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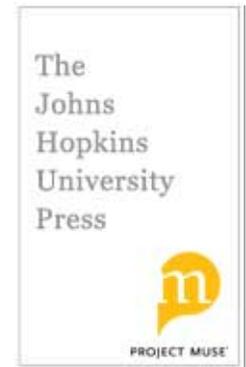
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ETHICAL PROBLEMS WITH THE MENTAL HEALTH EVALUATION STANDARDS OF CARE FOR ADULT GENDER VARIANT PROSPECTIVE PATIENTS

C. JACOB HALE

ABSTRACT The World Professional Association for Transgender Health's "Standards of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons" (SOC) set forth standards clinicians must meet to ensure ethical care of adequate quality. The SOC also set requirements gender variant prospective patients must meet to receive medical interventions to change their sexual characteristics to those more typical for the sex to which they were not assigned at birth. One such requirement is that mental health professionals must ascertain that prospective patients have met the SOC's eligibility and readiness criteria. This article raises two objections to this requirement: ethically obligatory considerations of the overall balance of potential harms and benefits tell against it, and it violates the principle of respect for autonomy. This requirement treats gender variant prospective patients who request medical intervention as different in kind, not merely degree, from other patient populations, as it

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constructs the very request as a phenomenon of incapacity. This is ethically indefensible in and of itself, but it is especially pernicious in a sociocultural and political context that already denies gender variant people full moral status.

IN 1979, THE Harry Benjamin International Gender Dysphoria Association (recently renamed the World Professional Association for Transgender Health [WPATH]), issued a document, “Standards of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons” (SOC). WPATH is a professional association devoted to furthering “the understanding of gender identity disorders by professionals in medicine, psychology, law, social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech and voice therapy, and other related fields” (WPATH 2007). The SOC were the first codification by any professional group of the “appropriate standards of care to be offered to applicants for hormonal and surgical sex reassignment” (Walker et al. 1985, p. 80); the sixth and current version was adopted in February 2001 (Meyer et al. 2001). The phrase “standards of care” suggests that this document sets forth standards medical health professionals must meet to ensure ethical care of adequate quality, and indeed it does so. As the document’s language indicates, however, the SOC also set requirements for prospective patients: “All patients . . . should follow the SOC” (Meyer et al. 2001, p. 2). Prospective patients must meet specific eligibility and readiness criteria for hormone therapy, genital surgeries, and gonadal surgeries, which the SOC count as genital surgeries.

For hormone therapy for adults, the eligibility criteria require that the prospective patient demonstrate knowledge of what hormones medically can and cannot do, and of their social benefits and risks, and that the prospective patient has undergone either a documented “real-life experience” (living “full-time” in the gender to which one is transitioning) for three months, or psychotherapy for a period specified by the mental health professional (usually three months). To meet the readiness criteria, the prospective patient must: (1) have had “further consolidation of gender identity” (one’s subjectively experienced sense of being a woman, a man, or something else) during the “real-life experience” or psychotherapy; (2) have made “some progress in mastering other identified problems leading to improving or continuing stable mental health”; and (3) be likely to take hormones in a responsible manner (Meyer et al. 2001, pp. 13–14).

For genital (and gonadal) surgery in adults, the eligibility criteria are: (1) “usually 12 months of continuous hormonal therapy for those without a medical contraindication”; (2) a successful “real-life experience” of at least 12 months; (3) “regular responsible participation in psychotherapy” if required by the mental health professional; (4) “demonstrable knowledge of the cost, required lengths of hospitalization, likely complications, and post surgical rehabilitation requirements of various surgical approaches”; and (5) knowledge of different competent

surgeons. The readiness criteria specify that the prospective patient demonstrate progress in consolidating his or her gender identity and “in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health” (Meyer et al. 2001, p. 20).

Mental health professionals must ascertain that prospective patients have met these requirements, and letters from mental health professionals are required for hormone therapy, breast/chest surgery and genital (including gonadal) surgery. Thus, the SOC put mental health professionals in a “gate-keeping role” (Bockting 2004; Bullough, Bullough, and Elias 1997; Rachlin 2002). To my knowledge, no other class of prospective patients is subjected to a similar requirement.

Conflicts have arisen about various elements of the SOC. There are four common criticisms, three of which I will not discuss in depth. First, the SOC create a barrier to the establishment of trusting and productive therapeutic relationships, thereby diminishing mental health service provision for gender variant clients and creating ethical dilemmas for mental health professionals. Second, they are pathologizing because diagnosis with a mental disorder (gender identity disorder) plays a role in mental health professionals’ recommendation for hormonal and surgical therapy. Finally, the cost of this requirement creates an additional financial barrier to medical interventions and is therefore classist. I will concentrate here on one further controversy: the ethical status of the gate-keeping position in which the SOC place mental health professionals (Anderson 1997; Bockting 2004; Cromwell 1999; Denny and Roberts 1997; Kuiper and Cohen-Kettenis 1998; Lombardi and van Servellen 2000; Nangeroni 1997; Nelson 1998; Pfäfflin 1997; Pollack 1997; Rachlin 2002; Spade 2006; Stryker 1994, 1997; Vitale 1997; Wilchins 1997.) I will argue that this aspect of the SOC is unethical when judged by the dominant principles of biomedical ethics in the contemporary United States. The SOC construct gender variant prospective patients—a term I use to indicate people who seek medical interventions to change their sexual characteristics to those more typical for the sex to which they were not assigned at birth—as a category whose members are granted far less autonomy than is given to any other category of adult prospective patients. This difference is a difference not only in degree but in kind. This is damaging individually and collectively, as it constructs the request for hormonal and surgical intervention as a phenomenon of incapacity in a sociocultural and political context that already denies gender variant people full moral status.

Several qualifications are in order. First, my discussion is confined to the contemporary United States and to gender variant prospective patients who are legally competent adults. Second, I follow the SOC’s usage by counting gonadectomy as genital surgery. And finally, I do not address legal issues.

For the dominant approach to biomedical ethics in the contemporary United States, I draw on the fifth edition of Tom L. Beauchamp and James F. Childress’s *Principles of Biomedical Ethics* (2001). Beauchamp and Childress articulate four

moral principles central to medical decision-making: respect for autonomy, beneficence, non-maleficence, and justice. Although the philosophical meaning of *autonomy* is controversial, self-determination is at its core. Beauchamp and Childress write: “Respect [for autonomy] . . . involves acknowledging decision-making rights and enabling persons to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult, or demean others’ rights of autonomy” (p. 63). Non-maleficence is “a norm of avoiding the causation of harm”; non-maleficence judgments must be overall judgments and should include quality-of-life considerations. Beneficence is “a group of norms for providing benefits and balancing benefits versus risks and costs”; and, justice is “a group of norms for distributing benefits, risks, and costs fairly” (p. 12).

Each of these principles is *prima facie*, in that it “must be fulfilled unless it conflicts on a particular occasion with an equal or stronger obligation” (p. 14). When conflicts between principles arise, there is no mechanical way to determine which principle provides the actual duty. Beauchamp and Childress give guidance about how to make decisions when principles conflict by endorsing a form of wide reflective equilibrium, in which the considered judgments of “our common morality” and the principles are given equal weight. Using this approach, one tests and balances the principles against considered judgments about specific cases, one tests considered judgments about specific cases against the principles, and one tests the fit—or coherence—between the two, at least in part, against considered moral judgments about relevantly similar cases. Thus, the use of analogies is a critical part of this process, even though analogies are never perfect—never similar in all relevant aspects to the case in question (p. 404).

The moral status of the SOC’s requirement of mental health evaluation prior to hormones and surgeries is a problem of balancing the competing demands of the duties of respect for autonomy, beneficence, and non-maleficence. The possible harms that might be used to justify the SOC’s requirement are: (1) irreversible loss of reproductive capacities; (2) medical risks; (3) social risks; (4) irreversible changes other than the loss of reproductive capabilities; and (5) possible later regrets (Bullough, Bullough, and Elias 1997; Meyer et al. 2001; Rachlin 2001; Stoller 1978). Although the principle of non-maleficence requires that these risks be taken into account, it is necessary to make a reasoned judgment about which principle—non-maleficence, respect for autonomy, or beneficence—provides the actual duty (Denny and Roberts 1997). I will argue that considerations of the overall balance of potential harms and benefits tell against the SOC’s mental health evaluation requirement, and that potential risks do not justify overriding respect for autonomy.

I begin by considering as an analogue elective vasectomy, because it shares with hormonal and genital treatments for gender variant people several morally relevant features: it is considered irreversible for decision-making purposes; it eliminates reproductive capacities; and it is sought on the basis of patients’ desires rather than to prevent death from physical causes, alleviate physical pain, or treat

physical injury or disease.¹ The American Urological Association's policy statement on "Vasectomy as a population control mechanism" reads, in part:

Decision making should be between the patient and physician. . . . Since at this time sterilization should be regarded as a permanent step, a patient's decision should be arrived at after careful thought, weighing the risks and benefits of temporary and permanent methods of contraception. This implies the need for patient education and understanding. No sterilization should be performed unless the patient fully understands the consequences of the procedure, as well as the risks and benefits of other contraceptive measures. The physician should be assured that the procedure is either medically indicated or is for contraceptive purposes, and that the patient is physically and mentally prepared for it. Some patients are prepared for surgery when they are first seen, others require time and discussion, and some should be rejected for it. The AUA believes that the physician is the best judge of this. (AUA 1996; emphasis added)

One might object that vasectomy is not an appropriate analogy because it is reversible. Yet the AUA clearly states that vasectomy must be regarded as irreversible for purposes of medical decision-making. What is the justification for this? First, vasectomy is intended to be permanent. Second, it is irreversible in a significant percentage of patients, and the longer the period of time between vasectomy and vasovasostomy (vasectomy reversal), the lower the success rate of reversal (Wilson 1996). There is no way to tell in advance whether vasectomy will be reversible for any particular patient. Thus, it must be considered permanent when a surgeon is deciding whether or not to accede to any particular patient's request for the procedure.

The AUA charges urologic surgeons with ensuring that prospective patients are physically and mentally prepared for vasectomy. Since we can reasonably attribute endorsement of the "ought implies can" principle to the AUA, we should conclude that the AUA believes that urologists have sufficient expertise in assessing readiness through consultation and a thorough, careful informed consent process. Referral for mental health evaluation is not routine. Rather, the urologic surgeon presumes that a prospective patient is competent and has the capacity to request vasectomy autonomously. This presumption is defeasible: the behavior of a particular prospective patient could lead the urologic surgeon to question his competence, in which case the surgeon might require mental health evaluation.

Vasectomy is similar to genital surgeries requested by gender variant prospective patients in that it must be considered for decision-making purposes as causing irreversible elimination of reproductive capacity, which a patient might later regret. But it is treated differently in that mental health evaluation is not rou-

¹By using an elective procedure as an analogy, I do not mean to suggest that medical interventions sought by gender variant people are elective. The SOC state: "Sex reassignment is not 'experimental,' 'investigational,' 'elective,' 'cosmetic,' or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID [gender identity disorder]" (Meyer et al. 2001, p. 18).

tinely required before a physician decides whether or not to grant a prospective patient's request. The principle of parity dictates that the relevant genital operations should be treated in the same way, insofar as irreversible loss of reproductive function and possible later regret over such loss are moral considerations. The SOC, however, fail to take this into account. On this matter, the SOC presuppose either that the general presumptions of competence and capacity to make autonomous choices do not apply to gender variant prospective patients, or that physicians are uniquely incapable of assessing the readiness of these patients. The SOC state that "informed consent implies" patient understanding of loss of fertility and reproductive capacity, but they also assert that responsibility for ensuring such patient understanding rests not only with the physician but also with the mental health professional (Meyer et al. 2001, p. 17).

Irreversible loss of reproductive capacity and possible later regret over such loss are not, of course, the only relevant moral considerations. One morally significant difference between the relevant surgeries and vasectomy is that the former involve greater medical risk: most are major operations, requiring general anesthesia and hospitalization, not simple out-patient procedures. As the level of risk increases, so does the diligence with which one must attend to the demands of the principle of non-maleficence. This tells in favor of proceeding with greater caution. But it does not in and of itself justify the mental health evaluation requirement, for the legitimate concerns deriving from the principle of non-maleficence can be protected with less infringement of autonomy by careful physician-patient consultation and a thorough informed consent process. This is already routine in most areas of surgical practice, including those involving major operations such as bariatric surgery.

The SOC gesture toward another morally relevant consideration, which Katherine Rachlin (2001) discusses at greater length: social risks. Rachlin asks us to consider

someone who has a male body and requests breast enlargements or hormones which cause breast growth and infertility. The individual is making this request because of something s/he feels inside. The doctor cannot see it, measure it or assess it. There is no shared cultural belief about what is socially desirable. In fact, female breasts on a male body are considered undesirable. The client is requesting something that will make them less socially acceptable and may leave them open to ridicule. It may jeopardize their professional, social and family relationships. How can the doctor be sure that s/he is not doing harm? *If a non-transgendered woman requests breast enlargements and the responsible doctor does not agree that he can improve her appearance s/he will usually refuse to perform the surgery.* Compared to breast enlargement procedures done on female bodies, there is very little research and most doctors have relatively few cases to draw on as precedent. This is why the medical doctor or surgeon depends upon the diagnostic information supplied by the psychotherapist.

By performing any type of gender-enhancing surgery (genital, facial, breast, etc.) the doctor is contributing to the patient's change in social status. A change which might make him/her vulnerable to prejudice and even violence. It is not only a physical/medical intervention it is a social intervention and therefore needs a social assessment prior to treatment. (p. 16; original emphasis)

One important theme Rachlin addresses is the lack of a shared social belief about the desirability of the outcomes sought by gender variant prospective patients. This, by itself, is not an adequate basis for overriding a prospective patient's wishes, since an outcome that is profoundly harmful to one prospective patient might be deeply beneficial to another. Social perspectives about desirable bodily configurations shared by people who are not gender variant are not the relevant perspectives to apply to gender variant people; to do so would be akin to applying to people of color social perspectives white people share about desirable bodily features. Indeed, for some gender variant people, medical interventions, including those which produce bodies considered undesirable by most people who are not gender variant, are part of a process that makes life livable. The principle of beneficence tells in favor of providing gender variant prospective patients with that which is beneficial to them.

The differences between shared social beliefs and positions in structural power relations, however, entail social risks for gender variant people. Rachlin is certainly right to point out that ridicule, discrimination, and violence are risks to be considered. Indeed, even rape, murder, and death from medical negligence are risks. One well-known case of such negligence is that of Tyra Hunter, who was in a car accident in Washington, DC, in 1995. Eyewitnesses reported that after paramedics cut open her pants and discovered her penis, they temporarily suspended treatment and ridiculed her. After Hunter died in an emergency room, her mother won a wrongful death suit against the District in which the jury held both the paramedics and the emergency room physician accountable (Feinberg 2001). Highly publicized cases in which forced genital exposure—which Talia Mae Bettcher argues constitutes a form of sexual violence itself—preceded rape or murder include those of Gwen Araujo and Brandon “Teena” (Bettcher 2006a, 2006b, 2007; Hale 1998). Gender variant people sometimes seek hormones, breast/chest surgeries, hysterectomy, and orchiectomy as precursors to vaginoplasty, phalloplasty, or metoidioplasty. So, considerations of the social risks of the former procedures should not be considered in isolation from the social risks of an entire process leading to a more normative alignment between genital and other bodily zones.

Operations that alter sexual characteristics are prerequisites for changing the sex designation on legal documents, such as U.S. passports and driver's licenses and birth certificates in many states. Without documents that bear a sex designation matching one's appearance, one is doubtless at increased risk of harass-

ment, loss of mobility, incarceration, discrimination in employment, housing, and public accommodations, denial of services from governmental, corporate, and social service entities, and violence.

In many cases when gender variant prospective patients seek nongenital medical interventions but not as precursors to genital surgeries, it is also reasonable to believe that the desired medical interventions decrease, rather than increase, some social risks. For example, many female-to-male gender variant people are gender ambiguous before beginning testosterone, but once on testosterone some very quickly come to appear unremarkably male (when fully clothed); this dramatically reduces the risks of discrimination, violence, and other forms of mistreatment. For some, mastectomy and chest reconstruction facilitate the ability to appear unremarkably male when fully clothed or when clothed from the waist up, thereby decreasing risks. Leslie Feinberg (2001), for instance, writes compellingly about being ridiculed and denied medical treatment for appearing gender ambiguous when fully clothed.

Finally, in addition to consequences caused directly by others' perceptions of gender variant people, some potential social benefits stem from individuals' perceptions of themselves. Insofar as medical interventions enable gender variant people to overcome profound discomfort with their bodies, their bodies are less of an obstacle to the formation and maintenance of important social and intimate relationships.

Thus, Rachlin overlooks potential benefits of medical interventions. Her rhetorical question—"How can the doctor be certain that s/he is not doing harm?"—asks both too little and too much. It asks too little, because it asks only about harm that the medical intervention in question might cause, not about the net balance of harms and benefits that might be caused by the intervention sought, by alternative interventions, and by refusal to intervene. It also asks too much, for it asks for certainty when medical decisions typically occur in situations of uncertainty. Even a recommendation that a patient take an over-the-counter medication, such as aspirin or ibuprofen, carries the risk that this particular patient may experience harmful side effects.

Another theme in the passage quoted from Rachlin appears in her last sentence. There, she begins with an accurate premise: the relevant medical interventions regulated by the SOC are, in part, social interventions. From this, she draws the conclusion that a social assessment is necessary prior to receiving these medical interventions. But this inference is unwarranted, if we understand her to mean a social assessment by mental health professionals. Were it warranted, every medical intervention with social consequences would require prior social assessment by a mental health professional. This, however, is radically at odds with commonly accepted medical practice. Vasectomy, for example, is a social intervention in that it changes the patient's status from reproductive to nonreproductive. This has the potential for social consequences, since lack of reproductive capacity can create unforeseen difficulties in relationships, especially spousal

ones, including some that might not have existed at the time of the procedure. Even interventions as commonplace as prescription medications that can cause sleeplessness, irritability, or loss of sexual function carry potential social consequences. Finally, Rachlin's arguments give no weight to the principle of respect for autonomy and, thus, are ethically indefensible.

Another morally relevant difference between vasectomy and the medical interventions sought by gender variant people is that the latter involve not merely irreversible loss of reproductive capacity but also other irreversible changes that have important social consequences. Some hormonal changes—such as breast enlargement in male-to-female patients, and deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair, and male pattern baldness in female-to-male patients—are permanent (Meyer et al. 2001). Irreversibility should not be overstated: breast augmentation can be removed, or can be performed on a patient who has had mastectomy and chest reconstruction, and mastectomy can be performed on a patient who has developed breasts due to hormone usage. For the most part, however, gonadal and genital structures, once removed, cannot be replaced or restored. This renders it more difficult for patients who have received medical interventions to return to their original gender statuses; if they do, they will have foregone permanently some of the physical characteristics generally believed to be in accordance with those gender statuses. This morally relevant concern partially converges with that of the possibility of later patient regrets.

Making a decision in accordance with the principles of beneficence and non-maleficence requires weighing a complex balance of benefits and risks. So perhaps Rachlin's point should be recast as follows: a mental health professional is so much better equipped than a physician to decide which outcome is most likely for a particular prospective patient that a mental health professional must be involved.

Several factors tell against this, though not conclusively. First, physicians whose patient bases already include significant numbers of gender variant patients may already have extensive professional experience with such patients from which to draw in considering requests from new prospective patients. Physicians without this experience can consult with their more experienced colleagues. Second, the incidence of postoperative regret is extremely low. A large study conducted by Friedemann Pfäfflin and Astrid Junge (1998), considered authoritative by many in the field, found less than 1% in female-to-males and 1–1.5% in male-to-females (see also Green 1999; Lawrence 2003; Rachlin 2002).

Some might argue that the mental health evaluation requirement is (at least partly) responsible for the low rate of postoperative regret. Richard Green (1999) writes: "If gender patients can procure surgeons who do not require psychiatric or psychological referrals, research should address outcome for those who are professionally referred versus the self-referred." Almost no evidence is available on this question. Although a study of 232 male-to-female transsexuals showed

no significant association between patient compliance with the SOC, including psychotherapy requirements, and incidence of postoperative regret, all respondents had letters of recommendation from two mental health care professionals (Lawrence 2003).

Consideration of the overall balance of potential risks and benefits must take into account that the mental health evaluation requirement is a barrier that some gender variant prospective patients do not surmount, for several reasons. Some cannot bear its financial burden. Some lack access to mental health professionals who have experience with gender variant clients, or the mental professionals with experience in this area to whom they have access do not provide services that are culturally sensitive in other important respects (socioeconomic class, ethnicity, immigration status, sexual orientation, etc.). Some resent the requirement and hence refuse to submit to it. This leads some gender variant people to use hormones obtained from friends, relatives, pharmacies in other countries, or street dealers, without medical supervision. Lack of medical supervision increases risks that side effects will go unnoticed, and it also increases risks of increasing doses beyond safe levels. Insofar as lack of medical supervision leads to inadequate knowledge of the effects of hormones, there is an increased propensity for other unsafe body modification practices such as “pumping”—injection of substances such as industrial-grade silicone—intended to increase the size of the breasts, buttocks, hips, or other areas of the body. The risks of transmission of blood-borne diseases are increased through sharing of needles used for hormone injection. Insofar as the networks involved with illicit hormone use overlap with those of illicit drug use and HIV-risk behavior, substance abuse and HIV risks are also increased. Further, risks of arrest and incarceration are heightened through illegal purchase of hormones, and through increased participation in social networks where other illegal behaviors occur (Beam 2007; Lombardi 2001; Lombardi and van Servellen 2000; Spade 2006).

The SOC take these risks into account, but inadequately. The SOC state that as an alternative to “black market” hormones or unsupervised hormone use, it can be acceptable to provide hormones to patients who have undergone neither a documented real-life experience nor a period of psychotherapy of a duration specified by the mental health professional. This is insufficient, for it overlooks the barrier created by the very requirement of mental health evaluation.

The principles of non-maleficence and beneficence alone cannot provide us with a way to resolve the issue at hand. We must also consider the principle of respect for autonomy. It is crucial to recognize that believing oneself capable of autonomous choice and being accorded the status of one who is capable of autonomous choice is a benefit. Such status enables a person to be viewed, and to view himself or herself, as of full moral worth, possessing the characteristics that make persons equal in moral value, and also increases a person’s ability to be and feel independent and able to care for oneself—capable of equal, mutually affirming relationships with others, in control of himself or herself, able to influ-

ence the external world, and responsible for one's own actions. If one views oneself as incapable of autonomous choice, one views one's capacities as diminished. Indeed, insofar as autonomy is a capacity for distinctly human values, if one views oneself as lacking it, one may see oneself as lacking distinctly human values, and, thereby, as lacking the capacities that are necessarily involved in being worthy of full moral respect from others and from oneself (Hill 1991, pp. 34–36). Hence, viewing oneself as capable of autonomous choice and being so viewed by others are important components of self-esteem and moral self-respect. Respect for autonomy involves not only respect for the capacity to make autonomous choices but also respect for the ability to act on autonomous decisions (Beauchamp and Childress 2001, p. 63).

Adult gender variant prospective patients are prohibited by policy from obtaining medical interventions without the permission of mental health professionals. The SOC, therefore, deny and undermine the independence of these patients. The result is often experienced as “an infantile state of dependency” or as being “returned to a childlike status” (Buchanan and Brock 1989; Pollack 1997). Thus, Riki Anne Wilchins (1997) facetiously defines “Standards of Care,” in part, as follows: “Something invented by professionals to protect us widdle transpeople from hurting our widdle selves with sharp things” (p. 229). Her sarcasm is appropriate in that the SOC's mental health evaluation requirement is analogous to policies that require parental consent for minors to act on their desires, except that the SOC's mental health evaluation requirement applies to adults.²

As the SOC do not charge mental health professionals with determining the competence of gender variant prospective patients, it appears that the general presumption of competence applies to these patients—mental health professionals must merely ascertain whether prospective patients have met the eligibility and readiness criteria. However, if they must also determine the likely overall harm-benefit balance for a particular prospective patient, they must go well beyond the assessment required by the SOC's eligibility and readiness criteria and also take into account the social risks. If mental health professionals take this more thoroughgoing approach, they must decide what is likely to be in the best interests of their clients, and they are thus in a position of (partial) surrogacy in relation to their clients. The “best-interests standard” is the least autonomy-preserving of the three standards for surrogate decision-making considered by Allen E. Buchanan and Dan W. Brock in *Deciding for Others* (1989). This is why they restrict its use to situations in which an incompetent patient did not execute an advance directive and in which substituted judgment cannot be used because there is inadequate

²By stressing independence, I do not mean to slight the importance of sociality or relationality in the formation of desires or the ability to act on desires, nor do I mean to endorse an individualist notion of autonomy. This should be clear from the contrast drawn in the body of this paper between the autonomous and the childlike, not between the autonomous and the social. For an argument that those who urge the removal of GID from the APA's *Diagnostic and Statistical Manual* assume an individualist notion of autonomy, see Butler 2004.

evidence from which to determine what the incompetent patient's preferences would be were the patient competent (pp. 117–22). In the bioethics literature, surrogate decision-making is most commonly discussed in relation to incompetent patients for whom surrogates must decide whether to proceed with medical interventions that physicians have recommended to treat physical injury or disease processes. These are not typically cases in which a prospective patient seeks medical interventions, nor ones in which there is no evident physical injury or disease, rather, the cases highlighted are ones in which patients refuse treatment, not in which they seek it. The SOC allow prospective patients the power to refrain from seeking treatment, but not the power to have their choices to seek treatment respected without mental health professionals' recommendations. This undermines the general presumption of competence for gender variant prospective patients and therefore constructs the request for hormonal and surgical intervention as a phenomenon of incapacity.

Even if mental health professionals refrain from this more thoroughgoing benefit-risk evaluation, they are still in the position of determining whether gender variant prospective patients should be allowed to act on their decisions. While this does not undermine the application of the general presumption of competence to gender variant prospective patients, it does undermine the application of the general presumption that adults have the capacity to make and act upon their autonomous choices (see Beauchamp and Childress 2001; Grisso and Appelbaum 1998). This also constructs the request for hormonal and surgical intervention as a phenomenon of incapacity. This is not merely a different in degree, for insofar as gender variant prospective patients' requests are constructed as a phenomenon of incapacity, these patients are constructed as different in kind from other categories of prospective patients whose very requests are not constructed as phenomena of incapacity.

Were the SOC isolated from other sociocultural and political forces, perhaps this consequence would not be as morally pernicious as it is. However, the abilities, autonomy, and full moral status of gender variant people are undermined in many ways by many institutions, policies, and juridical entities, which interact with one another and with the SOC in a variety of complex ways. The simple fact that the social risks of medical interventions are so great demonstrates this adequately. Ironically, the very social risks which tell in favor of the SOC's mental health evaluation requirement are supported by it, for by implying that gender variant prospective patients have less than full autonomy, and thus less than full moral status, this belief enables mistreatment of gender variant people.

The infringement of autonomy by the SOC's mental health evaluation requirement is great. The legitimate concerns of the non-maleficence principle can be protected with less infringement on the duty of respect for autonomy through careful patient-physician consultation and a thorough informed consent process, undertaken with the defeasible presumption of competence. Should the physician come to question a particular prospective patient's competence or

question the adequacy of that prospective patient's preparation, appropriate referrals to mental health professionals—and to community-based organizations, in the case of concerns about adequacy of preparation—should be given.

Therefore, the SOC's mental health evaluation requirement should be eliminated unless and until it is demonstrated that adult gender variant prospective patients are, as a category, significantly incapable of making autonomous choices in their own best interests. Further, Green (1999) asks: "if success is less (or failure greater) among the self-referred, should otherwise competent adults nevertheless have that autonomy of self-determination?" Even if it were to be demonstrated that adult gender variant prospective patients are, as a category, significantly incapable of making autonomous decisions in their own best interests, proponents of the SOC's mental health evaluation requirement would still need to argue convincingly that the principles of non-maleficence and beneficence override the principle of respect for autonomy in this area of medical policy-making. This is a high burden of proof, and until and unless it is met, the SOC's mental health evaluation requirement is unethical.

This is not an endorsement of "surgery on demand," not even the more moderate view that surgery is a right to be granted upon request. Nor do I support Susan Stryker's (1997) suggestion that the transsexual, rather than the psychotherapist, should ultimately determine what will happen to the transsexual's body. Ultimately, decisions about whether to prescribe hormones and perform operations must be made by physicians—not prospective patients or mental health professionals—after careful patient-physician consultation and a thorough informed consent process.

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