



SPANISH ASSOCIATION OF PAEDIATRICS

Statement by the Spanish Paediatric Association in relation to gender diversity in childhood and adolescence: Ethical and legal view from a multidisciplinary perspective[☆]



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Abstract An ethical and legal view of gender diversity in childhood and adolescence is presented from the perspective of the best interest of the child and the principle of protection against vulnerability. The identification of gender diversity in childhood and adolescence is a process that requires support, coordination and a multidisciplinary team that improves care and helps to obtain evidence that is lacking today. Secure, equitable and comprehensive access to care and health care should be guaranteed when required. It is necessary to promote a changing of social outlook, capable of overcoming the stereotypes that lead to discrimination and increase suffering. Respect for gender diversity in childhood and adolescence is a fundamental Human Right. The recognition of a positive value in diversity is an ethical imperative. All of this, without forgetting that we are talking about minors often in contexts of vulnerability, and currently very uncertain, so prudence is the main rule that should guide decision-making.

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PALABRAS CLAVE

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Posicionamiento

Posicionamiento Técnico de la Asociación Española de Pediatría en relación con la diversidad de género en la infancia y la adolescencia: mirada ética y jurídica desde una perspectiva multidisciplinar

Resumen Se realiza una mirada ética y jurídica de la diversidad de género en la infancia y la adolescencia desde la perspectiva del interés superior del menor y del principio de protección frente a la vulnerabilidad. La identificación de la diversidad de género en la infancia y la adolescencia es un proceso que además de acompañamiento exige coordinación y trabajo multidisciplinar que mejore la atención y ayude a obtener mayores evidencias que, a día de hoy, faltan. Se ha de garantizar el acceso seguro, equitativo e integral a cuidados y atención sanitaria en caso de que lo precisen. Es necesario promover un cambio de mirada social, capaz de superar los estereotipos que suponen discriminación y aumentan el sufrimiento. El respeto a la diversidad de género en la infancia y la adolescencia es un derecho humano fundamental. El reconocimiento de un valor positivo en la diversidad constituye un imperativo ético. Todo ello sin olvidar que hablamos de menores en contextos en muchas ocasiones de vulnerabilidad y actualmente de mucha incertidumbre, por lo que la prudencia es la regla principal que ha de guiar la toma de decisiones.

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Introduction

This document, developed by a multidisciplinary group of experts (a primary care paediatrician, paediatric endocrinologists, a child psychologist, members of Boards of Ethics of the Asociación Española de Pediatría [Spanish Association of Paediatrics, AEP] and the Sociedad Española de Endocrinología Pediátrica [Spanish Society of Paediatric Endocrinology, SEEP], and a jurist), aims at presenting a positive perspective on gender diversity in childhood and adolescence with a double aim. First, and as regards health professionals, to promote, where needed, greater quality and compassion in health care delivery through the pursuit of professional excellence and, second, as regards society, to promote the recognition of gender diversity as an essential human right, in an attempt to eradicate the transphobic attitudes that generate a great deal of suffering and to raise awareness on the positive aspects of diversity, dispelling false stereotypes and acknowledging that each human life is a unique, personal and inalienable project that the individual is entitled to configure. We also need to remember that all these aspects are discussed in reference to minors who, at present, are often in situations where they are highly vulnerable and there is significant uncertainty, which requires that, above all, we uphold prudence as the guiding principle in all our decision-making.

Status quo and the proposal of health professionals based on current knowledge

1.1. The demand of care for minors with issues related to gender diversity has increased in recent years in Spain and internationally. This increase could be explained, among other reasons, by a socio-cultural context that promotes greater visibility of both health care resources and gender

rights activism. This is not a new phenomenon, but it seems to be having a greater impact on public opinion of late, as evinced by the recent development and enactment at the national and regional levels of legislation on this matter, while spurring debate in society at large and in academic and scientific circles on how to approach it from the perspective of the best interests of the child and the principle of respect for vulnerability.

1.2. The pathologising and classification of gender variants is the first point of contention. The latest medical classifications (Diagnostic and Statistical Manual of Mental Health Disorders [DSM] and the International Statistical Classification of Diseases [ICD]) have introduced changes in terminology to avoid stigmatising these individuals: transsexuality, gender identity disorder, gender dysphoria (GD). The beta draft of the ICD-11 has changed the latter term to “gender incongruence” and removed these categories from the *Mental and Behavioural Disorders* chapter, including codes associated with trans health care in a new chapter called *Conditions related to sexual health*.¹ The aim of this change is to guarantee the best possible quality of care and the precedence of the best interests of the minor in clinical decision-making, with health professionals acting as guarantors of these interests.

1.3. Gender identity. These new realities pose complex dilemmas as we seem to face a paradigm shift from the binary perception of gender. Identity is constructed by the individual. The development of masculinity or femininity is the result of a process that is forged by the interaction of the individual with the family, society and culture. If we conceive of boys and girls as persons in the making, dependent on their environment, with a marked psychological plasticity and in whom gender identity may not be immutable—that is to say, that there are no guarantees that variations in gender will be permanent in every case²—it is essential that we act with caution, avoid rushed action and the creation

of stereotypes, respect the rhythms and changing needs of each individual and learn to live with this uncertainty. Health professionals would not be involved with the intent to “pathologise” the phenomenon, but rather to guarantee that decisions are made taking into account the current scientific evidence, in pursuit of the best interests of the minor and adhering to the vulnerability principle.

1.4. *The management of gender variance* has been changing and is based on the experience of a small number of units that have worked with diverse groups. However, there are not enough studies, either in Spain or abroad, providing scientific evidence. Furthermore, the most recently published works propose different approaches to the management of gender diversity, but based on overcoming stereotypes and offering care based on client-centred solutions and support.

1.5. *The new international consensus guideline for the treatment of gender dysphoric/gender-incongruent persons*³ proposes the following:

1.5.1. The clinical experience of facilities that have worked longest in this field has shown that different individuals have different circumstances and needs, and therefore the management of gender diversity issues must be multidisciplinary, long-term, and individualised.

1.5.2. The role of mental health professionals is key. They must be well educated, knowledgeable and experienced in regards to gender diversity, be willing to provide continuous care through transition.

1.5.3. Health providers should be careful to avoid harming individuals with conditions other than GD/gender incongruence with sex hormone treatment, as they may not benefit from the physical changes associated with this treatment.

1.5.4. It is pressing that further research be conducted, mainly prospective randomised controlled trials, to be able to improve the care provided to these persons.

This guideline mentions many of the concerns that we have noted thus far. The aim of psychological support should be to address painful experiences, such as discrimination or school bullying, and to promote wellbeing and psychological stability. It is important that we are aware that suffering is not intrinsic to gender variance, but often results from discriminatory responses from the environment.

Psychological assessment and evaluation may be tools that contribute to successful transitioning as opposed to impediments to free choice.

We ought to underscore that delaying or interfering with the implementation of appropriate medical interventions (hormone therapy) in adolescents could prolong the suffering of the person and contribute to a physical appearance that may elicit abuse and stigmatisation.

The ethical perspective: values that need to be taken into account

2.1. *The best interests of the minor*, respecting to the extent possible the will and wishes of the minor in an area as essential to the person as is the construction of gender identity and the free development of personality.

We must not forget that when it comes to children and adolescents, the decision-making powers of the parents are bound by the principle of beneficence, so that they always

have to act in the best interest of the individual they represent, their child. This is not equivalent to decision-making that only affects the individual making the decision, where autonomy is at play. Decisions made by another party, or, in legal terms, surrogate decision-making, are not governed by the principle of autonomy, but rather by the principle of beneficence. Parents may not freely make decisions on the behalf of their children, as they are bound to make decisions according to the child’s best interests and that will not harm the child.

Usually, parents are best suited to determine what the best interests of the child are (although there are occasions in which each parent has differing views, which further complicates the issue). However, this rule is not without limits: it is bound by the principle of nonmaleficence. Thus, when parental decisions are clearly harmful, either by action or by omission, the state must provide resolution to the conflict, adopting whichever solution advances the best interests of the minor.

To this end, the role of both the ethics boards of health care services and of the legal authorities is absolutely crucial in cases where health professionals consider that the choices pursued by parents do not conform to the principle of beneficence.

2.2. *The vulnerability principle*. In the broadest sense, vulnerability is an essential aspect of human nature. However, some individuals are particularly vulnerable, chief among them minors. When it comes to gender diversity, minors are not only vulnerable in that they face specific risks, but also since depending on their status, environment or circumstances they do not have the resources to face these risks without being harmed. Vulnerability involves exposure to a risk and the inability to avoid or overcome its harmful effects. Thus, from a bioethics perspective, the degree of protection to be offered to these minors should be based on their risk of being harmed and the likelihood that they will benefit from intervention.

2.3. *Support and active listening of the self-narrative of the minor*, allowing the expression of their identity and ensuring that the narrative is genuine and not shaped by external agents (society, family) or internal factors (emotions). That is, it is important to provide support, not add to the suffering and not pose barriers to the minor, while also avoiding pushing or manipulating them.

2.4. *Prudence*, since the construction of gender identity is a process. As we already noted, it is essential to act with caution, respecting the natural pace of each individual, and learning to live with uncertainty.

2.5. *Responsibility*. The role of professionals is to advocate for the wellbeing of the minor, always pursuing their best interests while exercising caution. It is important to avoid extremes, either trivialising the experience of the minor or prescribing any treatment requested by the minor or family. Responsibility understood as “a moral principle requiring care for the vulnerable.”⁴

2.6. *Recognition*. It is a moral imperative that we recognise the positive value of diversity. Such recognition allows the transformation of conflictual relationships into cooperative relationships, tending to the needs of all parties involved in the relationship. In children and adolescents, it allows turning a situation marked by conflict into one characterised by cooperation, so it can be confronted from a

more favourable perspective. This can be reflected in each of the spheres of recognition: (1) emotional: the experience of being accepted as one is, the acknowledgement of the individuality of the adolescent within the specific personal social context, promotes self-confidence; (2) legal: as a subject with rights and duties, which promotes self-respect; (3) social: manifested in the recognition of the positive contributions of the individual, which promotes self-esteem. In other words, recognition of the autonomy of the individual to the extent that is possible at each moment, allowing the person to exert their rights progressively and according to their maturity, listening to the individual and informing their values and expectations.

2.7. Respect for diversity. Beyond gender, what matters is the person. It is important to promote a shift in the social perspective so that stereotypes that lead to discrimination and suffering can be overcome. To think that these complex and diverse situations can be addressed just by allowing access to medication or surgery is oversimplifying matters. Thus, we must also act on the educational and social environments to prevent the "pathologization" of difference.

The legal perspective

3.1. The principles of the free development of the child's personality and of respect for human dignity call for a positive response to those individuals who, on perceiving a dissonance between their biological sex and their experienced gender, aim at adapting and developing their life plan according to their preferences, especially when this option does not affect or limit the rights and freedoms of others. The right to self-determination is so integral to human dignity that preventing a person from pursuing their own life plan is to negate the intangibility of human beings.

3.2. The State cannot keep a subject from developing a life plan according to their experienced gender and, furthermore, should actively promote it. However, when it comes to minors whose ability to make decisions is limited, the State also must act as the advocate of the minor.

3.3. From a legal perspective, the problem lies in gender variance occurring in *minors*, in some cases at very early ages. When it comes to minors and their decision-making powers, the Law distinguishes between decisions with reversible consequences and decisions with irreversible consequences, possibly limiting or even removing the power to decide until the person reaches adulthood. The quandary stems from those treatments that have irreversible consequences for the personal integrity of the minor or that carry significant risks.⁵ We must not forget, either, that as we noted before we are discussing the issue of decision-making by proxy, where the decision-making powers of parents are limited and bound by the principles of beneficence and the best interests of the minor. The Spanish Penal Code dictates that sterilisation and sex reassignment surgery performed by a doctor is punishable by law when the patient is a minor, regardless of consent from the legal guardians.

3.4. The lack of scientific evidence generates uncertainty as to what constitutes the best interests of the minor, which calls for utmost caution in the clinical management of these minors and even postponing treatments that have irreversible effects as long as possible.

Recommendations

Table 1 presents the overall and specific recommendations for the care of gender non-conforming children and adolescents.

4.1. The management of children and adolescents with gender variance must avoid their stigmatisation and guarantee safe, equitable and integral access to health care as needed.

4.2. In children and adolescents, gender variance is identified through active listening of the self-narrative of the minor, allowing the expression of their identity and ascertaining that the presented narrative is genuine and not conditioned by external agents (family, society) or internal factors (emotions). This is a prolonged, complex and individualised process that requires not only support, but the establishment of frameworks for coordination and multidisciplinary work to not only improve care, but also develop the body of evidence that we are currently lacking. Positive medical support would be that which advances the best interests of the minor.

4.3. In this regard, as the gatekeepers to the health system, primary care paediatricians play an essential role in this positive and individualised support, personalising care according to the needs that may arise, which may range from the etiquette of the health professional during appointments (such as respecting the name chosen by the minor to match their experienced gender) to the identification of patients requiring referrals on the request of the minor or their family. To achieve this, we recommend that primary care paediatricians have at least basic training on issues specific to gender diversity, as well as accurate and updated information on local resources, including specialists (with the aim of enabling the coordination required to provide accessible and high-quality integral care, including referral to paediatric endocrinology and child and adolescent mental health services) and community organisations that could support the families and the minors (adolescents may find sharing similar and diverse experiences with peers particularly helpful).

4.4. Primary care professionals are also responsible for identifying potential abuse, understood as one or both parents inflicting suffering on the minor due to their failure to respect their gender identity. In such cases, professionals will first involve the competent ethics committees, seeking to resolve the conflict through mediation and, as a last resort, the legal system, always advocating for the best interests of the minor.

4.5. Similarly, it is important to promote the active participation of the minor in decisions involving their health, to a degree determined by their level of maturity and the severity of the consequences of the decisions. This requires providing adequate information in language that is clear, understandable and adapted to the minor and the family.

4.6. Access to any medical or surgical care will require, in every case, verification of the individual's transsexuality with ruling out of potential disorders, a process that will include an endocrine and a psychological evaluation. These evaluations do not stem from a belief that transsexuality is a disease. Instead, it seeks to confirm that the self-narrative is not affected by potential disorders and, should any such

Table 1 Overall and specific recommendations for the care of children and adolescents with gender variance.

Overall recommendations for the multidisciplinary team (PC paediatrician, psychologist, paediatric endocrinologist)		
Positive and individualised support: individualised needs (use chosen name, requests for referrals, etc.)		
Role of advocates for the best interests of the minor		
Promote active involvement of the minor in making decisions about health (maturity, severity, consequences)		
Provide information using language that is clear, understandable and adapted to the minor and their family		
Fluid communication with the school system		
Multidisciplinary followup of cases; coordination of PC paediatrician/psychologist/paediatric endocrinologist		
Perform clinical research with the end of improving quality of care		
[10pt]		
Specific recommendations		
PC paediatrician	Psychologist	Paediatric endocrinologist
Specific training in basics of care	Verify transsexuality: active listening of minor's self-narrative (before treatment)	Verify transsexuality: active listening of minor's self-narrative (before treatment)
Coordination of PC/speciality services: integral care that is accessible and of high quality	Psychological support (minor, family): promote wellbeing and stability	Basic endocrine evaluation
Information on local resources:	Identification of painful experiences (bullying, discrimination, rejection by family): support, resources	Diagnostic tests to rule out intersexuality
– Specialised professionals	Support in school, facilitating transitioning	Ruling out disorders (initiate treatments)
– Social worker	Counselling in social transitioning	Decide on prescription (if requested) of:
– Advocacy groups (peer and family groups)	Rule out psychiatric disorders (offer treatment as needed)	– GnRH analogues (reversible)
Detection of suspected abuse (family, school): intervention through the Health Care Ethics Committee or the legal authorities		– Cross-sex therapy: sex hormones (partially irreversible)
Assess referral needs: psychologist and paediatric endocrinologists of the multidisciplinary team		Follow up: blood tests, side effects
Health education: healthy lifestyle (hormone treatments)		Exercise caution in prescription of irreversible treatments

disorders be identified, to provide adequate treatment. While these psychological interventions are underway, diagnostic tests should be performed to rule out possible disorders of sex development (intersexuality). The aim of all of the above is to guarantee to the degree possible the clinical safety of individuals that receive medical or surgical treatment. The role of health professionals is to guarantee the wellbeing of the minor, always in pursuit of their best interests, beyond the mere prescription of treatment.

4.7. Children and adolescents that meet the criteria for GD/gender incongruence and request medical care will be evaluated by the paediatric endocrinologist of the multidisciplinary team. Treatment with GnRH will be initiated when the person reaches puberty with the purpose of inhibiting the development of secondary sex characteristics. In adolescents that request cross-sex hormone therapy, whose results are partially irreversible, we recommend delaying its initiation until the multidisciplinary team (endocrinologist and mental health professional) has confirmed the persistence of GD/gender incongruence and the individual is mature enough to provide informed consent, which usually occurs by age 16 years in adolescents.

4.8. The lack of scientific evidence on what constitutes the best interests of the minor demands utmost caution in the management of cases overall, and possibly postponing treatments that have irreversible effects as long as possible.

In short, as scientific societies we must strive to promote respect for gender diversity in childhood and adolescence not only because it is an inalienable right, but also because it is a moral imperative to recognise the positive aspects of human diversity.

Conflicts of interest

The authors have no conflicts of interest to declare.

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