**Gender changes, implications, and ethical dilemmas**

**Ethical and medical aspects of the treatment of children with gender dysphoria**

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**Introduction**

There have always been a small number of children and adolescents in society who did not identify with their biological (or genetically determined) sex, which in virtually all cases was correctly determined at birth (and in the post-ultrasound era mostly earlier). The English language has the term "sex" for biological sex, as opposed to "gender", which is socially determined sex. Since situations in which an individual did not identify with his or her biological sex were, objectively speaking, extremely rare, there was no significant development of expertise and capacity in this field; professional terminology was almost non-existent and, as a rule, not very well defined. According to the DSM-5, gender dysphoria refers to "...distress that may accompany a discrepancy between one's own experienced or expressed gender and one's assigned gender" and also requires the presence of "...clinically significant distress or impairment in social, school, or other important areas of functioning"; the DSM-5 lists gender dysphoria as a mental disorder. On the other hand, the most recent version of the ICD-11 describes gender non-conformity as a condition "...characterised by a marked and persistent discrepancy between an individual's experiential sex and assigned sex"; the ICD-11 now lists gender non-conformity as a condition related to sexual health (whereas previous versions of the ICD listed it as a 'mental, behavioural or non-developmental disorder') (Drobnič Radobuljac et al., 2024).

Traditionally, paediatric medical treatment has been reserved almost exclusively for cases with (congenital) disorders of sex development (»intersex conditions«), but not for gender identity disorder or gender dysphoria (»transgender conditions«). According to the opinion of the National Medical Ethics Committee of the Republic of Slovenia, persons with gender dysphoria should be provided with appropriate medical treatment with the aim of reducing the individual's problems caused by gender dysphoria and of ensuring comprehensive personal development, with appropriate psychosexual development. The treatment process is always tailored to the person, based on careful and compassionate professional treatment (paedopsychiatrist, paediatric endocrinologist, clinical psychologist and, if necessary, others - grouped together in an interdisciplinary consortium).

**Epidemic proportions**

But in the last millennium, and especially in the last decade, there have been enormous changes in this area. There has been a dramatic increase in the number of people with gender dysphoria, particularly young people, and the issue has gradually moved beyond medicine and into the social sphere. As Abigail Schrier notes in her acclaimed book (Irreversible Damage: The Transgender Craze Seducing Our Daughters. Regnery Publishing, 2020), that until ten years ago, the "typical" child with gender dysphoria was a prepubescent male (biological) child, in fact very rare in the population, the situation has been turned "upside down" in just a few years. Suddenly, female (biological) adolescents started to show gender dysphoria, and in almost all cases the situation was new (i.e. these girls did not have a personal history of gender dysphoria at an earlier, pre-pubertal stage). Often, the gender dysphoria was already present in someone in their friendship or social circle, usually also a social media user. In particular, the more than 1000% increase in the prevalence of this disorder in this demographic group (as reported in several developed countries) is also unusual from an epidemiological perspective.

In medicine, we rarely see such an increase in the frequency of a condition in such a short time - except, of course, in infectious disease epidemics. Perhaps the most striking reminder of this phenomenon is the emergence of anorexia nervosa, an eating disorder (in particular) among adolescent girls. This has also seen a sharp increase over a period of time, with some characteristics of 'contagiousness' (e.g. occurring in clusters), and is several times more common among girls. However, in the next step, there was an important difference in the treatment of the two conditions. The medical goal in anorexia nervosa is to diagnose the condition as early as possible and then to intervene quickly, with appropriate psychological and dietary support, before the condition can be 'chronicised' (which usually has a very unfavourable prognosis). On the other hand, as many, including some doctors, advocate, in the case of gender dysphoria, medicine should automatically confirm the self-diagnosis of the condition made by the child or adolescent, and sometimes, on this basis alone, help her in the next steps with medication or surgery, or at least with puberty suppressants. This, of course, encourages the 'chronicisation' of the condition; in one (admittedly very rare) study in the Netherlands, all adolescents treated with puberty suppressants subsequently continued with hormone therapy.

On the other hand, some recent studies show that in very few cases (only 2%) does gender dysphoria intensify in young adults if untreated, while in all others it is alleviated or no longer present (Rawee et al., 2024). Although the brain - especially the frontal part, important for rational decision-making - matures by around 25 years of age, great caution is needed when making irreversible decisions.

**Tragic dimensions of the treatment of children and adolescents**

In the last few years, however, not long after the treatment of children and adolescents with gender dysphoria became clearer in professional terms, many, even tragic, dimensions of the treatment of children and adolescents with gender dysphoria have come to light, especially from countries and centres where the field has been "ploughed" in the past few years. As it turned out, the use of hormonal and surgical treatments was in many places conceived without regard for the most common medical professional standards and ethical safeguards. The latter are all the more important because we need to see children and adolescents with gender dysphoria as one of the most vulnerable groups of our time, and this requires the utmost protection and compassion. The failure of medicine is illustrated by the case of the world-famous Tavistock Child Gender Identity Clinic, which treats children and adolescents with gender dysphoria. As documented in Hannah Barnes' book "Time to Think: The Inside Story of the Collapse of Tavistock's Gender Service for Children". Swift Press, 2023), the origins of the field in the UK date back to the 1980s. The Tavistock Clinic was one of the epicentres of the development of the field, one could even say on a global scale. Thousands of children and adolescents with gender dysphoria appear to have been treated not only unethically but, at least in some cases, we can safely say criminally at this clinic. Experimental methods of 'treatment' have often not followed the usual principles of good clinical and research practice. Children and adolescents have been treated with drugs and interventions that have never been indicated and clinically tested for their condition, without any evidence of benefit for the young patient(s). One could say 'in the blind'. Many of these cases were undocumented, irreversible, with permanent consequences for health and the body (especially in the case of hormone treatments and mastectomies). In the case of adolescents below the legal age of autonomous decision-making, at least in some cases, these interventions were also carried out without (or even in spite of) the parents' expressed will, which is in itself unethical and illegal. All this has gradually led to a totally unsustainable situation and the closure of this clinic, which has left a sad wreck. But which may help to set a better ethical course elsewhere?

**»The Cass Review«**

Earlier this year, the UK National Health Service (NHS) published a major report by paediatrician Hilary Cass ("The Cass Review"), former President of the Royal College of Paediatricians (Cass, 2024). The report thoroughly refutes the arguments for invasive and irreversible interventions on children who wish to change their sex. Cass concludes that 'confirmation therapy' is not supported by adequate evidence and has irreversible consequences. The report's findings show that most of the studies supporting this therapy are exaggerated or misrepresented. The report warns against social transition for children as it increases the likelihood of further medical interventions. Most children outgrow their gender confusion without intervention. End routine prescribing of hormonal drugs: Cass recommends caution when prescribing hormonal treatment to minors under 18. The NHS has already introduced guidelines restricting the routine prescription of hormonal drugs.

**Statement by the European Society of Child and Adolescent Psychiatry (ESCAP)**

ESCAP published a statement in early 2024 calling for clinical, scientific and ethical standards in the management of children with gender dysphoria (Drobnič Radobuljac et al., 2024). They warn of the long-term harms of puberty suppressants and opposite-sex hormones. Encourage an open and evidence-based expert debate on best standards of care.

Key principles for working with adolescents with gender dysphoria: prohibition of experimental and unnecessarily invasive interventions; warnings about the unreliability of the diagnosis of gender dysphoria over time; ensuring appropriate diagnosis and treatment of co-occurring psychiatric disorders; stressing the importance of informing children and parents about the risks and benefits of treatment. Learning from past mistakes: ESCAP calls on the EU to set up a registry of studies to better understand the effects of different treatments for gender dysphoria; they stress the need to monitor long-term studies to better understand the natural course of gender dysphoria and the consequences of medical transition.

Finally, ESCAP urges health professionals to avoid experimental and unnecessarily invasive treatments and to adhere to the principle of "primum nil nocere" (first do no harm).

**Conclusions**

It seems that many of the safeguards, not only at the level of society, but especially those established in medicine and medical ethics after the horrors of the Second World War, have failed completely or to a significant extent in the case of the treatment of children and adolescents with gender dysphoria in many cases (the case of the Tavistock Clinic, also institutions in the USA and the Netherlands, perhaps elsewhere). It is as if nothing has been learned from the abuses of the profession and of science in the past. It is as if medicine, under pressure from society and ideology, has once again forgotten its usual ethical standards, in particular, first, do no harm (»primum nil nocere«), and also to treat with care, protect and seek the welfare (»bonum facere«), which is particularly necessary in the case of vulnerable groups. Have we really learnt nothing from the tragic chapters in the history of medicine and the episodes of medicine's defiance of unscrupulous social ideologies and vested interests? Every child and adolescent needs individual medical treatment by a doctor or psychologist, support in decision-making, and help in seeking the best interests of him or herself. Experimental treatments should always be carried out in accordance with the ethical principles of research, after prior assessment by ethics committees. The interests of society (or even of ideology) can never take precedence over the well-being of the individual in the treatment of an individual. Above all, in medicine, as Hippocrates instructed us long ago, we must first do no harm.

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