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Paternalism and Autonomy in Transgender Healthcare

Charles Finley
Butler University

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Paternalism and Autonomy in Transgender Healthcare

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Introduction

Bodily autonomy and the right to privacy are fundamental rights of all human beings. The ability to choose how to live one's life and what to do with one's own body is highly valued by people of all political affiliations and political parties. However, these rights for transgender people of all ages is still the topic of constant debate. Many allies, supporters, and members of the transgender community agree that the decision to transition — socially, medically, and legally — ought to be a question that transgender people alone should decide for themselves. Unfortunately, the reality of the divisive political and social landscape in the United States means that everyone feels they should have a say in how a transgender person should live their life, leading to harmful and archaic laws related to bathroom usage, sports participation, healthcare coverage, government-sanctioned employment and housing discrimination through religious exemptions, and so on.

Anti-discrimination protections for transgender people are capricious and inconsistent across the United States. Problems are so prevalent that many websites and civil rights organizations, such as the Transgender Law Center and Human Rights Campaign, produce lists and maps of the best and worst states to live in if you are a gender or sexual minority (GSM). The Transgender Law Center's "National Equality Map" presents in-depth information about laws covering same-sex relationships and parental rights, nondiscrimination policies, religious exemptions, the rights of LGBT youth, health care accessibility and coverage rules, and ease of identity document changes (Movement Advancement Project n.d.).

In this paper, I will focus one of the most critical areas of concern for transgender people: healthcare. For several decades, the widely accepted treatment for gender dysphoria has been a combination of counseling, cross-sex hormones, and gender confirmation surgery (American Psychiatric Association, n.d.). Despite this consensus, there are still many problems and obstacles that transgender patients can encounter throughout their medical transition. These problems are often related to lack of insurance coverage for transition-related procedures and accessibility to trans-friendly physicians and surgeons, including issues of gatekeeping — the creation of obstacles and higher than necessary standards to prevent people from accessing care — and denial of care as a result of the religious and personal beliefs of medical personnel and other hospital employees.

In a 2015 survey conducted by the National Center for Transgender Equality, 33% of transgender people reported having at least one negative experience in a healthcare setting, including refusal of treatment, verbal harassment, and physical and sexual assault (James, Herman, Rankin, Keisling, Mottet, and Anafi, 8). Half of all respondents reported having to teach a healthcare provider about transgender people in order to get appropriate care. One extreme example of healthcare discrimination is in Mississippi, where physicians of any kind and specialty can refuse to treat transgender patients, *even if that medical care is not related to transitioning* (Movement Advancement Project and National Center for Transgender Equality 2018, 5). An emergency room in Mississippi could turn away a transgender woman who requires life-saving care after a major car accident or a transgender man experiencing a miscarriage and, in both cases, face no repercussions, even if the patient dies because of the refusal to

treat. The kinds of problems that people run into are heavily dependent on where they live, because anti-discrimination and religious refusal laws vary widely across the United States.

Bodily autonomy is defined as “a person’s rational capacity for self-governance or self-determination” (Vaughn 2012, 71). In other words, the right to autonomy allows a rational person to decide for themself what is done and not done to their body. This right is guaranteed except in cases where someone is determined to be unable to make medical decisions for themself, such as when a person is very young, has mental difficulties due to illness or traumatic injury, is in a coma, or for some other extraordinary reason determined by their country’s court system. When a physician overrides a rational patient’s medical decision for the sake of the patient’s own welfare and safety, this is called paternalism (Vaughn 2012, 71). Physicians have a duty of beneficence — the obligation to do someone good and to not do them harm — to their patients, and for this reason they will sometimes run into situations where the best course of treatment is not what the patient decided for themself.

The purpose of this paper is to demonstrate how many of problems in transgender healthcare arise from the fundamental battle between paternalism by medical professionals and the autonomy of transgender people. It will examine how to ethically balance autonomy and paternalism so as to increase both safety and welfare for the adult transgender community, as well as give suggestions for how some of these issues can be overcome through policy changes. To begin, I will explain some of the important terminology that will be used in this paper. I will also give an overview of how historical policy and standards of care published by the World Professional Association for

Transgender Health (WPATH) have changed over the past several decades so that we may better understand the current state of transgender healthcare. Next, I will demonstrate how excessive paternalism by medical professionals has detrimentally affected transgender peoples' ease of access to medically necessary care and why more consideration needs to be given to bodily autonomy and choice. Lastly, I will offer suggestions for how WPATH and other medical professionals can alleviate the effects of past and current acts of paternalism through changes to healthcare policy and standards of care.

Terms

Many of the terms, initialisms, and other language used by and about the transgender community can be confusing to cisgender people, or people who identify with the gender they were assigned at birth. Niche vocabulary can also be unclear to transgender people themselves, especially if they do not have access to a local community or have just started their transition.

The terms “transgender” and “trans” are adjectives used to describe an individual who identifies with a gender that is different from their gender assigned at birth. The two terms are often used interchangeably. A transgender woman is someone who was assigned male at birth (AMAB), but now identifies as female. A trans man is someone who was assigned female at birth (AFAB), but now identifies as male. A non-binary person is someone who was assigned either male or female at birth, but identifies as agender (genderless, or without gender at all), bigender (both male and female simultaneously), or gender fluid (transient between male and female). There is some discourse about how many unique genders exist in the non-binary spectrum, but for simplicity I will divide all of them into the three general categories I listed.

Many non-binary people use “they/them” pronouns instead of “he/him” or “she/her.” In this paper, I will purposely use “they” and “them” in the singular form. Not only does writing out “he/she/they” become excessive but using “they” in the singular form is not considered grammatically incorrect; it is colloquially common to use “they” and “them” to describe another person when that person’s gender is ambiguous or unknown. On some occasions, non-binary people use alternative gender-neutral pronouns such as “ze/hir” (pronounced “zee” and “here”), but this is not as common. Additionally,

some people go by multiple sets of pronouns or all of them; for example, someone who identifies as more masculine may go by “he/they” and is content as long as “she” is *not* used.

For people who have little interaction and experience with transgender people, knowing how to address someone can be confusing. There are a couple best practices to keep in mind to avoid accidentally saying something offensive. Using the terms “it” or “he-she” to refer to any trans person is extremely rude and offensive. In the same vein, saying that a person is “transgendered” or “a transgender” is also heavily discouraged and frowned upon by the trans community. Not only are those terms grammatically incorrect — “transgender” is an adjective, not a verb or noun — but it implies that being trans is something that happened *to* someone and demonstrates cruel disregard for their personhood, instead of being an innate aspect of their identity. Just as it is improper to call a black person “colored,” calling a trans person “transgendered” is a similar transgression.

The easiest way to keep this straight is to focus on the “man” or “woman” portion of the label. Whatever follows the “trans” portion of the label is what that person identifies as and can usually indicate what pronouns they use as well. However, this is not a reliable way of figuring out how a person expresses themself to the outside world, such as through clothing, use or non-use of makeup, color preferences, and hair styling. Just as there is a wide variety of personal expression among cis men and women, these is an equally wide variety of personal expression within the trans community as well. Being a feminine trans man or a masculine trans woman *does not* mean that these people are not actually trans or that they do not experience gender dysphoria.

Some who oppose protections for transgender people or claim that being trans is not real will mistakenly use “trans man” to refer to a person who is AMAB and altogether forget that there are actually many people who transition from female to male. Using the term in this way focuses on the “trans” portion of the label and implies that a “trans man” is just a man in a dress and simply pretending to be a woman for some nefarious reason, such as unfairly dominating a sport or gaining access to women’s restrooms to spy on girls. This can result in the “accidental ally” phenomenon, in which someone will say “trans men are not women” without realizing that they used the term improperly and are in fact showing support for people who have transitioned from female to male.

A person who is not transgender is referred to as cisgender. Cisgender people identify with their gender assigned at birth and do not experience the gender dysphoria that many transgender people face. Gender dysphoria is a medical diagnosis: people with gender dysphoria experience a serious conflict between their physical sex/assigned gender and the gender that they identify with. It is not the same as being gay, lesbian, or bisexual because those are sexual orientations, not gender identity. Many (but not all) people with gender dysphoria express an intense desire to be seen and treated as the gender that they identify with. This usually leads to transitioning socially, medically, or a combination of the two.

Social transitions can involve choosing a new name, switching pronouns, clothing style, hairstyles, and using public bathrooms associated with the gender a person aligns with. Changing one’s legal name and gender marker can also be considered an aspect of someone’s social transition as well as their legal transition. Medical transitions can involve taking cross-sex hormones and/or undertaking gender confirmation surgeries. It

is important to note that not all transgender people seek out hormone replacement therapy (HRT) or surgeries. Many transgender people find relief after socially transitioning, and never require medical intervention. On the other hand, some people experience gender dysphoria that is so severe that the only treatment is a complete medical transition (including genital surgery).

A common misconception is that gender dysphoria and body dysmorphia are the same thing. The assumption is that trans people actually suffer from body dysmorphia — not gender dysphoria — is false. Although the words sound and look similar, body dysmorphia is a body-image disorder unrelated to the discomfort and stress caused by incongruence between a trans person's body and gender identity. People with body dysmorphic disorder are obsessed with an imagined or minor flaw in their appearance. This flaw can be about anything, but commonly is focused on the hair, skin, stomach, chest, and nose (Anxiety and Depression Association of America, n.d.). People who suffer from this disorder do not present with the desire to be seen and recognized as a different gender, nor do they wish to transition. Of course, there are some cases where transgender people have both gender dysphoria and body dysmorphia, but as long as the body dysmorphia has been properly treated and under control, this does not prevent a person from being able to transition.

Historically, the term "transsexual" was used to describe people who transitioned from one gender to another. Anyone familiar with the 1975 cult classic *The Rocky Horror Picture Show* will remember that the eccentric character Dr. Frank-n-Furter described themself as a transvestite (another historical term/slur used to describe trans people). Many trans people today find these terms to be offensive, cruel, and inappropriate for

describing how they identify. The word is often used as a slur as well. Some trans people, especially those who are older and started transitioning in the 1970s and 80s, still use this term to describe themselves, but it is wrong to assume that any given trans person today uses the term for themself unless they have explicitly told you that that is the case. Medical articles and doctors may use this term in a strictly neutral sense to mean "a person who has undergone treatment to acquire the physical characteristics of the opposite sex", but in recent years some have seemed to shift away from this terminology in favor of the word "transgender." In this paper, I will exclusively use the term "transgender" except in cases where the term "transsexual" is used in a direct quotation.

A final point to keep in mind: being transgender and engaging in cross-dressing or drag *is not* the same thing. There are many cisgender men and women who cross-dress as a hobby and for personal enjoyment. Similarly, there are trans men who may perform as drag queens/kings and trans women who perform as drag queens/kings — but doing so does not mean that these people do not experience dysphoria in everyday life, such as when they are referred to by the wrong pronouns or called the wrong name. On the other hand, while drag does have significant history within the trans community, not all trans people enjoy the practice or are willing to participate. Some people who cross-dress as a child (for instance, tomboys: young girls who enjoy traditionally masculine activities and clothing) or for fun as an adult may eventually come out as transgender. Many people also continue to identify as cisgender for the remainder of their lives. Therefore, cross-dressing is not a good indicator that someone is or will come out as transgender. People can be gender-nonconformative and not be transgender.

There are a wide variety of different ways that transgender people can present and express themselves to the outside world. Many trans people clinically present with what is called gender dysphoria. The accepted treatment for gender dysphoria is for a trans person to transition, often with a combination of therapy/counseling, cross-sex hormones, and various surgeries. Transition has consistently produced better outcomes — such as lower rates of suicide and depression — than not transitioning or engaging in conversion therapy (in which efforts are made to force someone to change their gender identity to align with their natal sex). It is important to recognize and respect that people's transitions can and will look different from one person to the other, and that the results of HRT and surgeries will not always be perfect. Progress still needs to be made in the effectiveness of hormone blockers and HRT as well as improvement of surgical methods.

Table 1

Transgender/Trans	An adjective used to describe a person who does not identify with their natal sex.
Cisgender/Cis	An adjective used to describe a person whose gender identity aligns with their natal sex.
Non-binary	An adjective used to describe a person who 1) does not identify as either male or female, 2) identifies as both male and female, or 3) may have a fluid idea of their gender identity, where at times they feel more feminine than masculine or vice versa.
AMAB	Assigned male at birth (by a doctor, nurse, parents, etc.)
AFAB	Assigned female at birth (by a doctor, nurse, parents, etc.)
Intersex[1]	An adjective used to describe a person who was born with an ambiguous natal sex and presents with some combination of both male and female genitalia or lack of any genitalia at all.
GSM	Gender or sexual minority; another term sometimes used in place of LGBTQ+
Gender dysphoria	A medical condition defined in the DSM-5 as "a conflict between a person's physical or assigned gender and the gender that he/she/they identify with" which results in significant discomfort and distress (American Psychiatric Association, n.d.). "Significant" discomfort and distress can be relative and unique for each person.
Gender euphoria	A term often used by the trans community to describe the happiness that comes from being addressed as or expressing oneself according to one's gender identity.
HRT	Hormone replacement therapy; testosterone for trans men and estrogen for trans women; some non-binary people do not use HRT and others do.
GCS	Gender confirmation surgery. In the past, the terms sex reassignment surgery and gender reassignment surgery were often used, but gender confirmation surgery has become the most commonly used term due to the more positive connotations of the word "confirmation" compared to "reassignment." "top" surgery – either breast removal for trans men, or breast implants for trans women. "bottom" surgery – often involves removal of the natal genitals and the use of grafts or existing tissue in the area to create either a vagina (for trans women) or a phallus and scrotum (for trans men).

[1] A person who is intersex is often considered to be under the umbrella of the transgender community, but in recent years there have been efforts to recognize that intersex people have different experiences and challenges to overcome throughout their lives. However, I include the term intersex here in order to distinguish the biological differences between what it means to be intersex and what it means to be transgender. Additionally, many intersex people have the same healthcare needs (i.e. hormone replacement therapy and surgical interventions) as trans men, trans women, and non-binary people.

Gender nonconformative	An adjective used to describe a person whose personal expression does not align with common norms and stereotypes associated with their gender identity.
Transsexual/Transvestite	Historical terms used to describe people who transitioned. These terms can often be found in older medical journals and movies but are now considered slurs. Some trans people still identity with these terms, but this is relatively uncommon.
Social transition	The act of transitioning to usage of a new name and pronouns with friends, family members, at school, and/or at work. This is usually, but not always, the first stage of a person's transition. Some people may or may not "come out" in every single sphere of their life, especially if it is not safe to do so.
Legal transition	The process of legally changing one's name and gender marker on important legal documents (birth certificate, drivers' license, state ID, social security card, etc.). This can also be considered to be under the umbrella of social transitioning. Due to court fees and other obstacles, many trans people are unable to afford to legally transition.
Gender marker	The "F" or "M" (or "X" to indicate non-binary) designation on drivers' licenses, birth certificates, etc. that indicate the legal sex of a person. Changing this often requires a court order or doctor's statement, and requirements vary based on which state or country a person lives in or was born in.
Medical transition	The process of altering one's body to better align with the physical appearance of their gender identity. This can include HRT and/or surgeries. Some trans people, due to other underlying medical issues, are unable to use cross-sex hormones and rely entirely on surgeries to achieve their desired appearance. Others may be unable or unwilling to undergo surgery, and therefore rely exclusively on HRT. Medical transitions are unique to each person and there is no such thing as a "one size fits all" approach.

The World Professional Association for Transgender Health

The mission of the World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, is "to promote evidence based care, education, research, public policy, and respect in transgender health" (World Professional Association for Transgender Health, n.d.). WPATH was founded in 1979 to address the inconsistencies in, and the lack of education concerning, the medical care of transgender people. The first *Standards of Care* (*SOC*) was published the same year.

In the early half of the 20th century, very few physicians understood how to properly treat gender dysphoria — formerly called gender identity disorder until 2013 with the release of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association n.d.). The desire to transition was often considered a severe mental illness, and many trans people ended up seeking out ways to self-treat due to lack of support from doctors and therapists. Some trans people accessed gender confirmation surgeries by traveling to countries that were more accepting or where medical regulations concerning these types of surgeries were relatively loose. This practice is still quite common today: many transgender people travel to Thailand to access GCS because the procedures are considerably cheaper than in the United States and quicker to access than in Canada or the UK, where the wait times for GCS can be occasionally be years long due to backlog. Long-abandoned forums discussing how to purchase hormones without a prescription and how to safely determine dosage without consulting an endocrinologist can still be found in the depths of the internet.

The WPATH *SOC* provides guidance to medical professionals and therapists concerning how to properly assess potential treatment plans for their transgender patients. Insurance companies also use the *SOC* to guide their policies on what patients need to do to qualify for coverage of certain procedures. It is important to note that the *SOC* are intended to outline the *minimum* requirements that medical professionals should use. The *SOC* does not prevent individual medical professionals or insurance companies from placing more stringent requirements on patients and reminds physicians that meeting the minimum eligibility requirements does not reliably indicate that a patient is ready for the next stage in treatment.

These requirements fall into a few different categories: gender dysphoria, lived experience, patient-therapist relationship, and endorsement letters. As a general rule, a doctor who follows the *SOC* will require that a trans patient be diagnosed with gender dysphoria by a psychiatrist or psychologist, preferably one specializing in gender identity. Lived experience refers to "living full-time in the gender role that is congruent with their gender identity" (World Professional Association for Transgender Health 2012). This includes at work, at school, with family and friends, and in every other aspect of one's life where possible. The *SOC* also requires that a patient be in therapy for a specific length of time depending on what type of care the patient is trying to access. The patient's therapist has a duty to document the persistence of gender dysphoria and, when the patient is deemed ready, offer a referral letter for hormone therapy and/or surgery. Across all the versions of the *SOC*, two referral letters (one from a behavioral specialist with a PhD) have been required for both trans men and trans women to access genital surgery.

In the first *SOC*, published in 1979, the primary requirement that had to be met for every step of medical transition (including hormone therapy) was that the patient have the urge to be rid of their natal genitalia for at least two years (Berger, Green, Laub, Reynolds, Walker, and Wollman 1979). This requirement could not be fulfilled simply by the patient's own word — "evidence may be obtained by interview of the patient's appointed informant (friend or relative) or it may be best obtained by the fact that the psychiatrist or psychologist has personally known the patient for an extended period of time" (Berger et al. 1979, 4.3.4). However, in cases when the therapist has not known the patient for an extended length of time, the patient-therapist relationship must be at least three months long before recommending hormone or non-genital/breast surgery and at least six months long before recommending genital surgery (ibid. 1979, 4.3.3).

The first *SOC* had similar requirements for lived experience: three months of living "full-time in the social role of the genetically other sex" prior to hormone therapy, six months of lived experience prior to non-genital/breast surgery, and twelve months of lived experience prior to genital/breast surgery (Berger et al. 1979). A new referral letter was required at each stage as well, with a peer review by a second behavioral specialist required prior to genital/breast surgery. These requirements applied exclusively to adults, as the *SOC* denied physicians from providing hormone treatment or surgery to patients who were not yet of the age of majority in their country. It was not until the fifth version of the *SOC*, published in 1990, that any sort of treatment for adolescents beyond psychotherapy would be indicated, and even then, it was still highly recommended that hormone therapy and lived experience not begin until age 18.

The second[2], third, and fourth versions of the *SOC* were published in 1980, 1981, and 1990, respectively. In these versions, requirements for lived experience are removed for hormone therapy, but the three months of a patient-therapist relationship remain and the eligibility requirements for genital/breast surgery remain the same as they were described in the first version. However, the lived experience requirements, hormone therapy requirements, and referral letter requirements for non-genital/breast surgery have been removed (Harry Benjamin International Gender Dysphoria Association 1980, 3). Previously, non-genital surgery required six months of lived experience and one referral letter (HBIGDA 1979, 4). Available non-genital surgeries for trans men are limited, and generally only involve liposuction to remove unwanted excessive fat in the thighs, hips, and buttocks (HBIGDA 2001, 22). On the other hand, trans women have a much wider selection of non-genital surgeries to choose from to assist in additional feminization. These include lipoplasty of the hips, rhinoplasty, facial bone reduction, and face-lifts (ibid. 2001, 20).

The fifth version of the SOC featured substantial changes to eligibility requirements for hormone therapy, breast surgery, and genital surgery. This version required that patients complete either three months of psychotherapy *or* three months of documented lived experience prior to hormone therapy (HBIGDA 1998, 8) The psychotherapy mandate is also removed — albeit still highly recommended — for breast and genital surgeries. The *SOC* allows for physicians and therapists to set their own psychotherapy requirements prior to signing off on a surgery. Additionally, the fifth

[2] I would like to thank WPATH for being willing to share their copy of the second version of the *Standards of Care* with me.

version introduced the requirement of twelve months of continuous hormone therapy prior to breast and genital surgeries. Although this kind of requirement could have been inferred in previous versions of the *SOC*, the fifth version is more explicit in discussing the benefits of continuous hormone therapy. For trans women especially, the continuous hormone therapy requirement allows for breast growth and, depending on individual needs, may contraindicate surgical breast augmentation. Some of the effects of hormone therapy are reversible, so this requirement also offers a buffer zone prior to an irreversible surgery in the event that a patient decides to discontinue their medical transition after experiencing the effects of HRT.

In the sixth version of the *SOC*, published in 2001, there are a few more changes to eligibility requirements for breast surgery. Unlike in previous versions, breast surgery is no longer considered a genital surgery because the presence of breasts or lack thereof is not a factor in the legal definitions of sex and gender (HBIGDA 2001, 19). As such, the eligibility requirements for breast surgery now mirror the requirements for hormone therapy. A patient only needs one referral letter and either three months of lived experience or three months of therapy before receiving breast surgery (HBIGDA 2001, 20). However, there are different recommendations for trans men compared to trans women. Testosterone therapy does not cause reduction in the amount of breast tissue, and so the *SOC* does not restrict trans men from starting hormones and having a mastectomy procedure at the same time. However, because estrogen therapy does induce breast growth in trans women, the sixth *SOC* advises that the hormone prescribing physician and surgeon should wait at least 18 months after an individual begins hormone therapy

before recommending a breast augmentation unless hormone therapy is contraindicated (HBIGDA 2001, 20).

The current version of the *SOC* was published in 2012 and contains significantly more information than previous editions about treatment considerations for adolescents, people living in institutional environments (such as prisons), and people who are intersex. It also includes guidelines for fertility and reproductive care, lifelong preventative and primary care, and speech therapy. The eligibility requirements for hormone therapy, breast surgery, and genital surgery have mostly remained the same, except for the removal of lived experience and patient-therapist relationship length requirements for hormone therapy and breast surgery (WPATH 2012). However, a psychiatric evaluation and referral letter from a therapist is still required for both of these procedures.

Overall, the *SOC* has trended towards easing the eligibility requirements for transition related care. For most stages, the requirements now boil down to 1) the desire to transition, 2) a diagnosis of gender dysphoria, and 3) a referral letter from a qualified therapist that backs up (1) and (2). Things such as lived experience and time spent in therapy are now just highly encouraged recommendations. The point of easing eligibility requirements was to remove the obstacles that placed undue strain on trans people and which would likely make their mental health worse (such as requiring individuals to "come out" to their potentially unaccepting friends and family members), but keep the standards just high enough that people could not transition "on demand."

Table Two

		SOC 1 (1979)	*SOC* 2 (1980)	*SOC* 3 (1981)	*SOC* 4 (1990)	*SOC* 5 (1998)	*SOC* 6 (2001)	*SOC* 7 (2012)
Patient-Therapy Relationship Required Prior To:	HRT	3 months	3 months	3 months	3 months	3 months*	3 months*	0
	Non-genital surgery	3 months	n/s	n/a	n/a	n/a	n/a	n/a
	Breast/chest surgery	6 months	6 months	6 months	6 months	Varies per patient	3 months*	0
	Genital Surgery	6 months	6 months	6 months	6 months		Varies per patient	Varies per patient
Lived Experience Required Prior To:	HRT	3 months	3 months	0 months	0 months	3 months*	3 months*	0 months
	Non-genital surgery	6 months	n/a	n/a	n/a	n/a	n/a	n/a
	Breast/chest surgery	12 months	12 months	12 months	12 months	12 months	3 months*	0 months
	Genital Surgery						12 months	12 months
Referral Letters Required For:	HRT	1	1	1	1	1	1	1
	Non-genital surgery	1	n/a	n/a	n/a	n/a	n/a	n/a
	Breast/chest surgery	2	2	2	2	2	1	1
	Genital Surgery	2	2	2	2	2	2	2
Continuous Hormone Therapy	Breast/chest surgery	n/a	n/a	n/a	n/a	12 months	n/a	n/a
	Genital Surgery	n/a	n/a	n/a	n/a	12 months	12 months**	12 months**

*In Version 5 and 6, either 3 months of psychotherapy OR 3 months of lived experience is required before administration of hormone therapy (and before breast surgery in Version 6).

**Version 6 provides an exception to the continuous hormone requirement in cases when a patient has convincingly lived as a member of the preferred gender for a long period of time. In Version 7, the continuous hormone requirement is waived if hormones are contraindicated for the individual.

Concerns about on-demand and fraudulent transition are not new. Since the first version of the *Standards of Care*, WPATH has required that any medical decisions related to transitioning had to be properly justified by a mental health specialist or a physician.

> Hormonal and/or surgical sex-reassignment on demand (i.e. justified simply because the patient has requested such procedures is contraindicated. It is herein declared to be professionally improper to conduct, offer, administer or perform hormonal sex reassignment and or/surgical sex-reassignment without careful evaluation of the patient's reasons for requesting such services and evaluation of the beliefs and attitudes upon which such reasons are based.
>
> Harry Benjamin International Gender Dysphoria Association 1979, 3

The current version of the SOC is not as explicit about this as the ones before it, but similar language can be found throughout the criteria sections for hormone therapy and surgeries:

> Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the SOC. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.
>
> World Professional Association for Transgender Health 2012, 34

> While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional.
>
> ibid. 2012, 58

WPATH and many other people, including transgender individuals themselves, worry that permitting on-demand access to hormone therapy and surgeries will allow people

who are not actually transgender to transition. Inappropriate reasons for transitioning could be anything from wanting to transition "just for fun" to wanting to transition in order to illicitly gain access to opposite gender bathrooms, locker rooms, and other private spaces. Much of the anti-trans literature claims that trans women are actually cisgender male pedophiles and perverts who want to intrude on women's bathrooms and locker rooms in order to molest children or sexually assault other women. Trans people have been using public bathrooms in line with their gender identities for decades without issue — long before the advent of non-discrimination laws related to public accommodations. Nearly all cases of sex crimes committed in bathrooms or other changing rooms have been committed by cisgender men, most of whom do not even attempt to disguise themselves as women (Barnett 2018). Men who wish to gain access to women's restrooms will not go through the trouble and cost of medically transitioning beforehand.

Another concern is that on-demand transitioning will lead to an uptick of those who ultimately "detransition." Detransitioning involves the discontinuation of any hormone therapies and, usually, a return to presenting as the gender assigned at birth. For the most part, the number of people who de-transition is exceedingly low. In one study, a little less than half of 46 surgeons surveyed had ever encountered a patient who regretted transitioning or was seeking to detransition (Danker, Narayan, Bluebond-Langer, Schechter, and Berli 2018). Of the 22,725 patients represented by these 46 surgeons, only 62 sought to detransition. That amounts to a detransition rate of approximately 0.27%. Reasons cited for detransition included a change in gender identity, rejection or alienation from family or social support, difficulty in romantic relationships, and chronic post-

operative pain or surgical complications (Danker et al. 2018). Of these, the most common was change in gender identity (22 patients) and genital surgical complications or chronic post-operative pain (15 patients).

One of the unfortunate realities of medical transition is that some trans people — due to genetics, insufficient access to surgeries or voice training, a hormone insensitivity, or other confounding factors — will never passably appear to others and/or themselves as the gender they identify as. Being constantly misgendered or clocked (American Psychiatric Association n.d.) (Berger, et al. 2020)[3] in everyday life can take a heavy toll on the mental health of trans individuals, especially those who have been socially and medically transitioning for several years. Having a weak or non-existent support system only makes these issues worse. In these cases, dealing with daily gender dysphoria can often be perceived as the lesser of two evils when faced with ostracism or an unaccepting community. For those who detransition for reasons other than a change in gender identity, it is possible that they will decide to retransition later on in life once they are in a safer social environment, their mental health has improved, their support system is strengthened, or they have access to different surgeons who can produce better outcomes.

For now, the *Standards of Care* does not address how to manage detransition and retransition procedures. Even though detransitioning is a rare phenomenon, surgeons and other medical professionals need to be prepared for it. New versions of the *SOC* should

[3] Being "clocked" is a colloquial term used to describe a situation when a person is "found out" as trans by a person that did not previously have that knowledge. This is a common worry by those who choose to not be public about their trans identity. Cis men and women who are gender nonconformative or who just have more feminine/ masculine body features compared to others might also be (incorrectly) clocked as trans. In some situations, being clocked both correctly or incorrectly can lead to verbal harassment and assault, physical violence, or death.

delineate how physicians should approach detransition options with their patients and give recommendations for what kind of care might be necessary.

Paternalism vs. Autonomy: Issues and Criticisms in Transgender Healthcare

In recent years, there has been a marked departure from the guidelines offered in the WPATH *Standards of Care* both by members of the trans community and by physicians due to the belief that requiring trans people to "prove" their trans-ness is unfair and demonstrates an inherent distrust of claims of gender dysphoria. It comes off as a "guilty until proven innocent" way of thinking; in other words, it assumes that a trans person is somehow "guilty" of fraudulently wanting to transition until they can demonstrate otherwise to multiple medical professionals. In addition, many trans individuals do not agree with the medical pathologization of gender dysphoria and argue that lumping gender dysphoria in with other mental disorders or conditions only increases the harsh stigmatization of transgender people. Despite WPATH's call to de-pathologize gender nonconformity worldwide, the *SOC* still recommends that mental health specialists rely on the DSM criteria for gender dysphoria in diagnosing transgender patients and acknowledges that the existence of a diagnosis of dysphoria facilitates access to health care (WPATH 2012).

Additionally, the *SOC* makes only notional attempts to recognize the cultural differences and diversity of experiences among the worldwide trans community. WPATH has had the *SOC* translated into 17 additional languages, but many English terms used in transgender healthcare do not have adequate or direct translations in other languages. This can create confusion among patients and physicians and ultimately decrease the quality of care available. Although physicians are permitted to alter the guidelines of the *SOC* as they see fit depending on a patient's needs, many are not properly trained in

transgender healthcare to begin with, so physicians tend to treat every trans patient as if they were exactly the same.

The problems present in the WPATH model go further than just the unnecessary pathologization of gender dysphoria and miniscule acknowledgement of the wide variety of the experiences of trans individuals. The *SOC* does not provide adequate information about caring for geriatric trans patients, does not properly distinguish between the treatment differences for binary and non-binary trans patients, and incorrectly assumes that the education and training of psychiatrists, physicians, and surgeons is consistently high quality and thorough.

The informed consent model as a means to increase bodily autonomy in treatment

In lieu of the WPATH method, a growing number of medical professionals are beginning to subscribe to what has come to be called the informed consent (IC) model, which is used almost exclusively for adult patients. The IC model allows transgender patients to access HRT and surgery without having to first engage with a medical health professional or acquire a referral letter (Schulz 2017, 72). A hormone-prescribing physician that follows the IC model will meet with a trans patient and discuss the patient's reasons for wanting to transition, as well as give a full explanation of the effects, risks, and alternatives to the relevant hormone treatment. Once the patient understands and consents to the treatment, the physician will sign off on the prescription.

Some surgeons who perform breast and chest surgeries also follow the IC model, and generally only require that a patient have been on a continuous hormone therapy regiment for a set amount of time prior to surgery (unless hormone treatment is

contraindicated, of course). Each surgeon can lay out their own requirements, but these are usually lower bars to meet than what the WPATH outlines in the *SOC*. Some surgeons will require a referral from a patient's hormone-prescriber, but others may choose to evaluate a patient's reasons for pursuing surgery during a consultation. Many of these surgeons are unable to receive payment through a patient's insurance because nearly all insurance companies model their coverage requirements based on the WPATH model. As such, patients will either pay out of pocket or take out medical loans in order to cover the cost of their surgeries.

Informed consent is a requirement for all medical procedures, not just for treatments related to a medical transition. It is a vital component of bodily autonomy. Without accurate and thorough information, a patient is unable to make an educated choice about their body. When physicians refuse to explain treatment plans or medical procedures to their patients or are unable to do so accurately in terms that a patient can understand, it puts dangerous limitations on bodily autonomy and strays into the realm of strong paternalism. The requirement for informed consent is found in both the IC model and the WPATH model, but the IC model places more power in the hands of the patient over how and when each step of their medical transition occurs.

Strong paternalism is immoral and unethical compared to weak paternalism because it excessively violates the autonomy of patients. A medical professional who exhibits strong paternalism will often ignore the legitimate concerns and wants of their patient because they believe that they know better and are better qualified to decide what kind of treatment plan should be pursued. An example of strong paternalism in transgender healthcare would be when a mental health specialist refuses to provide

affirming or supportive treatment to a trans patient, and instead attempts to convince the patient that they are confused, delusional, or psychotic. Another example would be when a hormone prescribing physician continuously delays the start of a patient's HRT because the patient has either not demonstrated "enough" gender dysphoria or has not had enough lived experience. Gatekeeping medically necessary care is a cruel form of strong paternalism towards transgender people and is not in line with recommendations set out by the WPATH *Standards of Care*.

On the other hand, weak paternalism is generally morally acceptable. In the vast majority of cases, doctors truly do know more about a given treatment or procedure and why a specific patient might be better suited for one versus another. Medical professionals of all types exhibit weak paternalistic behaviors on a daily basis. For example, it would be considered ethically acceptable for a surgeon to perform a mastectomy with the double incision method[4] on a transgender male patient because the amount of existing breast tissue disqualifies the patient from a less invasive mastectomy procedure, such as a keyhole method[5] mastectomy, even though the less invasive method was what the patient preferred. In this situation, performing the patient's desired type of mastectomy would have resulted in a much worse outcome than the more invasive type.

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[4] The double incision method involves making large incisions above and below the breast (along the top and bottom of the pectoral muscle). The nipple-areolar complex is also removed and resized. The breast capsule is then removed, and the chest skin sewn back together. At this point, the nipple and areola are grafted back onto the chest. This method results in large horizontal scars on the chest that often take several years to fade entirely and a loss of sensation of the nipple. Most trans men require this type of surgery due to medium-to-large breast size.

[5] The keyhole method involves making a small incision along the areola, then using liposuction to remove the breast tissue. The nipple may or may not also be resized, depending on an individual patient's needs. This method results in minimal scarring that is usually unnoticeable except when examined up close. Only trans men with very small breasts qualify for this method. If performed on patients with larger breasts, the skin on the chest will appear flabby and deflated because no excess skin in the area is removed.

Of course, it is still up to the surgeon to explain this information to the patient and obtain consent before performing the mastectomy — the surgeon cannot just unilaterally make this decision once in the operating room without the knowledge and consent of the patient.

The WPATH model explicitly allows physicians to modify the clinical guidelines for hormone therapy and surgeries. In many ways, the IC model is simply a modification of the WPATH model. Since the *SOC* permits medical professionals to adjust eligibility requirements for transition procedures, removing parts of the guidelines is technically allowed. However, proponents of the WPATH model would likely argue that since the *SOC* explicitly states that the guidelines are meant to explicate the *minimum* standards, going below those standards is not permissible and therefore unethical.

Diversity of experience and culture in the transgender community

A longstanding criticism of the WPATH treatment model is that it does not truly take into account the diverse experiences of transgender people and forces patients to kowtow to the will of medical professionals in the hopes of being permitted access to medically necessary care. A vast majority of medical professionals who administer and perform transition related care are not transgender themselves. This can create the perception of a very unequal power dynamic in a relationship that already leans heavily towards one party having considerably more authority than the other. Whereas this issue may not present a problem in other situations, such as for a patient with heart disease and a cardiovascular surgeon, the idea of wanting to rid oneself of natal genitalia and secondary sexual characteristics can be very foreign to cisgender people. For nearly all

conditions that require surgical intervention, doctors do not examine the patient's motive for surgery and only ask the standard questions required to obtain informed consent. When a cisgender woman wants to undergo a breast or buttock augmentation, the plastic surgeon does not require a referral letter from a therapist. Why does this suddenly change when it is a transgender woman that walks into the plastic surgeon's office instead?

The idea of having a heart attack or developing diabetes is much easier to understand because those things *could* happen to a cisgender physician and the process of how that may happen is quite clear cut. On the other hand, suddenly developing gender dysphoria is much more unlikely to happen to physicians, especially since studies are increasingly finding that gender dysphoria may originate from structural differences in the brain that were determined in utero (Bakker 2018). The brains of transgender people tend to resemble the gender that they identify as instead of their natal sex — for example, the brains of trans men tend to match the brains of cis men instead of those of cis women.

A majority of medical schools offer very little education in the way of LGBTQ+ healthcare needs and even the most well-intentioned physicians can fall victim to preconceived notions and assumptions of what a transgender person is "supposed" to look like and act like. When a trans patient does not match up to the imagined "standard" transgender person present in a physician's head, that is when problems of gatekeeping could occur. A common assumption in the medical community is that *all* transgender people must experience gender dysphoria and have hated their bodies for years to the point where there is significant impairment to functioning in daily life. Those individuals who do not experience gender dysphoria — or do not experience it enough to meet the DSM diagnosis requirements — are not truly transgender. The truth is not so cut and dry.

Even trans people with debilitating gender dysphoria recognize that being unable to properly function in society only leads to more problems, such as job loss, discrimination, and violence. Transgender people are capable of being productive members of society both pre- and post-transition yet doing so can put them at risk of being accused of not exhibiting enough dysphoria to meet the DSM criteria.

Information about the *Standards of Care* is readily available for free on the internet and most trans people go into healthcare situations fully aware of what they need to say and how to say it in order to prompt medical professionals to give them the care that they know they need. This is not to say that transgender people are trying to transition fraudulently; it is just to show that many patients spend a considerable amount of time researching the transition process and examining their own experiences as a way to demonstrate to themselves and others that they are transgender. Trans individuals often spend months and years battling their own inner doubts about their personal identity before their first attempt at coming out to another person, let alone to a medical professional. It is common for a trans person to fear that their personal experience with gender dysphoria (or gender euphoria[6], in some cases) is not adequate enough to convince a therapist or physician of their trans-ness.

Adequacy of physician training and knowledge

[6] While gender euphoria generally refers to the happiness that one feels when they are gendered correctly or present in a way that aligns with their gender identity, it is also used by some trans people as an alternative way to describe their experience with dysphoria. There are some trans people who have neutral or apathetic feelings towards their body and the idea of presenting as their assigned gender. However, presenting and being addressed as a member of the opposite sex creates feelings of euphoria and happiness. These people would be fine if they had to live out the rest of their lives in their assigned gender but would much rather transition if given the opportunity. According to the DSM-5 criteria for gender dysphoria and the *Standards of Care* guidelines, however, these individuals would be ineligible for hormone therapy and gender confirmation surgeries.

The WPATH model also assumes that all doctors who are willing to offer transition care are actually fully knowledgeable and trained to do so — which is untrue. The amount of transgender-specific training and curriculum in medical school ranges from sparse to completely non-existent. According to a 2018 study, the mean time spent on LGBTQ+ related content in medical schools was 5 hours, and transgender-specific topics were among the least addressed subjects. In addition, approximately 83.1% of medical students reported minimal to no transgender health education during residency (Dublin, Nolan, Streed, Greene, Radix, and Morrison 2018, 380-384). How can transgender patients expect to be treated properly and respectfully by their physicians when those physicians are completely unprepared and untrained on how correctly treat them? Even if a physician is capable of thinking through the procedures that a trans man or trans woman might require, an untrained physician will likely struggle to understand how to treat a non-binary patient.

Non-binary patients are often treated as if they are just another version of trans men, but the goals of these two sets of patients are usually quite different from each other. It is important to note that an AFAB non-binary patient and an AMAB non-binary patient will require different treatments even if the desired end result is the same. For example, if the desired body for both is to possess both breasts and a penis, the AFAB non-binary patient will require a phallus-creating procedure and vaginectomy while the AMAB non-binary patient will require HRT (estrogen) and potentially breast augmentation. If the desired body is to possess a flat chest and a vagina, then the AFAB non-binary patient requires a mastectomy and the AMAB patient requires a vaginoplasty, vulvoplasty, and orchiectomy. There are many instances where non-binary patients do

not require HRT at all. Physicians who are not properly trained in the treatment non-binary identities may turn these patients away or give them incorrect care, such as an improper hormone dosage or the wrong prescription.

It is not enough for WPATH to assume that physicians and surgeons will seek out the proper training and education on their own. The transgender population is rising in number due to increased societal acceptance and awareness, and the medical community must be prepared to offer consistent and reliable treatment regardless of location. It is unacceptable to expect transgender patients to travel excessive distances in order to access transition-related care. WPATH and other medical associations need to make a greater effort to advocate for inclusion of transgender-related care in mainstream medical education and residency programs. Transgender patients should not have to be concerned about whether their doctors will know how to properly treat them when they arrive for their initial appointment or consultation.

Care for geriatric transgender patients

Even though most trans people reach a point where their transition is considered "complete," they still require regular appointments and further treatment related to their medical transition. Hormone therapy is a lifelong process — both trans men and women stay on maintenance doses of testosterone and estrogen respectively for the remainder of their lives. When hormone therapy is discontinued or interrupted, the effects slowly begin to reverse and the body's natural hormone production ramps up again (especially if an individual's uterus or testes have not been surgically removed). The sudden and unexpected stoppage of HRT can also cause significant stress and anxiety. For trans men,

prescriptions for testosterone need to be renewed every six months by a physician because testosterone is a Schedule III controlled substance (Center for Drug Evaluation and Research 2016).

As trans patients grow older, they may at some point become dependent on caretakers to administer hormone treatment, among other things. For example, trans women who have had genital surgery require regular vaginal dilation to maintain appropriate depth and reduce pain. For trans men, testosterone is often administered as an intramuscular or subcutaneous injection on a weekly or bi-weekly basis. What are these patients supposed to do if they become disabled or otherwise unable to perform these actions themselves? There is considerable worry among older members of the trans community that nursing homes and caretakers will refuse to properly care for them, including withholding hormones, misgendering them, dressing them in inappropriate clothing, or not taking them to necessary appointments related to trans health.

The *Standards of Care* does not properly address potential care requirements for geriatric transgender patients. The only lifelong care information that the *SOC* offers is about cancer screening and gynecologic care for post-op trans women and pre-op trans men. These passages are worryingly brief. The point of their existence seems to be to acknowledge that this type care *is* necessary, but does not give, for example, recommendations for frequency of appointments or information about what potential problems a gynecologist should look out for. The *SOC* needs to go further in depth about the primary care needs for trans patients of all ages. WPATH should also publish guidance on how nursing homes and assisted living communities should care for their

elderly transgender patients and what training might be necessary for caretakers and nurses.

Insurance coverage issues

Nearly all insurance companies in the United States use WPATH guidelines as a reference for determining the coverage requirements of transition-related procedures. However, the coverage requirements published by some of these companies are not completely up to date with the current eligibility guidelines explicated by the *SOC*, which often forces patients to deal with two sets of conflicting guidelines in order to both access care and have that care properly paid for. For example, some insurance companies require 12 months of lived experience in order to be covered for breast and chest surgery, even though this requirement was removed from the *SOC* in 2001 (BlueCross BlueShield of North Carolina 2019, 3). Patients who have plans offered by these companies will need to meet the more stringent requirements in order for their surgery to be paid for, even though their surgeon would be willing to perform the procedure without proof of lived experience.

In an unfortunately large number of cases, an employer will specifically exclude transgender-related healthcare coverage from the plans that they offer to employees, even though this practice is currently still forbidden by U.S. federal law under the Section 1557 of the Affordable Care Act (HHS Office of the Secretary and Office for Civil Rights 2018). Most transgender patients cannot afford to risk their jobs and income in order to fight these unlawful exclusions. Many employer-provided plans will cover some transition-related care, such as hormone therapy, but will classify other types of care,

including gender confirmation surgeries, as cosmetic (and therefore optional) despite consensus by the medical profession that these surgeries are medically necessary.

The out-of-pocket cost for a surgical procedure is dependent on a few factors: the setting in which a surgeon practices, the type of surgery being performed, and whether or not the surgeon accepts insurance or Medicare/Medicaid. Both WPATH model surgeons and IC model surgeons may practice in either a hospital setting or a private practice. Most who operate within a hospital network are able to accept insurance and Medicare/Medicaid, but patients will need to meet the coverage eligibility guidelines of these plans regardless of whether the surgeon follows the WPATH model or the IC model.

If a patient does not have insurance or their insurance plan excludes gender confirmation surgeries from coverage, the cost of going to a hospital-based surgeon is much higher than that of a private practice surgeon. Hospital invoices for a chest/breast surgery can reach over $30,000[7] depending location and availability of discounts for cosmetic procedures. On the other hand, surgeons who run their own private practices will contract with nearby independent surgery centers to reduce patient costs. Prices for chest/breast surgery performed in a private practice setting usually range from $3500 to $9000 depending on the specific surgeon (Top Surgery 2020). Genital surgeries are typically the most expensive types of transition care regardless of whether the surgeon is private practice or hospital-based: a vaginoplasty[8] ranges from $10,000 to $30,000, a

[7] This is approximately the price that I was quoted for chest surgery by a nearby hospital after I was informed that my employer's healthcare insurance did not cover gender confirmation surgeries. Had my insurance plan covered the procedure, my out-of-pocket cost would have been only about $2,500. For comparison, the price quoted to me by a private practice surgeon was $7,147.

[8] A vaginoplasty is typically pursued by transgender women and some AMAB non-binary individuals. There are a few different techniques that surgeons may use, but all involve the creation of a vaginal canal and vulva.

metoidioplasty[9] ranges from $6,000 to $30,000, and a phalloplasty[10] can be as low as $20,000 or as high as $150,000 (Clary 2018). For most patients, paying for a genital surgery out-of-pocket is unrealistic. The only way that patients can access this type of care is if their employer-provided insurance plans include transgender-related healthcare coverage or they qualify for Medicare/Medicaid. Since a lot of plans do not include coverage of gender confirmation surgeries, many transgender individuals are forced to delay a medically necessary procedure and deal with the feelings of frustration and anger that results from such gatekeeping.

Gender confirmation surgeries are no longer considered to be experimental procedures and are medically necessary for many transgender patients to relieve gender dysphoria. Although current federal laws prevent discrimination based on gender identity and sex by employers and insurance companies, adherence to these rules are not well enforced. Additionally, the current administration has proposed removing gender identity from the anti-discrimination language in the Affordable Care Act, which will allow employers and insurance companies even more leeway in preventing transgender patients from accessing the care they require. WPATH and other professional medical associations need to put greater effort towards encouraging health insurance companies to

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[9] A metoidioplasty is usually performed on trans men and AFAB non-binary individuals. This technique releases the clitoris from the surrounding tissue and repositions it to match the location of a typical penis. Removal of the vagina may also be performed as a part of this procedure. The resulting neopenis is relatively small and is unlikely to be able to perform adequate penetrative sex.

[10] The phalloplasty procedure is performed in multiple stages and results in a larger neopenis than the metoidioplasty method. This technique involves using grafts donated from either the patient's forearm, thigh, or back to create the phallus, which is typically about the same size as a natal penis in average cisgender men. An erectile implant, such as a flexible rod or inflation device, may be inserted in a follow-up surgery to provide the ability to maintain an erection capable of performing penetrative sex. The type of implant used will dictate how expensive the procedure will be.

offer transition-related coverage with every level of healthcare plan and to stay up to date on *SOC* guidelines for transgender care. Patients should not be forced to pay out of pocket for procedures that are medically necessary, nor should they be required to meet standards that are no longer recommended by the *SOC*.

Conclusion

The World Professional Association for Transgender Healthcare has been a bastion of support and advocacy for transgender patients for several decades. Their contributions towards improving the quality and access to trans health has been an enormous help, especially in the 1980s when stigmatization and bigotry towards members of the LGBTQ+ community were at an all-time high due to the HIV/AIDS epidemic. Through extensive study and research of patients treated using the WPATH model, many traditional fears surrounding medical transition have been assuaged. Rates of detransition among transgender individuals is strikingly rare and commonly associated with surgical complications or lack of a strong support system, which contradicts the assumptions that gender dysphoria and nonconformity are "phases" that a person will grow out of and that people commonly regret undergoing a medical transition (Danker et. al. 2018). Studies have also demonstrated that hormone therapy and gender confirmation surgeries are highly effective at resolving the distress associated with gender dysphoria as well as increasing overall patient well-being, mental health, and body satisfaction (WPATH 2012, 107).

Transgender patients deserve the ability to access the medically necessary care that they determine is appropriate for their transition. As useful as the WPATH *Standards of Care* have been for increasing the quality and availability of transition-related care in recent decades, some of the current eligibility requirements place excessive constraints on the autonomy of patients who do not present with additional physical and mental health concerns. Adult transgender patients who are otherwise healthy should not be required to

participate in psychotherapy or obtain referral letters from mental health specialists in order to access transition care.

If medical schools and residency programs were to increase the amount of education that physicians receive on transgender identities and diagnosing gender dysphoria, more physicians would be able to follow the Informed Consent model and not have to depend on mental health specialists for patient diagnosis and referral letters. Additional transgender-related education for physicians would also improve consistency of care so that transgender patients in all areas do not need to worry about discrimination, poor treatment quality, or having to travel for the care they need. Removing the WPATH mandate for a mental health specialist to evaluate a patient in order to diagnose gender dysphoria, easement of coverage requirements by health insurance companies, and increased education for physicians will also decrease the risks of strongly paternalistic gatekeeping and mistreatment — all of which is important for facilitating increased patient autonomy with regards to transition-related treatment and reducing the stigmatization of transgender patients.

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