

Physical Interventions on the Bodies of Children to “Affirm” their “Gender Identity” Violate Sound Medical Ethics and Should be Prohibited

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Rather than teaching children to identify based on how well they fit prevailing cultural expectations on sex, we should be teaching them that the truth of their sexual identity is based on their bodies, and that sometimes cultural associations attached to the sexes are misguided or simply too narrow. There is a wonderfully rich array of ways of expressing one’s embodiment as male or female.

Several weeks ago, many Americans were concerned about a seven-year-old boy in Texas who was the subject of a custody battle after his parents divorced. Fights over the custody of children are always tragic, but what made this one especially disconcerting was that the parents disagreed about medical care for their son. This wasn’t just any usual medical decision for a child, where parents need to consider the treatment options and weigh the respective likelihoods of success, potential side-effects, and risks. No, this was a case where the parents favored radically different treatment options because they disagreed about the identity—the “gender”—of their little boy. One of the parents believes the child is actually a girl, a girl trapped in a boy’s body.

It was this disagreement that led to the bitter battle over treatment. So, without saying anything specific about this child’s case, we want to offer readers our best take on what is at stake: the anthropology, ideology, and ethics at issue.

We argue that 'gender affirmation' procedures violate sound medical ethics, that it is profoundly unethical to reinforce a male child in his belief that he is not a boy (or a female child in her belief that she is not a girl), and that it is particularly

unethical to intervene in the normal physical development of a child to “affirm” a “gender identity” that is at odds with bodily sex.

We argue that “gender affirmation” procedures violate sound medical ethics, that it is profoundly unethical to reinforce a male child in his belief that he is not a boy (or a female child in her belief that she is not a girl), and that it is particularly unethical to intervene in the normal physical development of a child to “affirm” a “gender identity” that is at odds with bodily sex. Childhood and adolescence are difficult enough as it is. Adults should not corrupt the social ecology in which children develop a mature understanding of themselves as boys or girls on the pathway to becoming men or women. Medical professionals certainly should not make radical interventions into the bodies of young people on the basis of a misguided ideology of identity.

We Are Not “In” Our Bodies, We *Are* Our Bodies

No one is born in the wrong body, because no one is born “in” a body. Rather, we *are* our bodies. There is nothing that could be “in” the wrong body, for the soul is the substantial form of the body—not some sort of separate substance.

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Human beings are not non-bodily persons who inhabit and use non-personal bodies. We are not ghosts in machines. Our bodies are essential aspects of ourselves as the kind of entity we are—a certain type of animal with a rational nature, a human being. We—you, I, and every other human being—are personal bodily organisms. And the sex of an organism is determined by how that organism is organized with respect to sexual reproduction. As there are two complementary ways of being sexually organized, so there are two sexes: male and female.

The sexual binary is a biological reality. There is no scientific—indeed, no non-ideological—ground for denying it. That some people experience disorders of sexual

development, sometimes referred to as intersex conditions, does not negate this reality. Disorders of sexual development do not constitute a third sex or a spectrum of sex. There is no third gamete, no third gonad, no third genital, no third reproductive system. Nor is there a “spectrum” between the two reproductive systems, despite the reality that these two systems can and sometimes do develop in certain disordered ways. (For more on this, see Chapter 4 of *When Harry Became Sally*.) It is a red herring to point to physical developmental disorders to justify an ideological view of gender as something fluid, non-binary, and utterly detached from our embodiment as male or female.

“Gender Affirmation” Is Based on Ideology and Sex Stereotypes

Of course, people can express their sexual identity as male or female in a variety of ways. They can conform to prevailing cultural norms or stereotypes, or they can deviate from them. They may feel comfortable with prevailing cultural expectations for persons of their sex, or they may feel uncomfortable. They can decide to act in a “gender non-conforming” way, or they can opt to be conventional. None of this, however, changes whether someone is male or female.

And yet, a growing and influential segment of our medical and educational establishments insist that someone’s sex is merely “assigned” at birth, and therefore might have been misassigned and can now be reassigned through “gender affirming” therapies. Here we see ideology calling the tune and scientific fact being shunted aside.

According to this ideology, the appropriate determinant of sex is “gender identity”—one’s putative “internal sense of gender” (what exactly that is, no one knows, but we are told that gender on this understanding is fluid and exists along a spectrum). When someone’s gender identity is at odds with his or her body, medical interventions are said to be appropriate and even desirable to align the body with the identity. The claim, made insistently and even indignantly, is that someone who identifies as a woman is a woman (even if “she”—the pronoun is insisted upon—is biologically male), and so medical technology should be used to provide that person with a “female” body.

This has obvious [philosophical problems](#). If someone who identifies as a woman is a woman, then whatever sort of body that person has already is a woman's body. A woman's body, on this account, is just whatever body someone who "identifies" as a woman has. This, after all, is how you get headlines about a "woman's penis," or a "pregnant man." So what is it that the person is aligning the body to?

Why should someone who identifies as a woman abide by "stereotypical" notions of what a woman's body ought to look like? Why should that person take hormones and undergo surgery to conform to those stereotypes? We've gone from breaking down cultural sex stereotypes to creating an industry in plastic surgery to refashion bodies according to them. And if gender is fluid and exists along a spectrum, what sorts of bodies should "gender non-binary" or "gender-ambidextrous" people be given? What sort of [hormones](#) and [surgery](#) should doctors be providing them? One doctor offers "Penile Preservation Vaginoplasty" where a "neovagina" is created while preserving the penis and testicles.

Rather than recognize the incoherence of their worldview, however, those on the cutting edge of "gender theory" take up this last question and reply: whatever body parts, modifications, and hormones that person desires. As a [2019 Journal of Adolescent Health article](#) put it:

With approximately one-third of TGD [transgender and gender diverse] adults and 40 percent of TGD youth identifying as nonbinary, care guidelines that reinforce binary systems of gender identity may limit access to clinical services and restrict the ability of nonbinary people to navigate medical systems. Framing gender as solely binary defines therapeutic options and outcomes only in reference to two gender experiences, which impacts access.

Moving beyond the binary is the next horizon of medical intervention. It also requires moving beyond medical diagnosis. **Indeed, the most recent proposals for "gender care" assert that it need not be based on any diagnosis of gender dysphoria** at all,

and should merely operate based on an individual’s choice—provided the individual give “informed consent” for that choice. According to [one recent state report](#), Healthcare for TNG [transgender, nonbinary, and gender expansive/nonconforming] youth must be patient-centered and as low-barrier as possible. Informed Consent Models of transition-related healthcare access allow TNG patients to access the essential medical care that they need [*sic*: desire] **without needing to get approval from a therapist or other mental health provider.**

So a minor’s say-so is all it should take to radically transform their body—even to the point of causing permanent sterility.

Affirming Falsehoods, Mutilating Bodies

The philosophical problems highlight why this treatment protocol is misguided—indeed, why it violates sound norms of medical ethics. The purpose of medicine is to bring about human health and wholeness, human flourishing in the physical and psychological domains. Here health is understood not as the satisfaction of desires but as the well-functioning of the mind and body, where our various bodily systems achieve their ends—the circulatory system to circulate blood, the digestive system to digest nutrients, the respiratory system to absorb oxygen, etc.—and where our thoughts and feelings achieve their ends of bringing us into contact with reality. Thus, any medical intervention intended to affirm someone’s false beliefs is inherently misguided. Affirming a falsehood via medical technology gets it wrong, right from the start.

It should go without saying that merely because someone identifies as something doesn’t necessarily mean that he or she is that thing. Some aspects of reality are determined by how someone identifies, but many aspects of reality are quite independent of our chosen identities. So, sometimes identifying as something—a Red Sox fan, for example—makes you that thing. But often it does not. Rachel Dolezal’s “identifying” as African-American didn’t make her African-American. When she claimed to be African-American, she was saying something that wasn’t true—something that didn’t correspond to reality—no matter her self-identification. Similarly, identifying as female or “as a woman” does not

make a male a female or a man a woman—such an “identity” doesn’t correspond to reality. What makes someone a woman (or a man) is being a human being (and, as such, a certain type of organism) who is organized for sexual reproduction in a certain way. And so medical professionals who seek to **“affirm” people in a “gender identity” at odds with reality set themselves about a misguided purpose.**

That’s not all. Not only are some medical professionals affirming falsehoods, they are mutilating bodies in the process. So they are deploying bad means (mutilation) in the service of bad ends (affirming falsehoods). Administering high doses of estrogen to a man who rejects his male reality for some alternative identity (whether as a woman, non-binary, gender-ambidextrous, etc.), or administering high doses of testosterone to a woman who rejects her female reality for some alternative identity (whether as a man, non-binary, etc.), or removing reproductive organs and using plastic surgery to create parts or appendages that resemble those of the opposite sex (or neither, or both), mutilates the body in an effort to reinforce false beliefs at odds with reality. This is a misdirection of the medical profession, a violation of sound medical ethics.

Interfering with Children’s Development

Things only get worse when it comes to prepubescent and adolescent children. Whatever one may think about the ethics of medical professionals’ “transitioning” adults, everyone should be able to agree that adults should not interfere with the natural, healthy development of the bodies and minds of children. Children must be provided with the time and space to develop to maturity. To tell a child that he or she is of the opposite sex (or both, or neither—something underwritten today by standard children’s “gender” books), or to encourage a child’s mistaken belief that he is something other than a boy, or she something other than a girl (however sensitively one may, and should, be handling such a situation), is deeply unjust to that child. To intervene in a child’s physical development, to block the child from going through normal puberty—all in an attempt to “affirm” a “gender identity” that rejects bodily reality—is profoundly unethical.

Adults should not interfere with the natural development of a child’s body to alter its appearance based on ideology. Yet that is precisely what many medical associations now advocate. They prescribe a four-part treatment protocol starting in early childhood for “transgender and gender diverse” children: social transition, puberty blockers, cross-sex hormones, and surgery.

These guidelines are based on a faulty philosophical anthropology, a misguided understanding of the purpose of medicine, and virtually no scientific evidence. Indeed, the [Endocrine Society’s official statement](#) promoting this treatment protocol notes that all six of their treatment recommendations for adolescents are based on “low” or “very low” quality evidence. Even apart from the philosophical and ethical problems with the treatment protocol, there is a glaring medical science problem: how can such a radical medical plan to transform children’s bodies be promoted based on research of such poor quality? Part of the explanation is that the medical associations as a whole have not embraced these standards, but ideologically driven subcommittees within those associations have taken it upon themselves to promulgate them.

Five Points to Remember

So what more can we say about these interventions—strictly speaking, these non-medical interventions—on the bodies of young people?

1. *Experimental*

First, these procedures are entirely experimental. There is not a single long-term prospective study of the long-term consequences of blocking an otherwise physically healthy child from undergoing normal pubertal development. Indeed, the drugs being used to indefinitely delay normally timed puberty are not FDA-approved for this purpose and are being used off-label. While we know certain negative consequences of this sort of long-term puberty-blocking—increased risk for low bone density, shorter height, and reduced memory—we simply have no idea what all of the physical and psychological consequences are. There’s no way of knowing—apart from conducting this experiment on the bodies of young people. That itself is unethical human experimentation—and

on *children*. We won't know the full consequences for twenty or thirty or forty or more years. Furthermore, the clinics conducting these experiments are typically not appropriately classifying them as experimental. They are neither disclosing this to patients and families nor seeking Institutional Review Board (IRB) approval, which is necessary for all experimental research on human subjects.

2. *Irreversible*

Second, parents are told that these procedures are “fully reversible,” but that is not true. Going off of puberty-blocking drugs, with the hope that development resumes, does nothing to reverse the delayed biologically appropriate development. **You can't go back in time and reverse that delay.** That said, as an empirical matter, virtually all children placed on puberty-blocking drugs as part of “gender affirmation” care go on to receive cross-sex hormones, continue to identify as of the opposite sex, and attempt to make their bodies appear as if of the opposite sex. The end result is sterilization. And so it is entirely accurate to say that placing a child on puberty-blocking drugs as part of a “gender affirming” intervention is to set that child on a pathway to irreversible, permanent infertility. This is something no child can fully understand, let alone consent to.

3. *Self-Fulfilling*

Third, many experts fear that these treatment protocols are self-fulfilling. Telling a little boy that he is a girl (or something else) or a girl that she is a boy (or something else), blocking his or her natural biological development into a man or a woman, and then flooding him or her with opposite-sex hormones will simply reinforce false beliefs. Indeed, it may very well be pubertal development that helps young people feel comfortable in their own bodies. Imagine the rush of testosterone, growth spurt, and maturation into a man's body and how it may help a young boy feel comfortable as a man. Indeed, 80 to 95 percent of young people with a gender identity conflict will naturally reconcile their identity with the body if their development is not interfered with. By comparison, [100 percent of children in a Dutch study](#) who were placed on puberty

blockers went on to receive cross-sex hormones. Puberty blockers, rather than “buying more time” to decide, seem to lock in transgender identity.

4. *Lack of Diagnostic Rigor, Especially for Immature Children*

Fourth, while the diagnosis that someone “is” of the opposite sex is medically and scientifically baseless, it is particularly outrageous when applied to children. On what other issue do we allow a child’s self-assertion to be the basis for such life-altering decisions, or to allow children to undergo such permanent changes to their bodies? Children lack the experience and cognitive abilities even to know what it means to be a boy or a girl, a man or a woman. And yet “gender experts” tell parents that if a child is “persistent, insistent, and consistent” in asserting that he or she is of the opposite sex (or neither, or both), that means he or she is of the opposite sex (or neither, or both). This is nonsense. Of course gender dysphoria—a feeling of distress at one’s bodily sex—is a very real and serious condition. All sexual confusion is. It deserves compassion and proper treatment, treatment to help a patient feel comfortable with his or her own body. But experiencing gender dysphoria or other sexual confusion doesn’t make someone of the opposite sex. Or both sexes. Or neither sex.

Driving the diagnoses of the “gender experts” are ideological judgments based on stereotypes. Leading “gender experts” claim that nonconformity to sex stereotypes is a sign of someone’s true “gender identity.” For example, when asked how one- or two-year-old, pre-verbal children could communicate their true gender identity, Dr. Diane Ehrensaft, the Director of Mental Health of the Child and Adolescent Gender Center at the University of California, San Francisco, [gave the following answer](#): “I have a colleague who is transgender. And there is a video of him as a toddler—so he was assigned female at birth—there’s a video of him as a toddler tearing barrettes out of then-her hair. And throwing them on the ground. And sobbing. That’s a gender message.” Ehrensaft [continued](#):

Sometimes kids between the age of one and two, with beginning language, will say, “I BOY!” when you say “girl.” Those two words. That’s not a pre-verbal, but an early

verbal message. And sometimes there's a tendency to say, "Well, honey, no you're a girl because little girls have vaginas, and you have a vagina so you're a girl." And then when they get a little older you'll hear them say, "Did you not listen to me? I said I am a boy with a vagina." Ok, but they can't say that between one and two. But they can show you about what they want to play with and if they feel uncomfortable about how you are responding to them and their gender, if you're misgendering them.

This is the sort of diagnostic rigor—self-reports of "gender" from children—that leads medical doctors to make these drastic interventions into the bodies of young people. Rather than recognize that children at early developmental stages are simply too immature even to understand what makes someone a boy or a girl, this diagnostic approach simply reifies internal feelings based on limited human experience and knowledge. From a scientific and medical perspective, what does it even mean to say someone is a boy with a vagina? What does it mean to be a "boy" in such an ideology? And yet, doctors are using medical technology to profoundly mutilate the bodies of young people—all because they say they are boys with a vagina—and surgeons believe they can create something that would resemble a penis. Though, as we mentioned above, why a boy needs a penis—on this ideological understanding of "gender"—is never explained. Adults in the medical profession are exploiting the confusion of children. We could readily supply countless additional examples of this "gender-affirming" approach—attempting to diagnose an impossibility ("being trapped in the wrong body," "being a boy/girl") based on an ideology founded on stereotypes ("internal sense of gender"), all disclosed by children who lack the bodily development, intellectual capacity, and social experiences even to know what it means to be fully male or female. But perhaps one more example will suffice for now. Johanna Olson-Kennedy, the Medical Director of The Center for Transyouth Health and Development at the Children's Hospital of Los Angeles, [describes how she helped an eight-year-old girl discover she was really a boy](#):

I said, “Do you ever eat pop tarts?” And the kid was like, oh, of course. And I said, “well you know how they come in that foil packet?” Yes. “Well, what if there was a strawberry pop tart in a foil packet, in a box that said ‘Cinnamon Pop Tarts.’? Is it a strawberry pop tart, or a cinnamon pop tart?” The kid’s like, “Duh! A strawberry pop tart.” And I was like, “so...” And the kid turned to the mom and said, “I think I’m a boy and the girl’s covering me up.”

This is body-self dualism on full display. The body is just the “foil packet” of the real self, the machine in which the ghost resides. This is the sort of expert advice dished out by medical directors of leading gender clinics.

This same embrace of dualism has led Olson-Kennedy’s clinic to [perform double-mastectomies on thirteen-year-old girls](#). It’s this same embrace of dualism that led Olson-Kennedy to cavalierly dismiss concerns about transition regret: “And here’s the other thing about chest surgery: [if you want breasts at a later point in your life you can go and get them](#).” She dismisses concerns about the cognitive capacity of adolescents to make such life-altering decisions, [with sheer assertion](#): “Actually, people make life-altering decisions in adolescence. All the time. All the time. . . . What we do know is that adolescents actually have the capacity to make a reasoned, logical decision.” Oh, and those [thirteen-year-old double-mastectomies](#) took place as part of an NIH-funded study that Olson-Kennedy is leading on transitioning children.

5. *Reassignment Doesn’t Produce Good Outcomes*

Fifth, and finally, not only is sex reassignment physically and metaphysically impossible, [it doesn’t even produce good psychosomatic results](#). So even if you disagreed with us about the philosophy of the body and the medical ethics of “transitioning,” you would still need to be concerned that an entirely experimental, self-fulfilling treatment protocol that is based on nonsensical diagnostic criteria doesn’t even produce the desired outcomes of happiness and wholeness. Forty-one percent of all adults who identify as transgender attempt suicide at some point in their lives, and adults who have had sex reassignment surgery are nineteen times more likely than the general

population to die by suicide. These outcomes are unacceptable. And the best research shows that reassignment procedures do little to nothing to improve well-being. As even the [Obama Administration reported in 2016](#), the best studies of sex-reassignment procedures “did not demonstrate clinically significant changes or differences in psychometric test results” after the reassignment. A large, long-term data set from Sweden released just this year (2019) shows a similar result: [hormonal transition produced absolutely no mental health benefits for those patients](#). Meanwhile, the [data from that study](#) demonstrate that “the beneficial effect of surgery for transgender people is so small that a clinic may have to perform as many as 49 gender-affirming surgeries before they could expect to prevent one additional person from seeking subsequent mental health treatment.” Imagine suffering so much, feeling so uncomfortable with your own body that you would contemplate “transitioning,” and then receiving virtually no improvement. If these are the results of “transitioning,” why would anyone encourage a child down this path?

What Children Need

Children who feel deep discomfort with their bodily sex should be treated with kindness, respect, compassion, and love. They need to be protected from bullying, teasing, discrimination, and any form of mistreatment. They are precious human beings who need to be given whatever assistance we can give to help them feel comfortable with their bodies.

This includes providing counseling for any underlying trauma or for social dynamics at home or school that may play a role in the dysphoria. And it includes helping them to break down misguided sex stereotypes or cultural expectations that may underlie their dysphoria. But it must also entail a resolute refusal to go along with ideologies that reinforce sex stereotypes. Preferring the color pink or playing with dolls does not make someone a girl. Rather than teaching children to identify based on how well they fit prevailing cultural expectations on sex, we should be teaching them that the truth of their sexual identity is based on their bodies, and that sometimes cultural associations attached

to the sexes are in fact misguided or simply too narrow. (On this last point, see Chapter 7 of *When Harry Became Sally*.) Girls can like football and hunting without being “boys” or “nonbinary.” There is a wonderfully rich array of ways of expressing one’s embodiment as female.

Prudent legislation is needed to prevent adults from interfering with a child’s normal, natural bodily development. “Gender affirmation” procedures violate sound medical ethics. It is profoundly unethical to intervene in the normal physical development of a child as part of “affirming” a “gender identity” at odds with bodily sex. While puberty-blocking drugs may be an appropriate treatment for precocious puberty—the early onset of puberty—in order to delay puberty to a biologically appropriate age, that is not what is going on here. The use of puberty blockers to delay or permanently block natural biological puberty is unethical and violates the rights of children to bodily integrity.

Administering cross-sex hormones to minors, in an attempt to make their bodies cosmetically resemble those of the opposite sex or of their preferred “gender identity,” is likewise a violation of sound ethical norms and the rights of minors. Surgically removing genitals or secondary sex characteristics in an effort to “affirm” a “gender identity”—as done to those thirteen-year-old girls who underwent double-mastectomies in taxpayer-funded “research”—is particularly heinous. Governments should prohibit this misuse of medical technology and protect children from these harms.

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