporting trans people in clinical practice. *Trends in Urology & Men's Health, 7*(6), 9–13.

[34]Panagiotakopoulos, op. cit., note 1. Giordano and Holm note that there is some evidence that adolescents treated with GnRHa *and later with cross-sex hormones* may not reach the same peak bone mass as if left untreated, but that the findings are difficult to interpret. Giordano, S., & Holm, S. (2020). Is puberty delaying treatment 'experimental treatment'? *International Journal of Transgender Health, 21*(2), 113–121.

[35]Hembree et al., op. cit. note 1.

used to treat central precocious puberty since the late 1980s,[36] and to delay puberty in trans youth since the 1990s.[37] As Ashley notes, both cases involve the same underlying biology.[38] Some cite an additional category of risks related to the ways that wider social non-acceptance of, and hostility towards, trans people may lead to future hardships that are causally attributable to decisions to transition,[39] and we grant that such risks might also attend the decision to visibly delay puberty. But to allow such considerations to determine clinical practices would effectively endorse a kind of "bigot's veto" on effective care. Balanced against improvements this intervention can bring in quality of life, the case for skepticism about PBT being in the best interests of those seeking it is weak. These reasons, combined, undergird the broad acceptance of this treatment within relevant medical specialties.[40]

A related group of worries about the long-term impact of PBT draw on the observation that many TGQ youth on PBT go on to take cross-sex hormones, and infer from this that competence to consent to cross-sex hormones should be a prerequisite for access to PBT.[41] The concern that PBT somehow creates a desire for cross-sex hormones strikes us as, at best, unsupported speculation, and in the absence of such a causal relationship, the vague concern that PBT and cross-sex hormones represent "two stages of one clinical pathway"[42] does not constitute a reason to deny access to the first stage. The concerns about such a causal link are further undermined by the use of PBT without subsequent gender transition in other patient populations (e.g., children with precocious puberty), by the lack of a credible proposal for a causal mechanism, and by the availability of other, more plausible explanations (such as the impact of self-selection or gatekeeping on which TGQ youth receive PBT) for reports that "the vast majority of children who take [puberty blockers] move on to take cross-sex hormones."[43] Indeed, as activists have noted, this rhetoric creates something of a double bind: if most TGQ youth on PBT go on to transition, this will be cited as evidence that PBT *causes* transition, but if any sizable segment do not go on to transition, this will be cited as evidence that PBT is overprescribed to youth who don't need it.[44]

The role of a parent or clinician in subsuming the decision-making role for a child is to protect and promote the future interests of that child. However, the ongoing development of the child's identity as a temporally extended agent with consistent values and preferences introduces particular epistemic barriers to determining what those interests are. Given this epistemic barrier, a reasonably prudent approach is to keep future options open as much as possible,[45] which is of course what the right to an open future is after. Importantly, this is precisely the role that PBT can play for trans, and perhaps more importantly, gender questioning youth.

5 | CONCLUSION

Appeals to SSR behaviors as a primary basis for granting access to gender-affirming care are problematic for a number of reasons. Perhaps most importantly, predicating access on such behaviors endangers TGQ youth by potentially making risk of such behaviors into a prerequisite for access to interventions that are known to improve psychological outcomes and quality of life. Importantly, however, this does not mean that risks of SSR behaviors in untreated TGQ youth should not be seen as good reasons for such interventions. The benefits of gender-affirming care generally, and PBT more specifically, for alleviating psychological distress in TGQ youth should not be discounted. We have argued only that such behaviors, or an elevated risk of them, should not be considered a necessary prerequisite for access to such care for individual patients or for the general population of TGQ youth.

Rather, our claim is that there are better reasons to ensure that TGQ youth have access to PBT, reasons that do not have the harmful implications of a grounding in SSR behavior, reasons that justify access to care far in advance of the serious harms that can accompany SSR behaviors, and that correlate with the deeply fiduciary role of parents and physicians in helping to protect and promote the future agency of adolescent patients.

It is important to note, also, that grounding access to PBT in TGQ youth's right to an open future lends itself naturally to a view of adolescents as gradually becoming more autonomous and being accorded more decision-making power as they approach the age of consent. Considerations about a child's open future provide adequate grounding for access to a reversible intervention such as PBT. As individuals approach maturity, society does and should allow them to make more momentous decisions that will have long-term impacts on the choices that are available to them. The right to an open future does not foreclose individuals making such decisions for themselves; however, the decision-making capacity required to consent to less reversible interventions should naturally be higher. For this reason, less reversible and more invasive interventions such as cross-sex hormones or

[36]Moll, G. W. J., Collins, D. C., Depuey, G., & Parks, J. S. (1987). Lupron treatment of precocious puberty (CPP) has not produced loss of bone mineral. *Pediatric Research, 21*, 251; Kappy, M. S., Stuart, T., & Perelman, A. (1988). Efficacy of leuprolide therapy in children with central precocious puberty. *American Journal of Diseases of Children, 142*(10), 1061–1064; Lee, P. A., Page, J. G., & Group, T. L. S. (1989). Effects of leuprolide in the treatment of central precocious puberty. *Journal of Pediatrics, 114*(2), 321–324.; Kappy, M., Stuart, T., Perelman, A., & Clemons, R. (1989). Suppression of gonadotropin secretion by a long-acting gonadotropin-releasing hormone analog (leuprolide acetate, lupron depot) in children with precocious puberty. *Journal of Clinical Endocrinology & Metabolism, 69*(5), 1087–1089.

[37]Giordano & Holm, op. cit. note 34.

[38]Ashley, F. (2019, March 31). An evidence-based affirmative perspective on hormonal interventions for trans youth. *Bioethics.net*. http://www.bioethics.net/2019/03/an-evidence-based-affirmative-perspective-on-hormonal-interventions-for-trans-youth/

[39]Levine, S. B. (2017). Ethical concerns about emerging treatment paradigms for gender dysphoria. *Journal of Sex & Marital Therapy, 44*(1), 29–44; Levine, S. B. (2018). Informed consent for transgendered patients. *Journal of Sex & Marital Therapy, 45*(3), 218–229.

[40]See, for example, Hembree et al., op. cit. note 1.

[41]This line of reasoning features prominently in the recent High Court of Justice decision, op. cit. note 13.

[42]Ibid: paragraph 136.

[43]Ibid.

[44]Jones, Z. (2017, August 31). Do all trans youth on puberty blockers go on to transition? Gender Analysis. https://genderanalysis.net/2017/08/do-all-trans-youth-on-puberty-blockers-go-on-to-transition/

[45]Noggle, R. (2002). Special agents: Children's autonomy and parental authority. In D. Archard & C. McLeod (Eds.), *The moral and political status of children* (pp. 97–117). Oxford University Press.

surgical intervention may require a higher bar. For these types of interventions, questions about capacity to give full informed consent may take on greater significance. Our grounding of access to PBT in the right to an open future therefore does not preclude decisions by older adolescents or young adults to pursue more permanent medical interventions should they deem it appropriate, but leaves open the possibility that such interventions warrant a higher bar of decision-making capacity.

A truly equitable and inclusive approach to trans care must do more than just recognize that interventions such as PBT are not as bad as suicide and self-harm. It should recognize transgender and cisgender life paths as equally legitimate, without holding the latter to laxer standards of legitimacy,[46] and it should recognize the value of PBT as a tool for supporting trans and questioning youth through a process of healthy self-discovery and self-authorship.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR BIOGRAPHIES

Danielle M. Wenner is Associate Professor of Philosophy and Associate Director of the Center for Ethics & Policy at Carnegie Mellon University. Her research focuses on the ethics of research involving human subjects, the nature of relationships of power in research and other health-related interactions, and the structural sources of injustice.

B. R. George is an Assistant Professor of Philosophy at Carnegie Mellon University. Their research interests include trans experience, disability, and feminist philosophy of language.

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[46]George, B. R., & Wenner, D. M. (2019). Puberty-blocking treatment and the rights of bad candidates. *American Journal of Bioethics, 19*(2), 80–82.