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Providing Puberty Suppression Treatment for Transgender Youth: What Constitutes Competence?

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There is growing recognition that gender identity is a non-binary construct that is defined as a person's inherent sense of being a female, a male, a blend of male-female, or an alternative gender. Transgender and gender-nonbinary persons (TGNB) have a gender identity that is not fully aligned with their sex assignment at birth (APA, 2015). Pubertal suppression using gonadotrophin-releasing hormone (GnRH) agonists prevents the development of irreversible secondary sex characteristics (e.g., breast development, facial hair) in pre-pubertal adolescents who find the emergence of physical characteristics incongruent with their gender identity. While that may be the goal for patients who wish to permanently achieve a body consistent with their gender identity, the use of gender-affirming hormone therapy is not without significant medical risks (Olson & Garofalo, 2014). This case raises questions regarding the education, training, and experiential competence necessary for a physician to provide pubertal suppression treatment to a 10-year-old youth ("Seth") entering puberty who presents with a consistent developmental history of transgender identity.

Competence is the foundation upon which physicians can fulfill their ethical obligations to do good and do no harm. Competence is not a static characteristic of responsible care. Physicians are required to undertake ongoing efforts to maintain and develop new competencies based on the evolving nature of established scientific and professional knowledge. As treatments for transgender and other traditionally marginalized patients become available, continuing to update one's competence through additional training, knowledge, or consultation is ethically required to ensure that all patients receive equitable access to and are not denied treatment. However, the question in this case is whether the physician has a duty to obtain such competence by acquiring additional training or refer the patient to another provider. In this case, Dr. Nash's training as a pediatric endocrinologist, his prior experience treating a patient with gender dysphoria, and his willingness to reach out to colleagues for consultation to ensure

that treatment meets current standards provides evidence demonstrating that he could provide competent treatment for Seth that is within ethical standards of his scope of practice. Related, Dr. Walker, Seth's pediatrician, who did not have expertise in endocrinology, rightly recognized the limits of her training and made an appropriate referral.

It appears that Dr. Jessup, in his refusal to provide pubertal suppression treatment to Seth, and his recommendation for mental health treatment, has the uninformed misimpression that transgender identity is a mental health disorder. Although mental health assessment is an important component of competent treatment decisions regarding pubertal suppression, a child's identification as TGNB is not pathological: it can be healthy and self-affirming (SAMSHA, 2015). It can also be associated with dysphoria, suicidal ideation, and other forms of emotional distress due to discordance between one's gender identity and one's body, limited availability of mental health services, low access to health care providers with expertise in caring for TGNB youth, discrimination, and social rejection (American Academy of Pediatrics, 2018). Pubertal suppression provides time for further identity exploration, which can minimize distress associated with pubertal maturation that is inconsistent with one's gender identity and improve future healthy adjustment (Edwards-Leeper & Spack, 2012).

Although Dr. Nash may be (or with additional consultation and/or training, *become*) competent to provide the hormone therapy, it is not clear whether he recognizes the importance of linking medical care with behavioral health services. Psychological assessment in conjunction with the decision to provide pubertal suppressing hormones is required to understand the present status of Seth's gender identity and distress, to assist with readiness for medical treatment, and to provide developmentally appropriate information to Seth and his family detailing the potential risks, benefits, and implications of pubertal suppression, to ensure fully informed assent and parental consent (APA, 2015; Janssen & Leibowitz, 2018).

This case raises questions regarding the competence of the ethics consultant to advise on this issue. Given the current sociopolitical climate promulgating biased or uninformed societal attitudes toward transgender persons, it is unprofessional for an ethics consultant to legitimize the recommendations of an anonymous caller in the absence of other evidence. As presented in this case, the ethics consultant takes as fact the anonymous caller's unsupported claims that he works at the same hospital as Dr. Nash. The consultant also gives credence, in the absence of other information, to the caller's medical advice regarding problems with Dr. Nash's monthly availability, and the hospital at which Seth would be best served. It is not clear what additional information the ethics consultant will obtain to "weigh in" on Dr. Nash's competence to provide treatment since he has confirming evidence from Dr. Nash regarding availability, experience, and steps Dr. Nash will take to consult with colleagues. What is clear is that the delay will result in Seth's ongoing distress, and presents the possibility that Seth and his parents will lack trust in Dr. Nash as a competent provider going forward.

Fairness and justice require that ethics consultants exercise reasonable judgment when considering treatment for patients from socially marginalized groups, to ensure their biases and boundaries of competence do not lead to inequities in access to care. In this case, the hospital center specializing in care for transgender youth is 300 miles away; a burden that will be difficult for the family to overcome. That burden may, in turn, result in Seth being deprived of treatment critical to his psychological well-being. The ethics consultant should not be placing ethically unjustified barriers on Seth's treatment based on uninformed opinions regarding the competencies required for adequate pubertal suppression treatment, and the medical harms that can arise when appropriate services are geographically limited.,. A resolution to this case is for the consultant to recognize Dr. Nash's current competencies and to support his commitment to establishing collaborative relationships with colleagues to ensure his ongoing competence to provide pubertal suppression therapy. The consultant should also recommend that prior to the initiation of hormone treatment, Dr. Nash make arrangements for Seth and his family to meet with a mental health professional who will assess Seth's gender identity status, his desire and

understanding of what he can expect from pubertal suppression, and his ongoing psychological treatment needs once hormone treatment is initiated. These steps will help Seth and his family make the treatment choice most appropriate and affirming for Seth's treatment needs and ensure the competency of his medical care.

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