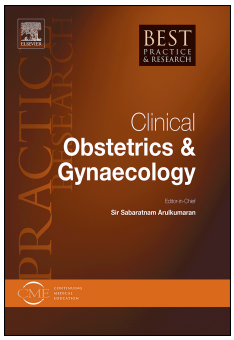
Journal Pre-proof



Gender-Affirming Surgery for Transgender Adolescents: ethical and legal considerations

Simona Giordano, Ed Horowicz

PII: S1521-6934(22)00176-6

DOI: https://doi.org/10.1016/j.bpobgyn.2022.102295

Reference: YBEOG 102295

To appear in: *Best Practice & Research Clinical Obstetrics & Gynaecology*

Received Date: 5 November 2022

Revised Date: 12 November 2022

Accepted Date: 14 November 2022

Please cite this article as: Giordano S, Horowicz E, Gender-Affirming Surgery for Transgender Adolescents: ethical and legal considerations, *Best Practice & Research Clinical Obstetrics & Gynaecology*, https://doi.org/10.1016/j.bpobgyn.2022.102295.

Gender-Affirming Surgery for Transgender Adolescents: ethical and legal considerations

Simona Giordano

Centre for Social Ethics and Policy (CSEP), School of Social Sciences, The University of Manchester, Oxford Road, Manchester M13 9PL, simona.giordano@manchester.ac.uk

Ed Horowicz

School of Law and Social Justice, The University of Liverpool, Chatham Street, Liverpool, L69 7ZR, e.horowicz@liverpool.ac.uk

Corresponding author: Simona Giordano, simona.giordano@manchester.ac.uk

Abstract

In this paper we consider the ethico-legal issues surrounding gender-affirming surgeries in minors, with a specific focus on English law. First, we outline and discuss the current clinical guidelines on genital surgery for minors with gender incongruence/dysphoria. Second, we consider the recent legal developments following *R (on the application of) Quincy Bell and A v Tavistock and Portman NHS Trust and others* and discuss how these might impact upon the ability of doctors to agree to surgical procedures when their patients are still minors. Finally, we explain why the removal of the adulthood threshold is justified. However, we argue that surgical interventions should remain differentiated from fully reversible interventions, and clear guidance on eligibility criteria for genital surgery is needed from clinical guidelines, which, in consideration of the legal, professional and regulatory framework in which clinicians work, can provide needed reassurance as to when it is in the best interests of competent young people to be considered suitable candidates for genital surgery.

Key words Genital surgery, transgender minors, ethical issues, Bell v Tavistock, negligence, battery.

OVERVIEW OF CURRENT INTERNATIONAL GUIDANCE

Genital surgery for gender incongruence/dysphoria has not been recommended traditionally until the patient achieves the age of majority.[1] The 8th version of the WPATH Standards of Care (SoC8)[2] removed however any age-based recommendation, with a shift towards a more individualised assessment of the patient's best interests.

With the exception of the SoC8, typically the treatment for gender incongruence is differentiated into fully reversible interventions (puberty blockers, from now onwards PBs), partially irreversible interventions (gender-affirming hormones), and irreversible interventions (surgery). PBs are usually not recommended earlier than Tanner Stage 2 (the onset of puberty); older adolescents (around the age of sixteen) could consider cross-sex hormone therapy, following a shared decision-making approach between clinicians, the patient and their family, which must include consideration of long-term irreversible effects on fertility.

In respect of surgery, the Endocrine Society differentiates between fertility-affecting and fertility non-affecting surgery. It recommends that genital surgery involving gonadectomy and/or hysterectomy should not be carried out until the patient is of legal age of majority in his or her country. (5.5), and can be considered only after a mental health professional and the treating clinician both agree that surgery is 'medically necessary and would benefit the patient's overall health and/or well-being' (5.1) Breast surgery, instead, should be advised on a case-by-case basis. The WPATH (SoC7, p.54)[1] also recommended genital/gonadal surgery only once the patient achieves legal adulthood. In England surgery is only provided by gender identity services for adults.[3]

In a somewhat unexpected development, SoC8 has eliminated any reference to any age for any treatment, hormonal or surgical. Hormone treatment can be provided after Tanner Stage 2, if the clinician is satisfied that this is in the minor's interests and a thorough multidisciplinary assessment of the child's capacity and best interests has taken place. Surgery can be provided after 12 months of hormone therapy with cross-sex hormones, unless these are contra indicated or 'not desired' (S257). Due to the complexities of the procedure, phalloplasty is still recommended in adulthood (S66). It is also noteworthy that SoC8 no longer explicitly recommend parental consent (this was instead required by SoC7 for the provision of PBs and

considered 'ideal' for the provision of cross-sex hormones). However, it suggests that in standard situations parents are expected to consent with the child (S62).

We are now presented with an unprecedented situation, in which two major clinical guidelines offer starkly different advice, both with regard to the timing of medical intervention, and to who should consent to treatment. Although the SoC8 do not *recommend* that surgery takes place only 12 months after Tanner Stage 2 (which could be, chronologically, as early as age 8 or 9), it does not exclude it, leaving ample discretion to clinicians.

Gender-affirming surgical interventions in minors could give raise to both questions of criminal and civil legal liability. Before considering these, we will discuss the legal position of the child and recent legal developments, likely to influence how the medical profession might interpret a minor's best interests.

THE LEGAL POSITION OF THE CHILD

In medical decision-making and the provision of lawful valid consent for minors, generally there is a tri-partite shared decision-making approach, involving the minor, their families and healthcare professionals, for the most part without conflict and involvement of the courts.[4]

A child is defined in English law as a person under the age of eighteen (Children Act 1989, section 105(1)). Section 8 of the FLRA provides that minors aged sixteen and seventeen can consent independently for medical, surgical or dental treatment, including the administration of anaesthetic.[5] Capacity to make decisions is also presumed when a child attains the age of sixteen under the Mental Capacity Act 2005 (MCA); however, the courts seemingly favour the approach of competence assessment rather than presumed capacity in mature minors where consent to treatment may not be unanimously regarded as being in their best interests.[6]

In *Gillick*[7], the House of Lords held that doctors could obtain valid and lawful consent from a minor under the age of sixteen, independently from their parents or those with parental responsibility 'if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed' (187).

The ability for competent minors to consent to medical treatment within English law is thus protected through common law for those under the age of sixteen set out in *Gillick* and statute

for those aged sixteen and seventeen set out in the FLRA 1969. Where there is disagreement as to whether medical treatment is in a minor's best interests or that a minor is not competent (including mature minors), the courts can use the authority held within their inherent jurisdiction to authorise or refuse treatment,[6] or alternatively parents or those with parental responsibility will retain their role as legal decision-makers.[8]

Capacity, it should be noted, is decision-specific: 'It is important that you assess maturity and understanding on an individual basis and with regard to the complexity and importance of the decision to be made. […] a young person who has the capacity to consent to straightforward, relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences'.[9] Having the capacity to consent to PBs thus does not entail capacity to consent to cross-sex hormones or to surgery, and having capacity to consent to, say, top surgery, does not entail capacity to consent to genital surgery. Decision-making capacity is further reflective of the clinical and ethical importance of these medical and surgical interventions being staged, not only to facilitate appropriate clinical outcomes but the long-term goals for each individual patient. At each stage, and for each clinical intervention, capacity needs to be assessed and appropriate consent needs to be gathered again. This not only ensures proper respect for the minor's autonomy, but also ensures that the clinician's conduct is legally defensible (see later).

GENDER TREATMENT IN THE ENGLISH COURTS

In 2020 the English High Court ruled on a judicial review application in the case of *Bell.*[10] The High Court held that children were highly unlikely to satisfy a test of competence for the provision of PBs, therefore court authorisation would be required: this may even be the case for older adolescents despite statutory decision-making protection [151-152].

This decision departed from the established legal principles of consent for those under the age of majority. Court authorisation has only been sought in a narrow band of cases for competent minors: where a minor's *refusal* (rather than request) has not been considered to be in their best interests or where there was a dispute, for example, between doctors and parents or between the parents themselves, or in regards to controversial or non-therapeutic procedures which lack medical benefit for that child.[11] *Bell* set out gender diverse minors as a uniquely vulnerable group who are very unlikely to achieve *Gillick* competence to consent to PBs. The High Court

decision in *Bell* also implied that the role of the courts, through the inherent jurisdiction, was justified on the basis that PBs are a category of treatment that is innovative and experimental.

In September 2021 the Court of Appeal (CA) overturned the High Court's decision.

Burnett LCJ stated:

> *The treatment of children for gender dysphoria is controversial*. *Medical opinion is far from unanimous about the wisdom of embarking on treatment before adulthood*. […] The present proceedings do not require the courts to determine whether the treatment for gender dysphoria is a wise or unwise course or whether it should be available through medical facilities in England and Wales. Such policy decisions are for the National Health Service, the medical profession and its regulators and Government and Parliament. The treatment of children for gender dysphoria is lawful in this jurisdiction.[12] (Our emphasis).

The decision of the CA foremost reaffirmed the position of *Gillick* as it applied to the provision of PBs: it is 'for doctors and not judges to decide on the capacity of a person under 16 to consent to medical treatment' [76].

The CA reaffirmed:

1) That the decision to prescribe treatment for gender dysphoria remained a clinical rather than judicial matter.
2) That the High Court was wrong to generalise about the competency of children suffering from gender dysphoria on the basis of perceived vulnerability; and
3) That decisions in respect of contentious areas of health and which are subject to clinical and social controversies, should not be the remit of the courts.

The CA further acknowledged the standards expected from clinicians:

> We should not finish this judgment without recognising the difficulties and complexities associated with the question of whether children are competent to consent to the prescription of puberty blockers and cross-sex hormones. They raise all the deep issues identified in Gillick, and more. *Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment*.

> *Great care is needed to ensure that the necessary consents are properly obtained*. As Gillick itself made clear, *clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested*. [92] (Our emphasis).

Whilst the *Bell* cases did not consider surgery, the CA judgment suggests that gender care interventions require *great care from clinicians in respect of the risks and intended benefits*, as well as reflexivity to current and ongoing evidence. The onus is then on clinicians to ensure such standards are achieved. However, we should highlight that this is no different to other forms of irreversible surgery.

Of note, the CA considers treatment for gender dysphoria as *controversial and divisive*, and seemingly implicitly endorses the requirement of parental consent. Despite the SoC8 mitigating the requirement of parental consent, if a clinician were to perform gender-affirming surgery upon a competent adolescent they would be, as the CA highlighted, 'alive to the possibility of civil or regulatory action', and it can be implied from the letter of the judgment, that this might be so even in the presence of parental consent. A referral to the General Medical Council can be issued by any concerned medical or healthcare practitioner, employer or member of the public, against a clinician who fails to adhere to the accepted clinical protocols. In the presence of multiple bodies of medical opinion, a clinician could, in principle, provide a valid defence against allegations of this kind, insofar as their conduct was logical, reasonable, and in line with *one* body of medical opinion. What needs to be asked, however, is whether appealing to the SoC8 could provide a solid defence against professional regulatory investigation or action, given that, up until September 2022 all international authoritative bodies, including the WPATH itself, set the age of majority as a minimum criterion for obtaining surgery, and given that this has, by and large, been accepted practice for about two decades.

Furthermore, given the CA's reminder to clinicians regarding civil liability, and in the case of gynaecological genital surgery there may be potential concerns as to criminal liability, further questions arise in respect of legal accountability.

COULD GENDER-AFFIRMING GENITAL/GONADAL SURGERY PERFORMED ON MINORS BE A CRIMINAL OFFENCE?

In England the legality of surgical treatment as an exemption to criminal harm is outlined in *Attorney-General's Reference* (No 6 of 1980).[13] Lane CJ explained this as being harm that results from 'reasonable surgical interference' (719). What amounts to a *reasonable* surgical interference is yet to be properly defined by the courts; however medical professionals cannot just perform any medical procedure upon consenting patients.[14]

In terms of body modifications, *R v M(B)* [2018][15] set out out the following:

1. medical procedures can only be lawfully carried out by those qualified and regulated to perform them in order to protect the public;
2. the procedure must be for a valid therapeutic medical purpose, which should be determined by the decision makers at the time, balanced against the risks involved.

In the context of gender-aligning surgical procedures, these would fall within the medical exemption providing that the doctor is registered with the GMC and is appropriately competent; the standard of competence is for the most part determined by professional opinion[16], with the courts being able to apply logical analysis to determine the standard where there is disagreement.[17] The SoC8 set out standards of surgical expertise [2] and medical practice is professionally regulated by the GMC.[18] Moreover, the patient must have a diagnosis of gender incongruence/dysphoria, and the surgery must be in the best interests of the patient.

If such decisions were considered by the courts, the best interests of the child would be determinative, reflecting the UN Convention on the Rights of the Child. Determining a child's best interests is not simply based on medical necessity, as there are cultural, social, religious and legal considerations that may influence determination of these:[19] 'best interests are used in the widest sense and include every kind of consideration capable of impacting on the decision.'[20] However, medical necessity remains a crucial factor within clinical guidelines: without the provision of interventions, some transgender adolescents are at risk of suffering through distress and discomfort from their natal sex characteristics.[2]

One problem with medical necessity is that clinicians might hold different views on the matter.[21] This is reflected in the differing High Court and CA judgments in *Bell,* and on the High Court's reliance on medical opinion that expressed concern for decisions taken by minors to receive medical interventions. Despite differing views, it is important to reiterate the CA's

finding that the *treatment* of gender dysphoria in minors is lawful in this country. Surgery was not directly considered, but is one aspect of such treatment, and as such, it cannot be unlawful.

One further question for gynaecology practice is whether genital surgeries may constitute Female Genital Mutilation (FGM). Section 1 (1) of the FGM Act 2003 states that it is 'an offence if [a person] excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris.'[22] However, subsection 1(2) provides an exception whereby these procedures are not deemed unlawful if they are performed by a doctor on the grounds that it is 'necessary' for the 'physical or mental health' of the person on whom it is performed. Given the therapeutic nature of gender-affirming genital surgery, where it is agreed to be in the best interests of the patient, there would be no consideration of offences within the FGM Act.

In summary, gonadal and genital surgery in minors with a diagnosis of gender incongruence and dysphoria does not constitute criminal offence, if medically necessary, overall in the best interests of the patient, performed by suitably qualified physicians, and with the appropriate consents in place.

HOW COULD DOCTORS FACE CIVIL ACTION FOR PERFORMING SURGERIES ON MINORS?

Within civil law it has long been established that a clinician touching a person without valid consent will constitute a claim in battery.[23] Under English law, a clinician must inform patients of the risks that the patients themselves would deem as 'material'; they must also discuss reasonable alternatives and then gain consent to treatment. [24]

Despite informed consent voiding any claim in battery, and even where the minor patient understands the material risks involved, clinicians can lawfully (and should) refuse to provide gender-affirming surgeries to minors, if these are not deemed in their best interests.

A related question is whether a clinician/team of clinicians could be found negligent, if a patient obtained surgery and later on claimed that they were harmed as a result of it. For a claim in negligence to succeed, the claimant should prove that the clinicians had a duty of care towards

the patient, that they breached their duty of care, and that the harm suffered is the direct result of the breach in the duty of care (so called 'but for' test – the harm wouldn't be suffered, but for the clinician's failure to adhere to the expected standards of care).[25] Claims in negligence are for claimants notoriously difficult to succeed in: the most difficult part of the test to prove is that, but for the clinician's breach in standard of care, the patient wouldn't have suffered the complaint.[26]

The general legal position is that, although clinical guidelines are not mandatory, adhering to them (even when differing bodies of medical opinion exist) would normally void any claim in negligence.[27] The elimination of the age threshold in the SoC8 might offer protection, where, after thorough assessment, qualified expert clinicians decided to offer genital surgery to a minor.[28] But even prior to the publication of the SoC8, departures from clinical guidelines that were fully documented and made on logical and reasonable grounds would have hardly exposed a clinician to claims in negligence, because the guidelines are intended to be used in a flexible manner.

Moreover, a patient suffering a complaint, or an unfavourable outcome, or regretting the choice, would not prove negligence: they would have to prove that the doctor's conduct failed in relevant respects to achieve the expected standards of care and that the harm would have not been suffered, had the doctor achieved those standards. We should therefore distinguish between postoperative complications and surgical technique that falls below the standard expected.

A different question, however, arises, following the publication of the SoC8: these suggest that cross-sex hormones might be prescribed from Tanner Stage 2, and surgery (with the exception of phalloplasty) 12 months after. In principle, under SoC8, a child aged 11 or 12 could be a suitable candidate for gonadal and genital surgery. We will not comment on whether this is clinically recommendable: however, because it has been, for a long time, accepted practice to only offer genital surgery to adults, it is unclear whether performing full genital surgery on a young minor could meet the requirement of medical necessity, when less invasive options may be available to alleviate distress, at least in the vast majority of young children.

The current situation is, thus, relatively more complex than prior to the SoC8. As already noted, clinical guidelines now offer differing advice: the Endocrine Society still has adulthood as one of the criteria to access genital surgery, and all major clinical guidelines, have, as we have highlighted earlier, so far recommended a staged approach to treatment, with only fully reversible interventions available to younger adolescents after the onset of puberty, and gender-affirming hormones and surgery only available to older adolescents and adults. The WPATH has eliminated the age threshold, but has also recommended much greater flexibility in provision of hormone intervention. In principle using a staged approach without an age threshold supports and individualised approach to decision-making but such differing clinical guidelines highlight the need for much clearer eligibility criteria beyond physiological and psychological development. Although the existence of differing bodies of medical opinion is not unique to gender care, the ample discretion given to individual clinical teams by SoC8 is likely to lead to different assessments of the child's needs and best interests in different clinics, local authorities, territories or States. This may raise issues of equity and fairness, dis-harmonisation of care (where different clinics would act significantly differently with the same patient), and might contribute to cause confusion in healthcare providers (where healthcare providers might be unsure what guidelines to follow, or how ethical or legally safe a certain procedure might be).

FUTURE REGRET AND FUTURE ALLEGATIONS

Potential for allegations of harm can be based not just on post-operative complications, but on future regret (as seen in the case of *Bell*)*;* potential regrets around the loss of future fertility might be particularly concerning.

As we highlighted earlier, fertility counselling is recommended within all clinical guidelines. Barriers such as funding for fertility preservation alongside the psychological impact of undertaking fertility preservation interventions were reported as contributing to low uptake of fertility preservation prior to gender-affirming medical and surgical treatments. [29] However, as Pang *et al.* note, such barriers can be overcome.[30]

Even where fertility counselling is integrated into decision-making, patients might still be unable to make firm decisions on future parenting goals.[31] However, even in these cases, the question as to whether proceeding with surgery would be negligent should not depend on this. The decision to proceed with surgery should consider implications upon fertility, but this

should be alongside an assessment of quality of life overall, as part of determining medical necessity and best interests.

Data on postsurgical outcome refer primarily to adult patients. Adult patient studies show that in the majority of cases surgery is beneficial,[32],[33] although some studies report psychosocial poor outcomes, higher mortality, particularly from suicide, and lower quality of life than cisgender cohorts.[34] Results do not appear fully consistent; studies suggest that and instances of regret, although not inexistent,[35] are 'exceedingly rare'.[36]

Outcomes vary also because the experience of the side-effects of various interventions may be different from what the individual anticipated. For example, a patient may experience the inability to urinate while standing, cosmetic appearance, donor site morbidity and scars, just to mention a few, as more (or less) frustrating than anticipated.[37] These are not strictly speaking surgical considerations: they are considerations about the patient's quality of life, present and future, and the patient's satisfaction in their own unique personal and social circumstances.

We should thus further differentiate between regret and *unfavourable outcomes*. 'Regret' might mean that some or all surgical interventions are later regarded as a 'mistake' by the patient; in these cases, patients might seek reversal surgery. Unfavourable outcomes mean that patients might be dissatisfied with some of the features of the surgery (size of the vagina, sensitivity or appearance), or that their quality of life has not increased in the way that was expected. Regret in the former sense is rare. Unfavourable outcomes are less rare.

Clinicians might be understandably worried that young patients might be unable to anticipate how they will feel far in the future, and might deem it more prudent to postpone irreversible interventions till after adulthood. However, it is not clear that only treating adult patients would facilitate the difficult task of long-term predictions.

Research shows that, although adolescents might be prone to make impulsive decisions, by mid adolescence the ability to make decisions on the basis of considerations of probability is comparable to those of adults in most settings. [38] Whereas there might be special features of adolescence that might make decision-making more problematic than in adulthood, those special features do not disappear on the 18th birthday. Some adults might lack forecasting skills, and some adolescents might show significant long-term vision. A specific age requirement

provides no reassurance, in itself, that the patient has the ability to make an irreversible decision (neither being a minor *per se* demonstrates lack of that ability).

The request to access surgery, moreover, seldom appear abruptly. As Grimstad and Boskey note:

> Surgery is not a singular event but a longitudinal experience […] It is also essential for patients and their caregivers to acknowledge that, while GAS [gender-affirming surgery] can accomplish some goals, it is not the golden ticket to solving all problems related to gender affirmation. Everyone involved […] must realize that it is possible to make the best possible informed decision and still have some regret, because the current reality of GAS is that it is almost never the perfect option, even when it is the best possible one. [39]

Being realistic about outcomes should not necessarily lead to prohibition, either at law or *de facto*, certain procedures which might be in an adolescent's best interests overall. Being in the best interests overall is not the same as being 'perfect' or 'fully satisfactory': in many cases, the outcome might be some way below ideal. If it is unlikely that surgery will be beneficial, and likely that patients will come to regret the choice to undergo surgery, this would provide an ethical and clinical reason to refuse an application, and this would be so *regardless of the age of the patient*.

The balance is admittedly difficult: offering irreversible interventions to a minor (be it hormonal or surgical) should happen under strict safeguarding, but postponing surgery is not necessarily always a cautionary approach (see next section): waiting can cause unnecessary suffering to some patients. The way to address concerns around how to make realistic assessments of future outcomes is not through prohibition, but through involvement of professionals with the relevant expertise who can provide support to the treating clinicians as much as to the patients. Clarification of eligibility criteria and clear guidance on how assessment should be made and who should be involved in such assessment would be necessary in order to guide clinicians in making clinically appropriate and ethically sound decisions.

In summary, neither future regret nor unfavourable outcomes would *per se* expose clinicians to claims in negligence, as far as the appropriate standards of care were offered, that the surgery appeared in the overall best interests of the patient, that the appropriate consents were in place, and that all relevant material risks (including risk of unfavourable outcomes and future regret) were explained at the time of gathering consent.

REASONS IN FAVOUR OF OFFERING GENITAL SURGERY TO MINORS

There might be many reasons why genital surgery might in the best interests of a minor. For example that romantic relationships for some adolescents may be essential to their immediate and long-term welfare, and the genitalia may render the natural progression of those relationships impossible or unnecessarily hard.[40] A 2001 study[41] showed that out of 22 adolescent patients who had undergone full gender surgery, and positive results crossed several domains: gender dysphoria, physical satisfaction, feelings of regret, gender role behaviour, psychological, social and sexual functioning. None expressed regret. The authors attribute such positive outcomes partly to the strict eligibility criteria. Applicants affected by significant psychiatric problems were not deemed eligible for surgery. The authors also noted that in a limited number of cases surgery 'may also be sought as a solution to nongender problems' (p.480). Irreversible treatments, they concluded, should not be considered when there are many adverse factors that operate simultaneously. They also noted that unfavourable outcomes were typically associated with *late* start of medical treatment. The clinicians here were very careful to point out that this does not mean treating anyone who applies for surgery, and we do not suggest this either. The least invasive and restrictive procedure should be preferred (and the same reasoning applies equally to minors and adults).

The landscape has changed significantly in the last twenty years: the population of gender diverse young people is much more heterogeneous, many more young people approach clinical services, and many identify as nonbinary. It is logical and reasonable to choose the intervention that is least invasive and that least forecloses options for a minor, and to provide irreversible treatments only to those who are highly unlikely to change their minds later on, or to suffer severe adverse and unfavourable outcomes. How this fair certainty can be reached, however, cannot be a function of chronological age, but it can in all likelihood only be reached over time, through continued assessment while remaining open to various possible trajectories that young

people might take.

Whilst a cautious approach to the provision of irreversible surgical interventions is in ethically defensible, providing they are not precluded when they may be in the best interests of a minor, such a cautionary approach is not universal. In what follows we will consider surgery for intersex conditions: we do not want to compare gender diversity with intersex conditions but consider what we ought to learn from the different ways in which surgery is framed as being in a minor's best interests.

ASSIGNING OR ALIGNING INTERSEX BODIES?

Differently from genital/gonadal surgery for transgender minors, genital/gonadal surgery has been, and still is, routinely performed to 'normalise' the genitalia or remove 'inappropriate' gonads of intersex infants and children (often before the age in which they might be competent to consent to those procedures).[42] Intersex conditions, or 'disorders of sex development' (DSD), encompass various conditions in which a person is born with a sexual or reproductive anatomy that does not fit the typical physical sex characteristic definitions of female or male sexes within society.[43]

The ICD-11 recommends genital or gonadal surgery for children as part of the management of some DSD, for example congenital adrenal hyperplasia.[44] Other recent clinical guidance for managing a DSD promotes the use of a broad multidisciplinary team to diagnose and support parents in assigning a binary sex to an intersex child, with potential use of hormonal and surgical interventions. Surgical interventions include both genital and gonadal surgeries, such as hypospadias repair, clitoral resection, vaginoplasty and gonadectomy, if indicated from the medical investigations. [45] Psychological support has been recognised as essential and beneficial in the management of children with a DSD, but in tandem with and not instead of medical treatment.[46]

Genital morphology that is considered as medically 'abnormal' or 'inappropriate' has been so far assumed to have a negative and potentially detrimental effect on the child with a DSD as they develop into adolescence and adulthood (despite the lack of evidence to support this).[47]

Therefore genital surgery may be carried out partly with the intended benefit of supporting aesthetic and functional future sexual health.

However, many later in life report feeling 'disabled' by the surgery obtained in childhood, both in respect of their identity and sexual health, [48] and forced to live a life of medical treatment and confusion around their gender.[49] Despite being highly controversial, to the extent that in some legal jurisdictions it is now unlawful,[50] genital 'normalising' surgery is still widely considered to be in the best interests of intersex children.[51]

Genital surgery and any subsequent lifelong medical management not only alter genital conformation; they also represent a decision about a child's gender. It difficult to understand why genital surgery for transgender minors has been effectively a taboo for nearly two decades, while genital surgery and gender assignment in young children with DSD has been and continues to be considered appropriate and *necessary* medical treatment in many countries. One reason may be that the longstanding psychiatric classification of gender dysphoria has resulted in an apprehensive approach, whereas intersex conditions are considered 'biological' conditions, and, by extension, somatic disorders. The nomenclature used within intersex and gender diverse conditions might have contributed to the different ways in which proper medical treatment and the best interests of minors have been construed.[52] However, in both cases the surgery involves altering the genitals of a minor congruently with a gender that is either predicted (in cases of DSD) or experienced (in cases of transgender minors).

It should be noted that the SoC8 recognise that intersex surgery is controversial, and advise to delay it until the minor can fully participate and consent to surgical interventions (Ch.10). In this way, the clinical practice towards intersex and gender diverse minors becomes less inconsistent. Both can be in a minor's interests; however, in both cases the minor's ability to fully participate and consent should be central to the decisions made.

We must be wary, however, of the residual presumption of negative prognosis associated with 'ambiguous' or 'unmatching' genitalia. This presumptive negative sexual health prognosis could be explained as this: if a person has a male or female gender identity, then clinically they should have corresponding genitalia for satisfactory sexual and mental health.

This is problematic in at least two ways: firstly, many people can develop a healthy gender identity and experience satisfying sexual health and wellbeing without the need for 'matching' or 'normal' genitals. Secondly, it would be reductive to present gender identity as something primarily to do with genital appearance. The SoC8 include a new chapter dedicated to Nonbinary patients, and stress the importance of individualised assessment and careful examination of individual needs, without assumption about what types of treatments might be needed (Ch.8). However, we should note that not all those who might not need genital/gonadal surgery identify as 'nonbinary'. Lowering or eliminating the age of access to genital surgery should not lead to the presumption that genital surgery is clinically necessary for all transgender adolescents, or that only those who have genital dysphoria may qualify as truly transmen or women.

In summary genital surgery has been provided to minors for a long time, as routine treatment, to ensure that genital appearance might match gender identity, in DSD patients. The history of treatment provided for intersex patients teaches us that those surgeries are often harmful, and that intervening on a young child unable to comprehend the nature and purposes of what is proposed is ethically problematic, if not outright wrong. However, patient regret has not grazed clinical practice; equally ethically problematic is to use an entirely different standard for gender diverse youth. A sensible balance is eliminating the age of majority threshold, while remaining mindful of the various possible ways in which individuals might develop and how their best interests may be determined using individual holistic assessment as to whether surgical interventions should be considered.

SUMMARY

Genital surgery on gender diverse minors is not unlawful under English law, but recent legal developments following *Bell* mean that clinicians are unlikely to be able to offer genital surgery without parental consent, and, in particular, to very young minors. Although the treatment for gender incongruence and dysphoria has been deemed lawful by the courts, it has also been considered 'controversial', and therefore special caution might be required.

Doctors should be suitably qualified, should thoroughly assess best interests and capacity, should duly inform patients of all material risks, including risks of unfavourable outcome and regret, and ensure that appropriate consents are in place. The ability to consent is specific to

the decision, and a child who might be competent to consent to PBs might still lack the capacity to consent to gender-affirming hormones and other irreversible interventions, including genital surgery. At each stage, consent needs to be gathered, and capacity and best interests must be assessed.

Clinicians should not operate on patients on request, if they deem the surgery as not being in the minor's (or in an adult's) best interests. Clear eligibility and assessment criteria for surgery should be provided, to assist clinicians and patients in ensuring that genital surgery can be made available to minors when this appears to be in their best interests, when it is highly likely that the person will overall benefit from the surgery in the short and long term, while remaining sensitive to professional, regulatory and legal contexts in which clinicians work.

Practice points

- Genital surgery for minors is not unlawful under English law.
- Only suitable qualified professionals should consider offering surgery, particularly to minors.
- Professional guidelines clarify the competencies required.
- Special caution should be used in the determination of best interests and competence of the minor.
- Capacity to consent to blockers does not imply capacity to consent to irreversible treatment.
- The appropriate consents should be in place.
- A staged approach to medical treatment can minimise the risk of offering irreversible procedures to those who might come to regret the decision.

Research agenda

- Data relating to surgery in minors should be published in relevant peer reviewed journal, to enhance evidence base.
- There are sound reasons for involving surgeons in paediatric care to discuss future fertility and sexual health concerns with young adolescents applying for hormone treatment.
- Data around competence and outcomes should be published.
- Appropriate follow-ups should be conducted, following research ethics established principles.

REFERENCES

[1] WPATH. *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People*, (2011).

[2] Coleman E, Radix AE, Bouman WP, Brown GR, de Vries ALC, Deutsch MB, et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International J of Transgender Health 2022; 23:sup1: S1-S259. DOI: 10.1080/26895269.2022.2100644.

[3] https://www.england.nhs.uk/publication/service-specification-gender-identity-services-for-adults-surgical-interventions/

[4] McDougall R, Notini L. Overriding parents' medical decisions for their children: a systematic review of normative literature. *JME* 2014; 40: 448-452.

[5] https://www.legislation.gov.uk/ukpga/1969/46

[6] Cave E. Goodbye Gillick? Identifying and resolving problems with the concept of child competence. *Leg Stud* 2014; 34(1):103-122.

[7] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7

[8] Re W (A Minor) (Medical Treatment) [1992] 4 All ER 627

[9] General Medical Council, 0-18, 25-26. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years.

[10] *R (on the application of) Quincy Bell and A v Tavistock and Portman NHS Trust and others* [2020] EWHC 3274 (Admin):

[11] Wooley S. The limits of parental responsibility regarding medical treatment decisions. *Arch Dis Child* 2011; 96: 1060-1065.

[12] *Bell and Another v Tavistock and Portman NHS Trust and others* [2021] ECiv 1363: [4].

[13] [1981] QB 715

[14] Thomas M, Pegg S. Proper Medical Purpose: Reviewing Consent and the Medical Exemption to Offences Against the Person: R v Paterson [2022] EWCA Crim 456. *The Journal of Criminal Law* 2022; p.00220183221115272.

[15] EWCA Crim 560.

[16] Bolam v Friern Hospital Management Committee [1957] 1 WLR 583.

[17] Jackson E. Medical Law: Text, Cases and Materials. Oxford: Oxford University Press: 2022.

[18] https://www.gmc-uk.org/

[19] Herring J, Foster C. Welfare means relationality, virtue and altruism. *Leg Stud* 2012; 32:480-498.

[20] [2006] EWHC 507: [16].

[21] Mitchell M, Rogers J. Prohibiting the queer body: gender affirmation, female genital cutting, and the promise of gender intelligibility. Crit criminal-neth 2021; 29: 707-721.

[22] Female Genital Mutilation Act 2003.
https://www.legislation.gov.uk/ukpga/2003/31/contents

[23] *Chatterton v Gerson* [1981] QBD 432.

[24] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

[25] *Metcalfe D, Pitkeathley C, and Herring J. 'Advice, not orders'? The evolving legal status of clinical guidelines. *JME* 2020; 47: e78-e78.

[26] Purshouse C. The impatient patient and the unreceptive receptionist: Darnley v Croydon health services NHS trust [2018] UKSC 50. *Medical Law Review* 2019; 27: 318-329.

[27] *C v Cumbria Health Authority* [2017] EWHC 128 (QB).

[28] Samanta A, Samanta J, Beswick J.. Responsible Practice Or Restricted Practice? An Empirical Study Of The Use Of Clinical Guidelines In Medical Negligence Litigation. *MLR* 2021; 29: 205-232.

[29] Baram S, Myers SA, Yee S, Librach CL. Fertility preservation for transgender adolescents and young adults: a systematic review. Hum Reprod Update 2019; 25: 694-716.

[30] *Pang KC, Peri Angus JS, Chung Hsu En, Telfer M, Elder Charlotte V, Grover Sonia. Rates of fertility preservation use among transgender adolescents. JAMA Pediatrics 2020; 174: 890-891.

[31] Cheng PJ, Pastuszak AW, Myers JB, Goodwin IA, Hotaling JM. Fertility concerns of the transgender patient. Translational andrology and urology 2019; 8: 209-218.

[32] Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A, Erwin PJ, Montori VM. Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes. *Clin Endocrinol* 2010; 72: 214–31.

[33] Bouman MB, van der Sluis WB, van Woudenberg Hamstra LE, Buncamper ME, Kreukels BPC, Meijerink WJHJ, et al. Patient-reported esthetic and functional outcomes of primary total laparoscopic intestinal vaginoplasty in transgender women with penoscrotal hypoplasia. *J Sex Med* 2016; 13: 1438-1444.

[34] Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS ONE* 2011; 6: e16885. https://doi.org/10.1371/journal.pone.0016885.

[35] Djordjevic ML, Bizic MR, Duisin D, Bouman MB, Buncamper M. Reversal Surgery in Regretful Male-to-Female Transsexuals After Sex Reassignment Surgery, *J Sex Med* 2016; 13: 1000–1007. https://doi.org/10.1016/j.jsxm.2016.02.173.

[36] Danker S, Narayan SK, Bluebond-Langner R, Schechter LS, Berli JU. Abstract: A Survey Study of Surgeons' Experience with Regret and/or Reversal of Gender-Confirmation Surgeries, Plast Reconstr Surg Glob Open 2018; 26:189. https://doi.org/10.1097/01.GOX.0000547077.23299.00.

[37] Selvaggi G, Giordano S. The role of mental health professionals in gender reassignment surgery: unjust discrimination or responsible care? *Aesth Plast Surg* 2014; 38: 1177-1183.

[38] Bernacki JM, Weimer AK, Role of development on youth decision-making and recovery from gender-affirming surgery. *Clinical Practice in Pediatric Psychology* 2019;7: 312–321. https://doi.org/10.1037/cpp0000294.

[39] *Grimstad F, Boskey E. How Should Decision-Sharing Roles Be Considered in Adolescent Gender Surgeries? *AMA Journal of Ethics* 2020; 22: 452-57.

[40] *Milrod C. How Young Is Too Young: Ethical Concerns in Genital Surgery of the Transgender MTF Adolescent, *J Sex Med* 2014; 11: 338-346.

[41] *Smith YL, van Goozen SH, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. J Am Acad Child Psy 2001; 40: 472-481. doi: 10.1097/00004583-200104000-00017. PMID: 11314574.

[42] Kennedy A. Fixed at Birth: Medical and Legal Erasures of Intersex Variations. University of New South Wales Law Journal 2016; 39: 813–842.

[43] Naezer M, Oerlemans A, Hablous G, Claahsen–van der Grinten H, van der Vleuten A, Verhaak C. We just want the best for this child': contestations of intersex/DSD and transgender healthcare interventions. J Gend Stud 2021; 30: 830-843.

[44] World Health Organization, Congenital adrenal hyperplasia, *ICD-11 Foundation*, 2018, https://icd.who.int/dev11/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f172733763

[45] Ahmed S, Achermann JC, Arlt W, Balen A, Conway G, Edwards Z, et al. Society for Endocrinology UK Guidance on the initial evaluation of an infant or an adolescent with a suspected disorder of sex development (Revised 2015). *Clin Endocrinol* 2016; 84: 771-788.

[46] Mouriquand P, Caldamone A, Malone P, Frank J, Hoebeke P. The ESPU/SPU standpoint on the surgical management of Disorders of Sex Development (DSD). Journal of Paediatric Urology 2014; 10: 8-10.

[47] Zillén K, Garland J, Slokenberga S. *The Rights of Children in Biomedicine: Challenges Posed by Scientific Advances and Uncertainties.* Committee on Bioethics of the Council of Europe 2017; 43, https://rm.coe.int/16806d8e2f

[48] Lee P, Schober J, Nordenström A, Hoebeke P, Houk C, Looijenga L, et al. Review of recent outcome data of disorders of sex development (DSD): emphasis on surgical and sexual outcomes. Journal of Pediatric Urology. 2012; 8: 611-615.

[49] Schweizer K, Brunner F, Handford C, Richter-Appelt H. Gender experience and satisfaction with gender allocation in adults with diverse intersex conditions (divergences of sex development, DSD). Psychology & Sexuality 2014; 5: 56-82.

[50] *Garland, F. and Travis, M., Making the state responsible: intersex embodiment, medical jurisdiction, and state responsibility. Journal of law and society. 2020; 47: 298-324.

[51] Krishna KB, Kogan BA, Mazur T, Hoebeke P, Bogaert G, Lee PA. Individualized care for patients with intersex (differences of sex development): part 4/5. Considering the Ifs, Whens,

and Whats regarding sexual-reproductive system surgery. Journal of Pediatric Urology 2021; 17: 338-345.

[52] Horowicz, E. and Giordano, S., Gender Incongruence as a Condition Relating to Sexual Health: The Mental Health 'Problem' and 'Proper' Medical Treatment. Droit et Cultures 2021; 80. https://journals.openedition.org/droitcultures/6460

Conflict of interests: none

HIGHLIGHTS

- Genital surgery for minors is not unlawful under English law.
- Future regret and unfavourable outcomes do not per se expose clinicians in claims in negligence.
- There are no ethical or legal reasons to retain the age of majority as an eligibility criterion for genital surgery.
- However, the differentiation of stages of treatment (blockers, cross-sex hormones, surgery) can minimise the risk of offering irreversible procedures to those who might come to regret the decision.
- Good practice should encompass staged approach, provision by competent and suitable qualified professional, and a thorough assessment of the minor's best interests; the appropriate consents should be in place.