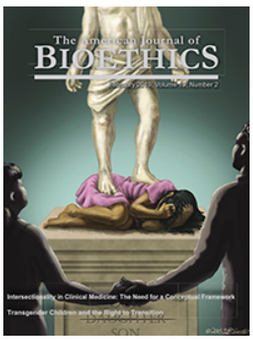

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PBT and the Rights of Bad Candidates

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necessary piece of this puzzle, if we wait to support these vulnerable youths until they attempt to access PBT, we have waited too long. We have discussed here some of the changes necessary—including improvements in the education of health care providers, changes in schools, alterations to current medical practice, and changes with parents of transgender youths—to better support these youths, and we provide additional details in Table 1. Only once we begin to take these steps to better identify and support transgender and gender-questioning youths can we begin to truly support their burgeoning autonomy and right to an open future (Feinberg 1980). Instituting these fundamental changes will increase the opportunities for health care providers and other youth-facing professionals to ensure protection of these vulnerable youths while still respecting the interests of their well-meaning parents (Katz et al. 2016). ■

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Puberty-Blocking Treatment and the Rights of Bad Candidates

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Maura Priest (2019) argues that puberty-blocking treatment (PBT) should be made available to gender-dysphoric adolescents "who (after an evaluation) are deemed good candidates" (48), even in the face of parental objections. Priest's argument for this claim focuses on the significant harms associated with undesired endogenous puberty and the state's obligation to ensure minors are protected from serious harms inflicted by their parents or other caretakers. We argue that the case for access to PBT can be strengthened, and its domain of application extended, by noting a double standard: Cisgender adolescents are permitted to decide by default to undergo endogenous hormone-induced puberty consistent with their presumed gender. This permission is granted without hesitation and without the need for professional evaluation to determine whether they are good candidates for this change. This double standard casts doubt on the legitimacy of limiting PBT access to those deemed "good candidates" by prevailing gatekeeping standards.

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There is a profound asymmetry between the treatment of adolescents presumed cisgender and the treatment of trans and questioning adolescents. The former find that their claims about their gender are validated as a matter of course, and are allowed to proceed by default through the irreversible changes of endogenous puberty. The latter find that their claims about their gender require supporting evidence to rule out the possibility that they are the result of whim, confusion, or peer pressure. They are often expected to produce this evidence, and to convince health professionals of the sufficiency of their gender dysphoria, even if they wish only to take reversible action to prevent the irreversible changes of endogenous puberty. Double standards of this sort are frequently discussed in trans advocacy (see, for example, Jasper [@cuddleyed] 2014; Baen [@itsbeanefun] 2015; Labelle 2016a, 2016b), and highlight the incongruousness of gatekeeping norms in trans care.

This point can be brought into focus by considering a hypothetical teen—call him "Sam." Sam insists that he is a boy, and, if asked, will declare that he finds the prospect of going through the irreversible body changes of "female"-type puberty undesirable and in fact quite alarming.

Suppose Sam's parents insist that he is a girl, and wish to compel him to go through "female"-type puberty on the same timetable as his peers. They insist he is too young to make consequential medical decisions for himself, and that they are best positioned to decide what sort of pubertal changes are in his best interests. If he disagrees, he can seek medical interventions to change his secondary sex characteristics once he is an adult.

If Sam was born with stereotypically male-type genitalia and a working pair of testes, and prefers to undergo his endogenous "male"-type puberty without interference, then parental attempts to compel him to instead undergo a "female"-type puberty by means of cross-sex hormones and related interventions would clearly be considered abusive. Meanwhile, if Sam was born with stereotypically female-type genitalia and a working pair of ovaries, and prefers to receive PBT to prevent "female"-type endogenous puberty, then parental attempts to compel him to undergo this puberty by denying him access to PBT involve imposing on him largely the same difficult-to-reverse undesired effects as in the first case, yet it remains contentious to argue, as Priest does, that such parental behavior constitutes serious abuse.

Absent an underlying belief that trans adulthood is an inherently worse outcome than cis adulthood, this double standard cannot be justified. This is especially clear when we remember that the effects of the endogenous puberty sought in the first case are far less reversible than the effects of the PBT sought in the second case. (If an asymmetry between the effects of compelled endogenous and exogenous puberty on fertility is a source of concern, note that parental imposition of cross-sex hormones remains appalling even if Sam is demonstrably infertile.) Recognizing the symmetry of irreversibility of an undesired puberty in the two cases should motivate respect for a dysphoric adolescent's claim to PBT that is at least as strong as the respect accorded to a cisgender adolescent's claim to their endogenous puberty.

This reasoning supports Priest's contention that access to PBT should not be limited by considerations of parental preferences, but it also undermines her commitment to the idea that such access should be limited to "good candidates" or contingent on comprehensive professional evaluation of the strength of a patient's gender identity. When access to irreversible endogenous puberty requires no evaluation and is available to adolescents who have never given the matter any thought at all, there is no justification for withholding PBT, even from those adolescents who profess uncertainty about their endogenous puberty.

This is not to say that PBT should be exempt from routine evaluations of medical risk and patient understanding, or that this might in special cases involve referral to mental health professionals. But typical standards of evaluation for youth seeking PBT exceed this. Current standards of care state that "before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken" (World Professional Association for Transgender Health [WPATH] 2011, 18). Unlike evaluations for most medical interventions, this prerequisite exploration is to be conducted by a specialized mental health professional. (Hale (2007) makes some similar points about the anomalous status of mental health evaluation for adult transition.) For puberty interventions, the standards of care require that the patient has "demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria" (World Professional Association for Transgender Health (WPATH) 2011, 19). Not only does this standard far exceed that necessary for cisgender adolescents to proceed with endogenous puberty, it is also easy to see how it can be leveraged to deny PBT access to questioning adolescents who merely seek the time to be sure of their preferences before undergoing pubertal changes that will be costly and difficult to reverse.

A sympathetic mental health professional could choose to interpret the WPATH standards of care in a way that did not impose much of an undue burden on trans and questioning adolescents. But the guidelines admit of more restrictive interpretations, and leave ample room for professional bias to exclude many adolescents with a considered desire for PBT. The broader experience of the trans community leaves little hope that such bias will be limited to the fringes of clinical practice, or that the requirement mental health evaluation will not be a source of unjustified practical difficulty. (See, for example, Serano [2007, ch. 7] and Gridley et al. [2016] for relevant discussion of trans history and experience.) When we consider that such gatekeeping by mental health professionals is neither the default for most medical interventions nor required before undergoing endogenous puberty,

along with such norms' vulnerability to bias, such barriers to access to PBT are difficult to justify.

These considerations lead us to the position that access to PBT for trans and questioning adolescents should not be limited to "good candidates" and should not require extensive mental health evaluation as a matter of course. While this may seem like a radical position, in one key respect it represents a cautious compromise: The intervention most closely analogous to endogenous puberty is not PBT but rather a full course of cross-sex hormone treatment at a typical age for endogenous puberty. Such interventions would, like endogenous puberty, be only incompletely reversible. The merits and drawbacks of this more extreme position are beyond the scope of this commentary, but the prima facie appeal of the analogy supporting this option situates relatively unencumbered access to PBT as a comparatively cautious minimal concession to the needs of trans and questioning youth. ■

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Transgender Children, Puberty Blockers, and the Law: Solutions to the Problem of Dissenting Parents

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I am pleased to provide this commentary on Margaret Priest's article, "Transgender Children and the Right to Transition" (2019). Priest is trained in and works at the intersection of philosophy and ethics, two critically important disciplines through which to analyze rights issues, including this one. Her subject, how best to take care of transgender children, is one of the most topical in current pediatric medicine, bioethics, and law.

Priest's objectives are shared by many scholars and advocates. She argues that children ought to be recognized as having rights they can enforce, not just interests others satisfy based on their own preferences, and that persistent trans children with dysphoria ought to be able to access puberty blockers without their parents' permission if the latter would deny their children physician-recommended care. Refreshingly, she understands that the doctrine of parental rights is a substantial obstacle to the

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