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ARTICLE

Healthcare Professionals' Conflicts When Treating Transgender Youth: Is It Necessary to Prioritize Protection Over Respect?

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Abstract

Increasingly, transgender minors are seeking medical care such as puberty-suppressing or gender-affirming hormone therapies. Yet, whether these interventions should be performed at all is highly controversial. Some healthcare practitioners oppose irreversible interventions, considering it their duty to protect children from harm. Others view minors, like adults, as transgender individuals who must be protected from discrimination. The underlying ethical question is presented as a problem of priority. Is it primarily relevant that *minors* are involved? Or should decision makers focus on the fact that they treat *transgender individuals*? The paper explores the relevance for medical practice. We provide results of an interview study with German healthcare professionals. We discuss the general question whether prioritization among different group memberships of the *same* person is ethically defensible. We conclude that priority conflicts between group memberships of the *same* person can be deceptive and should be addressed by an intersectional approach. Eventually, we discuss practical implications.

Keywords: child rights; intersectionality; transgender minors; ethics; puberty blockers; discrimination; health care

Introduction

Increasingly, transgender children and youth are seeking medical care such as puberty-suppressing or gender-affirming hormone therapies and mastectomies. Puberty-suppressing hormonal treatment is carried out at the onset of puberty around the age of 12-14 and is said to be fully reversible.[1] The effects of gender-affirming hormone treatment usually considered at the age of 14-16 are only partially reversible. Due to their irreversibility, mastectomies are performed from the age of 16 at the earliest. Yet, whether these medical interventions should be performed at all is highly controversial. On one hand, there is concern that hormonal interventions at such an early age are still experimental since only a few long-term studies on the side effects are available.[2] Experts also disagree about how to factor in the attendant risk of regretting later in life the irreversible consequences of a medical intervention performed at a young age.[3] On the other hand, the decision not to offer any medical treatment may also lead to serious consequences for children's health such as higher rate of depression and suicide.[4] Since decisions have to be made at an age when trans minors might not yet have acquired full competence to consent, a great responsibility rests on the physicians and psychologists involved. Should they give a treatment recommendation and, if so, which one?

This ethical question is presented as a problem of priority. Is it primarily relevant that *minors* are involved? Or should decision makers focus on the fact that they treat *transgender individuals*? Is it necessary to prioritize one social group membership over the other? Some oppose irreversible hormonal or surgical interventions in minors as a matter of principle, considering it their primary caring duty to protect children from harm. They harbor fundamental doubts about the capacity of young people to know their gender identity before the completion of puberty.[5] Others, however, view minors, like adults, primarily as transgender individuals who must be protected from discrimination and deserve respect for their wishes and choices.[6] In essence, this debate results in a polarizing conflict between one or the other: should the child be protected from taking a wrong path or, on the contrary, should the child's feelings of gender identity be respected? In the terminology of discrimination research, the conflict thus presents itself as a choice between two different options: Should minors be treated as members of the group of children or transgender individuals? Which group membership should be prioritized, and why?

In this paper, we explore whether this mainly theoretical debate has relevance for medical practice. Do healthcare professionals who treat trans minors encounter such a conflict? If so, how do they deal with it? To answer these empirical questions, we conducted a qualitative interview study with healthcare professionals in Germany. Based on the interview material, we will address the more general philosophical question, whether prioritization among different group memberships of the *same* person is appropriate and ethically defensible and how, in practice, intersectional approaches help overcome the problem. Thereby, we will contribute to the debate on the concept of discrimination. To this end, we proceed as follows. First, we present the study design and our methodological approach. Then we provide the results of our qualitative interview study and investigate whether and how practitioners perceive the outlined prioritization problem in their daily practice. Subsequently, we discuss the findings in light of the current philosophical debate about which social groups can become subject to discrimination. We close by drawing some theoretical and practical conclusions.

Material and Method

The study presented here was carried out within a broader interdisciplinary research project on discrimination against transgender children and adolescents in the German healthcare system. The project combines psychological, medical, and ethical perspectives.[7] Members of support groups are involved in designing the research program, recruiting probands, interpreting interviews, and disseminating results. The aim of the project was to gain knowledge about how healthcare professionals interpret their professional role, how they deal with transgender children and adolescents, and what they frame as discrimination. The study was approved by the ethics committees of the universities of Münster and Goettingen, Germany. Methodologically, the project follows an empirical ethics approach.[8]

Sample

A total of 17 experts were interviewed, including 6 psychotherapists and 11 physicians from the following specialties: General Medicine, Pediatrics, Pediatric Endocrinology, Urology (Surgery), Gynecology, Sexual Medicine, Psychosomatic Medicine, and Child and Adolescent Psychiatry. The interviews lasted between 38 and 121 minutes; 16 interviewees have or had contact with transgender children and adolescents in their daily professional life, and 1 interviewee cares for young adults. The interviewees were selected according to the procedure of theoretical sampling. This procedure follows a logic of "maximum structural variation."[9] Individuals with different professional backgrounds, varying degrees of professional familiarity with transgender identity in childhood and adolescence, and varying lengths of professional experience were specifically recruited for the interviews. Study information was disseminated throughout Germany via various medical societies and networks in the field of trans health, as well as published on the project website. In addition, access to the field was gained via the snowball principle[10]

and professional networks of the study leaders. Data were collected from December 2020 to June 2021. Due to the COVID-19 pandemic, only two interviews were conducted in person, the others by telephone. Interviews were recorded with a digital recording device.

Interviews were transcribed, personal information was pseudonymized, and content analysis according to Udo Kuckartz[11] was performed using MAXQDA software. The interview material was systematized using deductive and inductive thematic categories. Thematic categories have the "function of pointers,"[12] that is, they point to a specific place in the text where the previously defined topic is addressed by the interviewee. *Professional role, Own interaction with children and adolescents, Particularities in dealing with transgender individuals* were applied to the interview material as deductive thematic categories. Accordingly, all interview passages in which the interviewees discuss how they interpret their professional role and how they deal with the two group memberships of their patients in practice were filtered out. A more in-depth analysis of the transcripts was implemented with the help of inductive subcategories. The quality of the analysis was ensured by consensual peer coding and iterative team interpretations.

Healthcare Professionals' Interpretation of Their Professional Role

In the following, we present results of the qualitative-empirical study. We will investigate whether the prioritization conflict between the two social group memberships affects medical practice. Moreover, we will illustrate how interviewees interpret their professional role and how they refer to the social group memberships of their young patients.

The professional tasks of healthcare workers are contingent on the prevailing concepts of sex and gender in healthcare and their change over time.[13] For a long time, transgender identities have been pathologized. This attitude of the medical profession substantially changed over the past twenty years.[14] With the 11th revision of the International Statistical Classification of Diseases and Health Problems (ICD-11), which became effective in January 2022, the diagnoses "transsexualism" and "gender identity disorder in childhood" were erased from the chapter on mental illness. Instead, the chapter on conditions related to sexual health now includes the terms "gender incongruence" and "childhood gender incongruence." Human rights activists consider depathologization a significant step toward recognition of human diversity.

Yet, what does this imply for healthcare for transgender youth? Our interviewees are ambivalent regarding their professional role. Some emphasize their duty to arrive at an independent, objective diagnosis, others see themselves rather as companions and advisors of minors. Among psychotherapists, psychiatrists, and psychosomatic experts, role expectations can be reconstructed along these two aspects: "good diagnostics" and "good counseling." These refer to different group memberships of their patients.

For example, one interviewee emphasizes her diagnostic tasks: *So most of my cases have a depression or a social phobia, and I have then actually always taken this diagnosis as the main diagnosis and then checked again and again in the procedural diagnostics how things are developing, before I established the diagnosis* gender dysphoria *or* transsexualism *according to ICD-10.*[15,16] She underlines that her professional task as a psychotherapist is to judge according to objective standards whether her young patients rightly belong to the group of transgender individuals. Since her patients are children and adolescents, she assumes that such an objective assessment is her special caring obligation: *I think I have a higher responsibility than when adults sit in front of me.*

Another expert, who sees herself more as a companion, describes a different professional task: *To be honest, the most important thing for me is simply first of all an appreciative framework, because I think that these children and young people have often had the experience something like misgendering or not being taken seriously, yes that it is dismissed as a phase by adults, so I find that first of all it is very important that that I accept themas they feel.*[17] She, too, refers to her patients' group memberships. However, she emphasizes that young transgender individuals may share experiences of exclusion and devaluation in society due to their group memberships. She explains that her professional task is to treat children with respect.

Similarly contrasting attitudes can also be found among healthcare professionals with other professional backgrounds. One endocrinologist emphasizes the importance of diagnosis: *If that's certain, the diagnosis, and we treat that, then I think that's fine.*[18] From her perspective, a confirmed diagnosis is the moral justification for prescribing hormonal treatment. This, she thinks, is her major responsibility. The idea of initiating medical interventions with irreversible consequences triggers unease. The fact that children and adolescents are involved intensifies the potential for conflict. Thus, a surgeon who in rare cases considers operating on a patient who is under the age of 18 emphasizes the importance of an objective diagnosis: *[…] But what I do surgically cannot be undone. That means I always find it very reassuring when a lot of people help to be quite sure that everything is so, even if this is often perceived as stressful for those affected.*[19]

In contrast, another endocrinologist interprets his role in a different way: *I think it's very important that the young people simply know that you are interested in their well-being. And that they don't have the impression that they always go to a tribunal that decides something about them, but that you make joint decisions and you are companions, you are in the same boat and you don't somehow work against their feelings. Sometimes you get the impression that the young are really afraid to seek for any kind of treatment because they are not taken seriously in their feelings.*[20]

When it comes to addressing the minors by their chosen names and pronouns, the conflict is also present, if less prominent. Using the desired first names and pronouns is a way to express respect and may be important to realize a trusting therapeutic atmosphere. Most interviewees acknowledge the gender self-description of their young patients and behave accordingly. For example, a gynecologist talks about the importance of using the desired first names: *Yes, they are extremely important, because then the person immediately feels comfortable here. So if I accept that, then I have already opened the door, so to speak.*[21] Only one psychotherapist is opposed to using the desired name. She thereby hopes to secure open and unbiased results of the therapeutic process. Those who don't like to be addressed by their birth names might just leave: *Those who realize: "No, that doesn't fit", they are free to leave.*[22]

In general, many healthcare professionals were ambivalent regarding their professional roles. Even those who, at one point of the interview, tended to emphasize their diagnostic tasks, which would imply a distanced, objective view on an ailment, focused on the importance of building a respectful personal relationship with another. Two moral duties appear as competing: on one hand, to assume responsibility for a standardized medical procedure generating objective results and, on the other, to foster an individual trusting relationship with a young transgender person as a subject whose feelings deserve respect. These duties are derived from conflicting interpretations of transidentity in minors: Is being transgender something professionals can or even have to objectify? Or is it defined by the persons themselves? We were interested in finding out how professionals deal with this conflict in practice. Do they ultimately prioritize one group membership and the associated ethical duties? Underlying is the more general question of what exactly constitutes discrimination. Who can be affected by it in the first place, and why? How should multiple group memberships be dealt with?

Discrimination and the Group Criterion

Discrimination is commonly understood as the unequal treatment of persons due to their social group membership. However, philosophers disagree on how to characterize these groups. There are two competing approaches. According to Kasper Lippert-Rasmussen, the decisive factor is the social saliency of the group. "A group is socially salient if perceived membership of it is important to the structure of social interactions across a wide range of social contexts."[23] This is true, for example, of a person's gender, but not of eye color. He further argues that an individual is discriminated against when he or she is treated unequally and *harmed* as a *consequence.* Due to the social context, the injustice is recurring.

Deborah Hellman[24] also assumes that discrimination depends on the social context. However, she argues that the concept of the socially salient group does not adequately capture what constitutes discrimination. Firstly, it is not the social salience of a trait, but the social status of an individual in the network of social power relations that matters. Secondly, the moral wrong of the discriminatory act should not be measured by its consequences; rather, it is understood to be expressed by the act itself.

Discrimination is morally wrong if it is demeaning. In order to be able to demean someone, the acting individual must be in a relative position of power. Only members of some social groups are in such a position, for example heterosexual vis-à-vis queer individuals. Other examples for social groups with unequal power are healthcare professionals and patients.[25]

Children can also become the subject of discrimination. According to Lippert-Rasmussen, this is true because the group of minors is socially salient, and according to Hellman, because they are in a subordinate position in the structure of social power relations. Surprisingly, child discrimination is rarely the subject of philosophical debates. The concept of age discrimination is usually discussed in terms of old age.[26] Yet, if children are denied respect just because adults are more powerful, this, too, might amount to age discrimination. For example, during the COVID-19 pandemic, children's lives have been changed in profound ways, for example, by imposing homeschooling or contact reduction. These precautionary measures primarily served the interests of older adults since they were much more vulnerable to severe courses of the disease. Harms and benefits of the provisions to reduce viral transmission were distributed unequally, to the detriment of children's quality of life.[27] When children's concerns are given less importance just because of their age and because adults are in power, then it is a case of age discrimination. So, in the case of trans children, transgender identity *and* age may be a reason for discriminatory treatment. Thus, the picture is more complicated than the framing as a priority conflict wants us to believe. It is not just about protection versus respect. This will become clearer when we proceed to intersectional approaches.

Both Lippert-Rasmussen's and Hellman's approaches can be criticized for being one-dimensional. In reality, people belong to more than one social group, and the concept of discrimination must do justice to their multiple memberships. The one-dimensionality of discrimination concepts was first problematized by the U.S. Black women's movement in the 1970s. Activists criticized that the demands of the women's movement were primarily oriented towards the interests of white middle-class women and bypassed the realities of Black women's lives, especially those of the working class.[28] Based on this criticism, Kimberlé Crenshaw[29] developed the concept of *intersectionality*. She argues that individuals have very different social experiences because of their specific combination of group memberships and along other dimensions of inequality such as their socioeconomic background. At the intersections, the individual acquires a specific social position. Disadvantages or privileges due to different group memberships should not be analyzed separately or simply added. Rather, they are interrelated in complex ways. Some combinations can have a reinforcing, others a mitigating effect. Intersectionality identifies this blind spot of single-axis approaches, while acknowledging the importance of individual group memberships.[30] Intersectional approaches also make diversity within social groups visible and thus try to grapple with forms of multiple discrimination. It is "a method and a disposition, a heuristic and analytic tool."[31]

The intersectional analytical framework is particularly helpful when dealing with transgender youth. It can lead us to a more differentiated understanding of the problem. If, for instance, the views of a transgender child are not respected[32] in the healthcare context, this may be either due to the fact that the person is a minor or that she is trans, or both. It is not easy to determine which group membership is the reason for the demeaning behavior and it is not unlikely that the specific combination of both group memberships favors such a scenario. Thus, if an individual can be affected by discrimination on the basis of several group memberships, it is not appropriate to construct this person as representing only one group or the other. Rather, such a reductionist view runs the risk of underestimating the complex dynamics of discrimination. The question is not whether the patient should be treated as a child *or* as a person of transgender identity, but: How is the treatment to be designed without doing injustice to the patient as a child *and* as a transgender individual?

In the heated debate about the appropriate treatment of transgender minors, the dangers of age discrimination tend to be overlooked. Instead, the ethical conflict is framed as a question of priority between the group memberships "child" and "transgender individual," whereby the framing as "child" mainly prompts protective adult behavior. In this case, arguments are based on a one-dimensional concept of discrimination. Yet, from an intersectional perspective age and trans discrimination may reinforce each other. In practice, this complexity can be challenging. Our interview study shows that healthcare professionals are overwhelmed by the intersectional entanglement of the group memberships

of their clients. Of course, adults do have caring responsibilities towards children. Professionals therefore experience role ambivalence. Prioritization thinking and overprotective behavior may be the consequence. The dangers of age discrimination and potential reinforcing effects due to trans identity are ignored.

Obviously, our interviewees grapple with their professional role. Our data also show that some practitioners recognize the complexity of the issue and the dangers of intersectional discrimination. This is evident in their descriptions of how they try to do justice to the individual who is both trans and a minor. They emphasize that they treat individuals, not collectives. Thus, they describe how they strive to tailor their interventions to the needs of the individual patient and to avoid making treatment decisions simply on the basis of one group membership. An endocrinologist puts it like this: *[…] so every child, every adolescent and every family is different, every case is different. There is no standard program that you can somehow reel off.*[33] Moreover, they let the children participate in the decision-making processes. A psychiatrist described the importance of patients' views: *Well, it's nothing minor, just when someone is eight years old compared to someone who is 18 years old.*[34] Other interviewees emphasize that gender identity is something highly personal. It is the prerogative of children and adolescents to declare how they define themselves, they say: *For me, the focus is clearly on what the child himself says.*[35] In addition, they stress that young transgender persons may harbor different expectation regarding healthcare: *The level of suffering is quite different. Some, at the age of twelve, stand there and say: 'Now I want my male hormones,' and then I've also experienced several times now that, at the age of 17 ½, they say: 'I'm happy for now when I know that it's like that and I don't really need hormones yet.' And then one will give no hormones.*[36]

Accordingly, the interviewees consider it inappropriate to make treatment decisions without involving the children and adolescents they care for, or by communicating exclusively with the parents. A psychologist puts it this way: *One should rather ask: How are the parents to be involved? (well) my client is first and foremost the child.*[37] It is not appropriate to him to determine the child's interests mainly by relying on the parents' and the healthcare professionals' views. By such a participative approach, children are treated with respect without denying the fact that they might still need adult advocacy and protection. Such an approach is in accordance with article 12 of the United Nations Convention on the Rights of the Child[38] stating the right of minors to participate in all matters affecting them. This right is based on the assumption that every child can make a valuable contribution to determining his or her own well-being. This is also true for healthcare.[39]

And yet, meaningful participation cannot be taken for granted in a society where adults usually attach less importance to children's concerns and perspectives. In healthcare, this can result in children not being informed, not being heard, or not being taken seriously because of their age. This danger increases when children belong to a gender minority and when their wishes and desires seem rather unusual to adults, as in the case of transgender children who ask for gender affirming hormonal or surgical procedures. Particularly in cases like these, children's personal views are necessary to determine their best interest.[40]

Conclusions

In summary, healthcare practitioners pursue two ways of dealing with the group memberships of their clients. Some try to respect the individuality of their patients. The views of the minor are considered as important, even essential for deciding about the further course of treatment. Others are inclined to resort even to degrading forms of behavior in order to protect the child from irreversible medical interventions. They ignore the possibility of age discrimination and conceptualize the two group memberships "being trans" and "being a child" as competing and mutually exclusive. Many practitioners are unsure about what may count as discriminatory behavior and what merely serves to promote the child's well-being. The focus on objective diagnosis tends to be detrimental to a holistic view of minor's needs.

The concept of discrimination is multifaceted and is controversially discussed in philosophy. Yet, some aspects are widely agreed upon. One is that a person can only be discriminated against on the basis

of (the attribution of) belonging to a social group. We have been able to show that both young persons and transgender persons can be discriminated against. Discrimination because of multiple group memberships generates its own theoretical problems. Intersectionality is the only prominent model of thought that addresses them. Intersectional theories render visible how focusing on single group memberships may distort the whole picture. One loses sight of the fact that simultaneous membership in the group of transgender individuals *and* of children can amplify discriminatory effects. Thus, we conclude that it is not appropriate to frame the question of how to treat transgender children as a priority conflict. Priority conflicts between group memberships of the *same* person can be delusive. They are more appropriately captured by an intersectional approach.

The healthcare professionals in our interviews develop two different strategies: prioritizing the duty to protect the child and letting the child participate in the decision making. Since prioritizing the duty to protect increases the risk of discriminating against the patient both as a child and as a transgender individual, this is not an ethically defensible option. Instead, from an intersectional perspective, a professional attitude is needed that does not simply associate young age with advocacy and protection nor disposes of the idea of the minor as particularly vulnerable. In practice, awareness of intersectionality helps develop a balanced approach to the complex ethical issues that arise when treating a transgender minor. The health needs of minors must be assessed individually, and the decision for or against hormonal treatment or surgery must be made on an individual basis. To prevent discrimination based on the intersecting group memberships of young transgender individuals, new ways of participation should be explored.

Conflicts of Interest. Maximiliane Hädicke, Manuel Föcker, Georg Romer, and Claudia Wiesemann declare that they have no conflicts of interest.

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