Feedback Regarding Circular 44/2026: Treatment Guidelines for Children and Adolescents with Gender Dysphoria

Dear Ministry of Health and Members of the Guideline Committee,

I would first like to acknowledge the considerable effort, complexity, and responsibility involved in developing national guidance surrounding the care of children and adolescents experiencing gender dysphoria. I recognise that the committee has likely spent substantial time attempting to balance patient safety, evidence limitations, family concerns, and long-term clinical outcomes within a highly polarised international landscape.

I am writing not in opposition to safeguards or multidisciplinary care itself, but rather to respectfully share several operational and clinical concerns arising from frontline experience caring for gender-diverse patients within Singapore's healthcare system.

1. Impact on Patients and Families

Since the release of the circular, many patients and families have expressed significant distress, uncertainty, and confusion regarding future access to care pathways. A recurring theme among both adolescents and parents has been a sense of helplessness and fear regarding what options remain available to them moving forward.

These are often already vulnerable young people with pre-existing mental health struggles, social difficulties, family conflict, or histories of discrimination and isolation. The abrupt uncertainty surrounding continuity of care may unintentionally compound psychological distress during an already vulnerable developmental period.

I am also concerned that increasingly restrictive access pathways may unintentionally push some individuals toward unsupervised or informal hormone acquisition through online or non-medical channels. In real-world practice, clinicians occasionally encounter patients who are already self-medicating and require blood tests and medical monitoring under harm-reduction frameworks to reduce risks associated with unsupervised hormone use. Restrictive access may therefore inadvertently increase the number of medically and ethically complex presentations outside formal healthcare systems.

Ultimately, my concern is that vulnerable patients and families may feel abandoned from systems they had previously trusted enough to approach for help.

2. Operational Concerns Regarding the Treatment Review Panel (TRP) Framework

One of the major tensions within the new Treatment Review Panel (TRP) framework is that it appears operationally difficult to reconcile with several principles articulated within recent Singapore psychiatric literature itself regarding gender-focused care.

A recent article published in the *Annals of the Academy of Medicine Singapore* argued against "multiplying subspecialty silos" and instead advocated "building system-wide competence through training, shared protocols and collaborative networks" within mainstream healthcare systems. The article also emphasised avoiding fragmentation of care and developing scalable, sustainable service delivery models within Singapore's resource-constrained healthcare environment.

The practical concern is that the TRP framework risks creating an extremely centralised and highly specialised pathway requiring multiple professionals to review each case before treatment decisions can proceed. While multidisciplinary input is undoubtedly valuable in selected complex situations, operationalising such an intensive process broadly for individuals aged 18–20 may create significant bottlenecks, increase waiting times, and concentrate decision-making within a very small number of specialised providers.

This concern may be particularly relevant in Singapore's context, where the pool of gender-experienced clinicians remains relatively limited across psychiatry, endocrinology, psychology, and allied health services.

International standards of care similarly acknowledge these practical limitations. The WPATH Standards of Care Version 8 specifically notes that while multidisciplinary care can be beneficial, *"the lack of available disciplines should not preclude a young person from accessing needed care in a timely manner" (Statement 6.9)* and that *"this does not mean all disciplines are necessary to provide care to a particular youth and family." (Statement 6.9)*

Prior to the circular, many clinicians already practised cautiously and collaboratively through longitudinal referral-network models involving primary care physicians, psychiatrists, endocrinologists, surgeons, speech therapists, and allied health professionals according to clinical complexity and need.

As such, my concern is not opposition to multidisciplinary care itself, but rather concern that the current framework may become excessively specialised, centralised, and operationally difficult to scale while still maintaining timely and proportionate access to care.

3. Consent, Developmental Maturity, and Clinical Individualisation

Another area of concern is the use of a rigid chronological threshold of 21 years old as a determinant of access.

Developmental maturity and decisional capacity do not emerge suddenly on your 21st birthday. Singapore courts have already recognised the principle of Gillick competence within local jurisprudence - namely, that some adolescents may possess sufficient maturity and understanding to meaningfully participate in medical decision-making.

This principle was discussed in VYG v VYH and another matter [2021] SGFC 39, where the Singapore Family Court recognised that a minor may possess sufficient understanding and intelligence to participate meaningfully in healthcare decision-making depending on the nature and complexity of the intervention involved. This has subsequently been analysed in *Singapore legal scholarship*, which noted that Singapore law has moved toward recognising adolescent decisional capacity as something that should not be determined purely by chronological age alone.

From a clinical perspective, adolescents present with highly variable levels of psychosocial maturity, insight, persistence of dysphoria, family support, and capacity for informed consent. While safeguards are important, there is concern that a rigid age-based framework may not fully account for this clinical heterogeneity.

Importantly, many clinicians were already practising conservatively prior to the circular. Informed consent processes for younger patients were often extensive and involved significant parental participation. In many cases, clinicians were already seeking agreement from both parents before proceeding with major medical interventions, particularly where there were concerns surrounding psychosocial vulnerability or long-term implications of treatment.

As such, one possible concern is whether a strict age-threshold approach may unintentionally oversimplify the nuanced and individualised assessments of maturity and decisional capacity that clinicians routinely undertake across many other areas of adolescent healthcare.

4. The Role of Primary Care Providers in Gender-Affirming Care

Another important concern is that the current framework appears to give limited recognition to the role of primary care physicians (PCPs) in providing longitudinal, holistic, and integrated gender-affirming care.

The WPATH Standards of Care Version 8 contains an extensive chapter dedicated specifically to primary care and repeatedly emphasises that transgender healthcare should not exist solely within highly specialised tertiary systems. SOC8 explicitly states:

> *“For the most part, the general health and well-being of transgender people should be attended to within the primary care setting, without differentiation from services*

> *offered to cisgender (non-transgender) people for physical, psychological, and sexual health issues. Specific care for gender transition is also possible in primary care."*

SOC8 further notes that:

- *"the lack of available disciplines should not preclude a young person from accessing needed care in a timely manner";*
- *"Considering barriers to health care access and the importance of GAHT to this population, it is imperative that PCPs are able and willing to provide GAHT for TGD patients";*
- *"most of the commonly used medications in gender-affirming regimens are familiar to everyday primary care practice, including, but not limited to, testosterone, estradiol, progesterone and other progestagens, and spironolactone."*

The document also highlights that PCPs routinely provide broad-spectrum, integrated healthcare and should develop competency in transgender care in the same way they do for other evolving areas of medicine.

From a practical perspective, much of gender-diverse care naturally overlaps with the strengths of primary care precisely because primary care is not organised around narrow specialty silos, but around longitudinal, integrated, person-centred care.

In my own clinical practice, gender-affirming care frequently extends far beyond hormone prescribing alone and often involves managing multiple overlapping medical, psychological, sexual health, social, and post-surgical issues within the same therapeutic relationship.

Examples of care I routinely provide within the primary care setting include:

- provision of affirming, trans-informed sexual health services, including STI screening, HIV prevention counselling, HIV pre-exposure prophylaxis (PrEP), doxycycline post-exposure prophylaxis (doxyPEP), contraception counselling, and broader harm-reduction discussions surrounding high-risk sexual practices;

- management of common mental health concerns within the clinic setting, including supportive counselling, basic cognitive behavioural therapy techniques, discussion and initiation of psychotropic medications for mild-to-moderate mood and anxiety disorders, and recognition of body-image distress and disordered eating behaviours that may intersect with gender dysphoria;

- addiction medicine and smoking cessation support, including recognition of nicotine withdrawal symptoms and initiation of nicotine replacement therapies;

- management of gender-related dysphoria beyond hormones alone, including referral to affirming electrolysis and laser hair removal services, counselling surrounding pain-management strategies for hair-removal procedures, including advice regarding topical anaesthesia and procedural analgesia where appropriate;

- social and community-based support, including directing patients toward affirming makeup artists, cosmetic services, hairstylists, hairdressers, and hair restoration surgeons who are experienced in caring respectfully for transgender and gender-diverse individuals without subjecting them to stigma or unnecessary questioning;
- longitudinal post-surgical care for transgender patients, including management of keloidal scarring following top surgery with intralesional steroid injections, treatment of granulation tissue following penile inversion vaginoplasty, and familiarity with the anatomical and microbiological nuances of neovaginal care, including appropriate examination techniques and awareness of how differing tissue types may alter infection patterns and examination approaches.

Importantly, many patients disclose these concerns specifically because they experience the primary care environment as safer, less fragmented, and more relationally continuous than highly compartmentalised specialist systems.

This breadth of care reflects one of the core strengths of primary care itself: the ability to integrate hormonal care, preventive medicine, sexual health, mental health, post-surgical support, and social-contextual care into a single longitudinal therapeutic relationship.

My concern is therefore that excessively centralised or siloed models of gender care may unintentionally overlook the substantial role appropriately trained primary care physicians can play in delivering safe, holistic, and accessible gender-affirming healthcare within collaborative multidisciplinary networks.

5. Local Outcome Data and Timely Access to Care

Singapore's own emerging local data also suggests that treatment decisions cannot be viewed solely through the lens of restriction.

A retrospective Singapore study published in the *Annals of the Academy of Medicine Singapore* found that adolescents who received hormone replacement therapy demonstrated improvements in CGAS and CGI-S scores, suggesting improvements in psychological functioning and overall well-being among treated individuals.

The same study also observed increasing presentations of gender dysphoria over time, with diagnoses occurring at younger ages. The authors suggested that this may reflect greater self-awareness and willingness among younger individuals to seek help.

Importantly, this does not mean that all adolescents should automatically receive medical treatment. However, it does suggest that for carefully selected individuals, timely access to appropriately assessed care pathways may confer meaningful psychological benefit.

Clinically, prolonged untreated gender dysphoria may in some individuals be associated with worsening anxiety, depression, social withdrawal, family conflict, impaired school or occupational functioning, and increasing psychological distress. There is also concern that some patients may turn toward unregulated or DIY hormone use outside formal medical supervision if access pathways become excessively restrictive or unclear.

The challenge therefore may not simply be whether safeguards should exist, but rather how safeguards can remain proportionate, practical, scalable, and sufficiently flexible to minimise unintended harms while still protecting vulnerable young people.

6. Request for Further Operational Clarification and Engagement

Given the significant practical implications of the circular, I would be deeply grateful for further clarification regarding:

- how Treatment Review Panels are expected to be operationalised in practice;
- referral pathways for patients currently receiving care;
- the role of private-sector clinicians and primary care physicians within the new framework;
- how continuity of care should be managed for existing patients;
- expectations surrounding harm-reduction monitoring for patients already self-medicating;
- and mechanisms for ongoing clinician engagement and feedback as implementation evolves.

I also hope there may be opportunities for broader dialogue involving clinicians across primary care, psychiatry, endocrinology, psychology, and community healthcare settings, particularly those involved in longitudinal frontline care of gender-diverse patients.

Ultimately, I believe most clinicians share the same core goals:

- protecting vulnerable young people,
- ensuring thoughtful and evidence-informed care,
- maintaining appropriate safeguards,
- and minimising harm.

My hope is simply that implementation pathways remain compassionate, practical, scalable, and sufficiently flexible to avoid unintentionally worsening distress, fragmentation of care, or barriers to safe healthcare access for already vulnerable patients and families.

Thank you again for the considerable effort invested into this work and for taking the time to consider these reflections.

Regards,

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