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CASE STUDY

GENDER-AFFIRMING MEDICAL TREATMENT AND CHANGE OF SEX ON IDENTITY DOCUMENTS

A CASE STUDY IN HEALTH AND HUMAN RIGHTS

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Scenario

Natalie was born a biological male and registered as "male" on her birth certificate. In her childhood and adolescence, Natalie behaved as a "boy" – she enjoyed team sports and dressed in typically masculine clothing. In her twenties, Natalie disclosed to family and friends that she identified as a woman not a man. "I do not want to act like a man. This isn't me." She began to experiment openly with her dress, body language, and voice. She referred to herself and requested that others call her "Natalie." She remained depressed and discouraged, upset about the growing distance in her family. Some family members could not understand her behavior. Others reacted with disgust or hostility. Natalie moved away from her hometown, keeping very little contact with family and friends.

Natalie desired to change the appearance of her body. "I want to look more like a woman." She visited her general practitioner (GP) to learn more about medical treatment. Her GP was uncomfortable being involved in her care. He quickly referred Natalie to psychotherapeutic care, her problem being "mental not physical." Natalie visited Dr. Popva, a psychotherapist, and learned that diagnosis with a mental disorder is a precondition for hormone and surgical treatment. Natalie found her counseling sessions sometimes helpful, but viewed Dr. Popva as a gatekeeper to the treatment she needed and the diagnosis as a test to be passed. "Dr. Popva has a set story about the transgender experience, only one seems acceptable. I try to live up to it, so she will sign off on my treatment." Frustrated with the process, Natalie considered buying hormones on the black market and self-administering.

Natalie's transition has been difficult. She suffers from verbal abuse and harassment and fears violent attacks. Registration of her sex as "male" on identity documents is a source of daily humiliation and mistreatment. "I won't travel internationally because I hate to show my passport. I hate having to go into the bank or rent an apartment. Sometimes I just avoid these situations, forgo the opportunity." When Natalie sought to change her registered sex to "female" on her identity documents, she was informed of an eligibility requirement. She must present evidence of completed sex reassignment surgery. "There needs to be a clear cut point," a government clerk explained. "You can't simply choose."

Once she completed the diagnostic phase, Natalie was referred for hormone treatment. She learned, however, that this treatment was excluded from health insurance coverage. When Natalie called to inquire about the exclusion, a claims manager informed her that "We only cover medically necessary treatment. Hormonal and surgical treatments do not qualify. There is no medical evidence they cure the mental disorder. You are lucky to have the diagnosis. With that, we will cover more psychotherapy."

Background

Gender identity refers to a person's identification or experience of gender. Every person has a gender identity. Persons express their gender identity in day-to-day life through their appearance (e.g. dress), behavior (e.g. speech and mannerisms), and the physical body.[1] For some, gender identity is stable or fixed. For others, gender identity is fluid, regarded as a process and subject to change. Gender identity is distinct from *sexual orientation*, which refers to identity based on aspects of intimate and sexual relations with and emotional, affectional, and sexual attraction to other individuals.[2]

The term *transgender* broadly describes persons whose gender identity does not conform to conventional gender norms associated with their birth-assigned sex (e.g. feminine women and masculine men). Sex and gender are distinct, although both relate to femaleness/maleness. *Sex* refers to biological and physiological characteristics. *Gender* refers to social roles, behaviors,

[1] S. Corrêa and V. Muntarbhorn. *The Yogyakarta Principles: principles on the application of international human rights law in relation to sexual orientation and gender identity.* (2007) at Preamble. Online: http://www.yogyakartaprinciples.org. ("Yogyakarta Principles")
[2] *Yogyakarta Principles*, at Preamble.

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activities, and attributes. Transgender persons may identify with the traditional gender binary, but adopt the gender opposite to that associated with their birth-assigned sex. Transgender persons may also identify with aspects of both traditional genders, or reject the binary and identify with neither.

Persons who identify as *transsexual* seek to or have changed their physical appearance and/or genital anatomy to reflect the sex different from their birth-assigned sex in expression of their gender identity. Transsexual persons are often described by reference to this physical change as pre-or post- operative male-to-female (MTF or transgender women) or female-to-male (FTM or transgender men). Others simply identify as members of the sex to which they have transitioned. Transition is achieved through sex reassignment or gender-affirming treatment, including any or all of the following:

- *Hormone treatment/therapy:* the administration of exogenous endocrine agents to induce or enhance feminine/masculine secondary sex characteristics, e.g. voice, face and body hair, breast tissue, and body fat distribution and muscle mass.[3]
- *Sex reassignment surgery*: surgical intervention to alter secondary sex characteristics e.g. chest surgery (breast enhancement or mastectomy and reconstruction); tracheal shave, facial feminization, and voice surgery.
- *Genital reassignment surgery* is a subset category focused on primary sex characteristics, e.g. penectomy/oriectomy (to remove penis/testicles), vaginoplasty/phalloplasty (to create vagina/penis), hysterectomy (to remove pelvic organs).
- *Non-medical treatment* such as laser hair removal/electrolysis, and voice training.
- Psychiatric diagnosis and treatment are often required to access gender-affirming medical treatment. A further prerequisite is the requirement to live as a member of the transitioned sex for a period of time, known as the Real-Life Test or Experience.

The *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV), published by the American Psychiatric Association, is a standard classification of mental disorders with diagnostic criteria.[4] A diagnosis of "Gender Identity Disorder" (GID) is based on:

- a strong and persistent cross-gender identification, manifested by symptoms such as: a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, and the conviction of having feelings and reactions typical of the other sex; and
- persistent discomfort with assigned-sex or sense of incongruity in the gender role of that sex, manifested by symptoms such as preoccupation with changing primary and secondary sex characteristics to simulate the other sex through medical treatment or belief of having been born the wrong sex; and
- which causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- "Gender Identity Disorder – Not Otherwise Specified" is used as the diagnosis for persons who do not desire to fully transition to the other sex in the female/male binary scheme.

The *International Statistical Classification of Diseases and Related Health Problems*, 10th edition (ICD) is published by the World Health Organization and more commonly used in Europe.[5] The ICD identifies "transsexualism" as a mental and behavioral disorder, diagnosed by a desire to live and be accepted as a member of the opposite sex, usually accompanied by a wish to make the body as congruent as possible with the preferred sex through medical treatment.

[3] See: J. Feldman & J. Safer. "Hormone Therapy in Adults: Suggested Revisions to the Sixth Version of the Standards of Care" (2009) 11(3) *International Journal of Transgenderism* 146-182.

[4] American Psychiatric Association. *Diagnostic and statistical manual of mental disorders,* 4th ed. (1994). The DSM is periodically updated. The fifth edition (DSM-V) is scheduled for publication in May 2013. Preliminary draft revisions to the diagnostic criteria are available online: http://www.dsm5.org. Among the proposed changes is replacement of GID with "Gender Incongruence" (GI), diagnosed by "a marked incongruence between one's experienced/expressed gender and assigned gender." Other proposed changes include a reduced emphasis on "cross-gender identification" to reflect a multi-category concept or spectrum of gender rather than a dichotomy (male or female) and the removal of "distress/impairment" as a prerequisite for GI diagnosis.

[5] World Health Organization. *International statistical classification, 10th rev.* (1990).

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There are many standards of care or clinical guidelines on gender-affirming medical treatment, with local standards of care in some countries. *The Standards of Care for Gender Identity Disorders*, published by the World Professional Association for Transgender Health (WPATH-SOC),[6] are among the most well-known and are currently under revision. WPATH-SOC addresses conditions for access to gender-affirming medical treatment, including psychiatric diagnosis and treatment, among other standards.

Transphobia is described as fear and hostility against gender non-conformity,[7] often expressed in mistreatment and violence against transgender persons.[8] Transphobia can take different forms. Transgender persons often suffer from individual acts in inter-personal encounters within family, education, employment, and health care contexts. Transphobia is expressed through demeaning comments, harassment, and violence.[9] Many transgender persons experience a breakdown in relationships with families and are subject to verbal abuse, exclusion, and outright rejection.[10] Transphobia is experienced through prejudice and disadvantage, such as refusal to hire for employment, to rent housing, or to accommodate in gender-segregated facilities (e.g. public bathrooms). The transsexual population experience higher unemployment, homelessness, and poverty, contributing to engagement in informal and sometimes illegal economies (e.g. sex work). Fearing denied advancement, dismissal, and harassment, transgender persons may be reluctant to express their gender identity in the workplace.[11] In the health care context, health providers may demonstrate discomfort with or judgment of transgender persons, claiming to be incompetent to treat them even for primary care. General practitioners may also refuse requests to assist in access to gender-affirming treatment.[12] Transgender persons may thus avoid seeking care within the formal health system with risks to their health and well-being. Criminal, anti-discrimination and other laws are increasingly reformed and enforced to protect against and provide remedies for these individual acts.[13]

Transphobia is also enacted in an institutional form, implemented by administrative regulation in law and policy, resulting in systemic exclusion and disadvantage.[14] Two examples of institutional transphobia are medical requirements for change of registered sex in identity documents and exclusion of gender-affirming medical treatment under health insurance.

Recognizing the personal, social and economic difficulties faced by persons who identify and express a gender incongruent with their birth-assigned sex, many jurisdictions permit transgender persons to change their registered sex on identity documents. Eligibility requirements for this change vary widely.[15] The legal definition of sex and the requirements to change it may be

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[6] W. Meyer et al. The Harry Benjamin International Gender Dysphoria Association's standards of care for gender identity disorders – sixth version. (2001) 13(1) *Journal of Psychology & Human Sexuality* 1–30.
[7] European Union Agency for Fundamental Rights. *Homophobia and Discrimination on Grounds of Sexual Orientation and Gender Identity in the EU Member States: Part II – The Social Situation* (2009) ("EU Report GI Discrimination").
[8] E.L. Lombardi et al. "Gender violence: Transgender experiences with violence and discrimination" (2002) 42(1) *Journal of Homosexuality*" 89-101.
[9] S. Whittle, S. Turner & M. Al-Alami. "*Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*." (2007), at p. 53. Online: http://www.pfc.org.uk/files/EngenderedPenalties.pdf ("Engendered Penalties").
[10] *Engendered Penalties*, at p. 68. See also: Scottish Transgender Alliance. *Transgender Experiences in Scotland – Research Summary*. (2008), at p. 11 Online: http://www.scottishtrans.org/Uploads/Resources/staexperiencessummary03082.pdf; B. Solymár and J. Takács. "Wrong Bodies and Real Selves: Transsexual People in the Hungarian Social and Health Care System" in *Beyond the Pink Curtain: Everyday Life of LGBT People in Eastern Europe* (2007), at p. 153.
[11] *Engendered Penalties*, at p. 52.
[12] *Engendered Penalties*, at p. 44
[13] Council of Europe Commissioner for Human Rights. *Issue Paper: Human Rights and Gender Identity* (2009) at p 15. Online: https://wcd.coe.int/ViewDoc.jsp?id=1476365 ("COE HR Commissioner Report"). In *P. v. S. and Cornwall County Council*, Case C-13/94 [1996], the European Court of Justice held that discrimination arising from gender reassignment constitutes discrimination on grounds of sex. "To tolerate such discrimination would be tantamount, as regards such a person, to a failure to respect the dignity and freedom to which he or she is entitled and which the Court has a duty to safeguard." At para 22.
[14] "[D]iscrimination against some groups is pervasive and persistent and deeply entrenched in social behaviour and organization … Such systemic discrimination can be understood as legal rules, policies, practices … which create relative disadvantages for some groups, and privileges for other groups." U.N. Comm. on Econ., Soc. and Cultural Rights. *General Comment No. 20. Non-discrimination in economic, social and cultural rights (art. 2.2),* U.N. Doc. E/C.12/GC/20 (2 July 2009) at para. 32 [*CESCR General Comment No. 20*].
[15] *COE HR Commissioner Report*, at p. 18.

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established by law or regulation, with varying degrees of specificity and subject to much variance in interpretation and practice. Where no particular surgical intervention is specified, administering government actors may interpret the requirement narrowly to require evidence of *genital* surgery. A minority of jurisdictions permits change of registered sex with medical documentation that attests a person is transgender and living full-time in their transitioned gender. Others allow individuals to be legally recognized based solely on their expressed identity. The variation among and within jurisdictions demonstrates a lack of consensus on what constitutes femaleness or maleness for identification purposes.

Although medical treatment is required for change of registered sex, gender-conforming medical treatment is routinely excluded from health insurance.[16] The exclusion may be explicit, identifying the specific treatment, or implicit, based on case-by-case application of general criteria, such as medical necessity, or cosmetic or experimental care. In the *Transgender EuroStudy*, 80 percent of respondents were refused state funding for hormone treatment, 86 percent were refused funding for surgery, and more than 50 percent reported privately funding their treatment.[17] Insurance exclusions combined with marginalized economic status can require transgender persons to obtain gender-affirming medical treatment through informal means, such as the purchase of hormone treatment on the black market, with significant health risks and negative social consequences.[18]

HUMAN RIGHTS STANDARDS

Article 8: The Right to Respect for Private Life
The European Convention for the Protection of Human Rights and Fundamental Freedom[19]

Article 8.1. Everyone has the right to respect for his private … life.

Article 8.2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Articles 2.2 and 12: The Right to Non-Discrimination and the Right to Health
International Covenant on Economic, Social and Cultural Rights[20]

Article 2.2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Article 12.1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

[16] *COE HR Commissioner Report*, at p. 18. See also: P.S. Gehi & G. Arkles. "Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People" (2007) 4(4) *Sexuality Research & Social Policy Journal of NSRC* 7-35.
[17] S. Whittle, L. Turner, R. Combs & S. Rhodes. *Transgender EuroStudy: Legal Survey and Focus on the Transgender Experience of Health Care*. (2008), at p. 53ff. Online: http://www.pfc.org.uk/files/ILGA_report.pdf ("Transgender Eurostudy").
[18] A.I. Lev, "Ten Tasks of the Mental Health Provider: Recommendations for Revision of the World Professional Association for Transgender Health's Standards of Care'" (2009) 11(2) *International Journal of Transgenderism* 74-99 at p. 81.
[19] *European Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 U.N.T.S. 222 (entered into force 3 September 1953).
[20] *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (entered into force 3 January 1976)

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Yogyakarta Principles on the Application of Human Rights Law in Relation to Sexual Orientation and Gender Identity (2007)[21]

While they do not constitute international standards, these principles are an authoritative source of guidance in the interpretation and application of human rights respecting sexual orientations and gender identities.

I. MEDICAL REQUIREMENTS FOR CHANGE OF REGISTERED SEX IN IDENTITY DOCUMENTS

- A. Respect for Gender Identity
- B. Change of Registered Sex on Identity Documents
- C. Medical Requirements To Change Registered Sex
- D. Justification for Medical Requirements to Change Registered Sex

A. Respect for Gender Identity

Discussion Question: Is Respect for Gender Identity Protected as a Human Right? Why?

Natalie's gender identity does not conform to conventional gender norms associated with her birth-registered sex, male. Natalie can thus be described as a transgender individual. She identifies as a woman not a man, and expresses this identity in her dress, body language, and voice. She refers to herself and requests that others call her "Natalie."

The right to respect for private life encompasses an individual's physical and social identity including the right to personal autonomy and development.[22] An individual's gender identity and connected legal status fall within this scope. The *Yogyakarta Principles* recognize that "[e]ach person's self-defined … gender identity is integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom."[23] In *Goodwin v. U.K.*, the European Court of Human Rights (the European Court) recognized "the right of trannsexuals to personal development and to physical and moral security in the full sense enjoyed by others in society."[24] The European Court reaffirmed in *Van Kück v. Germany* that gender identification falls within the personal sphere protected by the right to respect for private life.[25]

B. Change of Registered Sex on Identity Documents

Discussion Question: Does Respect for Gender Identity Require Permission to Change Registered Sex on Identity Documents?

Natalie experiences humiliation and hardship in direct connection to her legal status, registration of her sex as male on identity documents. It is a status inconsistent with her gender identity and expression. Documents such as birth certificates, drivers' licenses, and passports are central to the everyday lives of individuals. Natalie's ability to travel, to find employment and a place to live, to obtain a bank loan—to do anything that requires identification—in the gender in which she lives is adversely affected. Natalie's exposure to and anxiety about transphobic reactions by individuals denies her full and meaningful participation in social and economic life.[26] In a number of

[21] Online: http://www.yogyakartaprinciples.org/
[22] *Pretty v. the United Kingdom*, [2002] E.C.H.R. 423, at para. 61.
[23] *Yogyakarta Principles*, at Principle 3.
[24] *Goodwin v. U.K.*, (2002) 35 E.H.R.R. 18, at para. 90 ("Goodwin").
[25] *Van Kück v. Germany*, (2003) 37 E.H.R.R. 51 at para. 69 ("Van Kück").
[26] *COE HR Commissioner Report*, at p. 21.

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instances, Natalie has chosen to forgo opportunities conditioned on her producing identity documents.

In *Goodwin*, the European Court held the government in violation of its positive obligation to ensure the right to respect for private by denying post-operative transsexual persons permission to change their registered sex.[27] The Court drew attention to the stress and alienation arising from discordance between gender expression and legal status, and thus recognized that a law that conflicts with an important aspect of personal identity interferes with private life. The Court reasoned that change in registered sex is essential to enable transgender individuals to live in dignity and worth.[28] As an aspect of personal autonomy, "protection is given to the personal sphere of each individual, including the right to establish details of their identity as individual human beings."[29] The *Yogyakarta Principles* recognize that "everyone has the right to recognition everywhere as a person before the law. Persons of diverse ... gender identities shall enjoy legal capacity in all aspects of life."[30]

In *Goodwin*, the European Court further acknowledged that feelings of vulnerability, humiliation, and anxiety experienced by transgender persons are more than mere inconveniences.[31] In *Van Kück*, the Court held that positive human rights obligations "may involve the adoption of measures designed to secure respect for private life even in the sphere of the relations of individuals between themselves."[32]

In international human rights law, these experiences of transgender persons are recognized as discrimination, which undermines the fulfillment of economic and social rights for transgender persons. Gender identity is a prohibited ground of discrimination.[33] "Persons who are transgender, transsexual or intersex often face serious human rights violations, such as harassment in schools or in the workplace."[34] To attribute Natalie's experience to the actions of individuals does not alleviate the state of its human rights obligations. Human rights law imposes positive obligations on the state to protect individuals from human rights violations in the private sphere. "States parties must therefore adopt measures, which should include legislation, to ensure that individuals and entities in the private sphere do not discriminate on prohibited grounds."[35] Given that identity documents that accurately reflect gender identity and expression protect against discrimination, any law that limits the right of transgender persons to change their registered sex on identity documents must be justified.

C. Medical Requirements to Change Registered Sex

Discussion Questions: Is it a matter of discretion on what basis to permit change of registered sex? Why might medical requirements, in particular, be unacceptable or unlawful?

When Natalie sought to change her registered sex, she was informed of an eligibility requirement. The government clerk told Natalie that she must present evidence of completed sex-reassignment surgery. Medical requirements for change of registered sex on identity documents constitute an infringement of the right to private life by the simple fact that they restricts the right of transgender persons to acquire identity documents that accurately reflect their gender identity. The nature of medical requirements—conditioning of legal status on surgical intervention—further implicate rights to physical integrity, health, and non-discrimination.

The right to physical integrity, an aspect of the right to private life, protects against coerced medical treatment. The right to health likewise includes "the right to control one's health and body ... and the right to be free from interference, such as the right to be free from ... non-

[27] *Goodwin,* at para 93.
[28] *Goodwin,* at para 93.
[29] *Goodwin,* at para 90.
[30] *Yogyakarta Principles,* at Principle 3.
[31] *Goodwin,* at para 77.
[32] *Van Kück,* at para 70.
[33] *CESCR General Comment No. 20,* at para 32.
[34] *CESCR General Comment No. 20,* at para 32.
[35] *CESCR General Comment No. 20,* at para 11.

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consensual medical treatment."[36] Pursuant to these rights, the *Yogyakarta Principles* recognize that "[n]o one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilization or hormonal therapy, as a requirement for legal recognition of their gender identity."[37]

Sex reassignment surgery is not always in the best interest of transgender persons, being contrary to their wishes or needs. There are several reasons transgender persons may not undergo surgery. Many individuals regard surgery, specifically genital reassignment surgery, as unnecessary for their gender transition. "People have different aims and desires for their bodies and express gendered characteristics in the ways that make the most sense to those needs and desires."[38] Some find the results of available surgical techniques unsatisfactory as assessed against the cost and risk of the intervention. Others cannot undergo surgery for reason of pre-existing medical condition or health status, such as AIDS, hepatitis C, and clotting disorders. WPATH-SOC and other standards of care emphasize the importance of individualized gender-affirming health care. Surgery is also more expensive than other treatment options. Many individuals who wish to undertake sex reassignment surgery, such as Natalie, are denied access for financial reasons (see analysis on insurance coverage). That not every person who seeks to change their registered sex can access sex reassignment surgery renders the requirement discriminatory. These persons are effectively denied exercise of a fundamental right based of their economic or health status.

D. Justification for Medical Requirements to Change Registered Sex

Discussion Question: can medical requirements be justified by a legitimate public interest? Two interests to consider are: the drawing of a clear line of sex-classification for identification purposes, and sex-classification as necessary for identification purposes.

Any limitation on a human right must be justified as necessary in a democratic society to achieve a legitimate public interest. In *Goodwin* v. *U.K.*, the European Court found no significant factors of public interest to weigh against the human rights interest of the individual in obtaining legal recognition of gender identity.[39]

The government clerk offered Natalie a public interest justification for the eligibility requirement of sex reassignment surgery: "There needs to be a clear cut point" to classify individuals as female or male for identification purposes.[40] The requirement of sex reassignment surgery suggests that the legal definition of sex rests on some feature of physical appearance or genital anatomy, a clear and verifiable indicator of female/male difference.

Sex reassignment surgery, however, includes a range of interventions with different outcomes: chest surgery, facial surgery, and various genital surgeries: penectomy or hysterectomy and vaginoplasty or phalloplasty, The clerk does not inform Natalie which, if any, of these surgeries is necessary to satisfy the requirement. Individuals with very different bodily characteristics may thus be classified as a single sex for identification purposes, such that the legal definition of sex does not reflect a clear indicator of female/male difference.

Such variance, moreover, is evident in the entire population of persons classified as female or male for identification purposes. In *Goodwin*, the European Court noted that "chromosomal anomalies may arise naturally ... and in those cases, some persons have to be assigned to one sex or the other as seems most appropriate in the circumstances of the individual case."[41] There is no single indicator of sex difference shared by all female but not male persons, and vice versa. This is because sex is not a biological entity. It is a collection of characteristics: morphological (seminal vesicles/prostate or vagina/uterus/fallopian tubes and genitalia), gonadal (testes or ovaries),

[36] U.N. Comm. on Econ., Soc. and Cultural Rights. *General Comment No. 14. The Right to the Highest Attainable Standard of Health (art. 12),* U.N. Doc. E/C.12/2000/4 (11 August 2000) at para. 8. ("CESCR General Comment No. 14").
[37] *Yogyakarta Principles,* at Principle 3.
[38] D. Spade. "Documenting Gender." 59 *Hastings L.J.* 731 (2008) at p. 754. ("Spade Documenting Gender").
[39] *Goodwin,* at para 93.
[40] See similar justification in *L v. Lithuania* [2007] E.C.H.R. 725: "[T]he Government argued that there was an overriding public interest in ensuring legal certainty as to a person's gender and the various relationships between people." at para 54.
[41] *Goodwin,* at para 82.

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chromosomal, hormonal (androgen or estrogen predominance), and phenotypic (secondary sex characteristics). Sex is the label given to the total impression of these characteristics.[42] Different characteristics may be deemed necessary to sex classification for different purposes. In *Goodwin*, the European Court did not agree "that the chromosomal element, amongst all the others, must inevitably take on decisive significance for the purposes of legal attribution of gender identity for transsexuals." [43] The state of medical science or scientific knowledge does not provide a determining argument on sex classification for purposes of the law.[44] Which characteristics are necessary is not a medical conclusion, but a legal one.

Selection of physical appearance and genital anatomy—sex reassignment surgery—cannot be justified as necessary to sex classification for it is not a characteristic universally applied to all persons classified as female or male for identification purposes. Not all persons registered as female have a uterus, nor all persons registered as male have a penis. Non-transgender persons without these features, whether because of accident or removal for medical reason unrelated to gender identity, retain their legal status as female or male. Emphasis on sex reassignment surgery moreover is rationally unrelated to the legitimate public interest: identification. Hormone treatment is undertaken expressly to alter secondary sex characteristics, physical appearance. Transgender persons who do not undergo any medical intervention may live fully—in appearance, behavior, roles, and activities—in the gender traditionally associated with the opposite sex. These aspects may be more significant for identification and their participation in social and economic life than the presence or absence of a uterus, penis, or other sex-based characteristic altered through surgery. Identification may thus be more accurate if sex classification was based on self-identification.[45] The law could allow transgender persons to change their registered sex once they have taken decisive steps, which may or may not include medical treatment, to live in a different gender.

Sex differences are not irrelevant to the lives of individuals, but they may prove of different value depending on the public interest in identification. A second remedial measure is thus to reconsider the necessity for sex classification itself. On measure of proportionality, do the benefits of classifying individuals as female/male for identification outweigh its costs, namely infringement of the human rights of transgender persons?

Two primary purposes of identification are the capacity to locate individuals uniquely and the creation of population-level statistics, e.g. demographic and economic.[46] Sex may be used as a classification for identity verification on the mistaken belief that it reflects a clear, stable, or reliable indicator of female/male difference, which as demonstrated, it does not. Sex does not appear to have any particular advantage in contrast to other and perhaps more accurate indicators for locating individuals uniquely, for example, blood type. Sex may have specific value, for example, as a vital statistic for public health surveillance and intervention, but this does not necessitate its use at the individual level.[47] Birth-assigned sex can be registered in population-level statistics for public health purposes, but omitted from documents used for identity verification in day-to-day life. Rather than eliminate sex classification, human rights obligate justification for its use as necessary to achieve a legitimate public interest.

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[42] H.J. Tobin. "Against the Surgical Requirement for Change of Legal Sex" (2006) 38 *Case W. Res. J. Int'l L.* 393 at 412-413.
[43] *Goodwin,* at para 82.
[44] *Goodwin,* at para 83.
[45] *Spade Documenting Gender*, at p. 801.
[46] *Spade Documenting Gender*, at p. 739.
[47] *Spade Documenting Gender*, at p. 814. A similar analysis can be applied to interrogate the use of "sex" for public health purposes. For example, information on an intervention on uterine cancer may be more accurate if information is collected on persons with uteruses, a single sex-related characteristic, rather than persons registered as "female" at birth. There are significant differences in the lives of transgender women and men who have sex with men which classification in the single category of "male" for purposes of identifying HIV-vulnerability neglects. Collecting data based on categories different than female/male or on specific sex-related characteristics may be both human rights compliant and a more effective public health practice.

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II. ACCESS TO GENDER-AFFIRMING MEDICAL TREATMENT UNDER A MENTAL HEALTH MODEL

- A. Classification as a Mental Disorder
- B. Effects of Regulating Access to Treatment under Mental Health Model
- C. Justification and Reform of the Mental Health Model

Natalie desires to change her physical appearance to "look more like a woman" through medical treatment. Hormone therapy will allow her to enhance feminine secondary sex characteristics, such as the growth of breast tissue and redistribution of body fat. Sex reassignment surgery will allow her to alter primary sex characteristics, such as removal of the penis and the creation of a vagina. Natalie learns, however, that psychiatric diagnosis and treatment is a precondition for hormone and surgical treatment. The regulation of access to gender-affirming treatment through a mental health model raises ethical and human rights concerns.

A. Classification as a Mental Disorder

Discussion Question: why is classification of transgender/transsexual persons as suffering from a mental disorder a human rights concern?

The classification of transgender/transsexual persons as suffering from a mental and/or behavioural disorder is increasingly contested.[48] Some advocates argue for the removal of GID and trannssexualism from the DSM-IV and ICD respectively (drawing a parallel with the removal of homosexuality). The claim is based on concern that a psychiatric diagnosis pathologizes the transgender experience and more broadly gender variance.[49] Transsexual persons are defined as mentally disordered persons.

GID or transsexualism consists of persistent discomfort with birth-assigned sex or its related gender role and cross-gender identification, the desire to live and be accepted as a member of the opposite sex, which cause distress (e.g. painful symptoms) or disability (e.g. impairment in social, economic, or other important areas of functioning). "Gender dysphoria" refers specifically to this distress and disability caused by gender incongruity.

Whatever the original cause of a mental disorder, all disorders are conceptualized as a "manifestation of a behavioral, psychological, or biological dysfunction in the individual."[50] Conflicts between the individual and society are not mental disorders unless the conflict is a symptom of a dysfunction in the individual.

The conditioning of access to gender-affirming medical treatment on diagnosis of mental disorder can be challenged as a violation of human rights law on two grounds. First, the diagnosis pathologizes an individual's gender identity, acknowledged to be an aspect of one's private life protected by human rights law. Second, much distress and disability experienced by transgender persons is not caused by gender identity itself: incongruity with conventional gender norms of birth-assigned sex. Transgenderism is not inherently associated with any psychopathology.[51] Adults diagnosed with GID generally function psychologically in the non-clinical range. Much of the distress and disability result from difficulties in expression of gender identity, inability to access

[48] *See:* W. Bockting. "Are Gender Identity Disorders Mental Disorders? Recommendations for Revision of the World Professional Association for Transgender Health's Standards of Care'" (2009) 11(1) *International Journal of Transgenderism* 53-62.
[49] See e.g. the "Stop Trans Pathologization: Goal 2012" campaign of the Trans Depathologization Network, supported by Transgender Europe.
[50] American Psychiatric Association, at p. xxxi.
[51] H.F.L. Meyer-Bahlburg. "From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions." (2010) 39(2) *Archives of Sexual Behavior* 461-76.

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gender-affirming medical treatment, and the social conflict created by the transphobic attitudes or actions of others.[52] Such distress is not "in the individual" but primarily a result of social conflict.

Natalie is depressed and discouraged in part because of the treatment of others: verbal abuse and harassment, daily humiliation, the fear of violent attacks and her isolation from family and friends. Gender identity is thus more akin to a disability in human rights analysis. Transgender persons are capable of full participation in social and economic life, but for the transphobic barriers erected by individuals and institutions that exclude them. The controversy of the mental health model is that distress and disability is more often than not wrongly attributed to a disordered individual, rather than a disordered society, one which defines gender nonconformity—a positive variation in the human condition—as problematic in the first place.

B. Effects of Regulating Access to Treatment under a Mental Health Model

Discussion Questions: what are the consequences of regulating access to gender-affirming treatments through a mental health model? What human rights do these effects implicate?

Reaffirming misunderstandings about transsexual persons, namely that all are mentally disordered, may perpetuate mistreatment and discrimination. Physicians may infer, for example, that transsexual persons should only be treated by mental health professionals, with intervention directed to their mental state.[53] When Natalie visited a GP to learn more about medical treatment, he dismissed her on the basis that her problem was "mental not physical." The reaction of her GP failed to acknowledge that good coordination among a range of health professionals is necessary to provide competent and good quality medical treatment for transgender persons.[54] No single discipline can meet all the medical needs of transgender persons. Transgender endocrine therapy, for example, is best undertaken in the context of a complete approach to health that includes comprehensive primary care.[55] Moreover, with appropriate training, hormone treatment can be managed by a variety of providers, including nurse-practitioners and primary care physicians. "Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care."[56] With appropriate training, gender-affirming medical treatment can be delivered in a broader range of health care facilities and offered by a more diverse and larger set of health providers thereby increasing availability and accessibility to care, both key dimensions of the right to health.[57]

Conditioning access to gender-affirming treatment on psychiatric diagnosis can undermine the patient-provider relationship. Natalie viewed Dr. Popva as a gatekeeper to the treatment she needed and the diagnosis as a test to be passed. Many transsexual persons acquiesce to psychiatric diagnosis and treatment as a condition of access. The validity of the diagnosis and treatment are thus undermined, guided by the need to gain approval and not the best interests of the individual.

Transsexual persons may feel coerced to portray and affirm standardized diagnostic criteria, fearful of otherwise being denied approval for hormone or surgical treatment. Although the diagnostic criteria for GID or transsexualism reflect the genuine experience of many transsexual individuals, the criteria are criticized for their routine use as standards or expectations of how a transsexual person should act or appear.[58] It is well documented that transsexual persons who do not see the value in the exercise seek to subvert it. Individuals are aware of what to say in order to receive the treatments they require and may lie to the mental health professional, telling a

[52] L. Nuttbrock et al., "Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons" (2010) 47(1) *Journal of Sex Research* 12-23.
[53] *Lev,* at p. 77.
[54] *See:* L. Schechter. "The Surgeon's Relationship with the Physician Prescribing Hormones and the Mental Health Professional: Review for Version 7 of the World Professional Association for Transgender Health's Standards of Care'" (2009) 11(4) *International Journal of Transgenderism* 222-225.
[55] *Feldman & Safer*, at p. 161.
[56] *Feldman & Safer*, at p. 162.
[57] *CESCR General Comment No. 14*, at para 12.
[58] *COE HR Commissioner Report,* at p. 25.

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predetermined story.[59] Natalie described Dr. Popva as subscribing to only one acceptable story about the transgender experience, which Natalie sought to make her experience fit to ensure approval for treatment.

Consider, for example, persistent discomfort with assigned-sex manifested by the belief of having been born the wrong sex. Undue attention may be placed on a consistent gender identity from childhood through adulthood, subjecting the individual to historical examination. For example, Natalie may be concerned that she would not meet this standard for having enjoyed typical masculine activities, playing competitive sports not house, and dressing in masculine not feminine clothing in her childhood and adolescence. In *Goodwin*, the European Court recognized that "given the numerous and painful interventions involved in such surgery and the level of commitment and conviction required to achieve a change in social gender role … [it cannot] be suggested that there is anything arbitrary or capricious in the decision taken by a person to undergo gender re-assignment."[60] Supported by this recognition, the European Court in *Van Kück* held that requiring an individual "to show the 'genuine nature' of her transsexuality although … the essential nature and cause of transsexualism are uncertain" violates the right to respect for private life.[61]

The Court in *Van Kück* further held that the right to respect for private life is implicated by assessment of the feelings and experiences of transgender persons against "gender assumptions as to male and female behavior."[62] Emphasis on the female/male binary in the diagnostic criteria is thus of human rights concern. Consider the criterion of strong and persistent cross-gender identification, manifested by having feelings and reactions typical of the other sex.[63] Attention is focused on gender stereotypes, typical feelings and reactions, and the extent to which a transsexual person meets these stereotypes. Transgender persons may thus feel a need to exhibit hyper-masculine or feminine characteristics—to fulfill normative gender roles and expectations more perfectly than non-trangender persons.[64] There is a greater range of gender identities and expressions than reflected in the diagnostic criteria. Access to medical treatment premised on fulfilling gender role stereotypes violates the right to non-discrimination in access to health care.

It is a human rights violation to subject individuals to a process where they feel compelled to and routinely do misrepresent their gender identity and expression, subscribing to a pathological diagnosis, in order to access medical treatment. The Yogyakarta Principles recognize that "[n]o one shall be subjected to pressure to conceal, suppress or deny their … gender identity,"[65] which can be interpreted to include its misrepresentation.

C. Justification and Reform of the Mental Health Model

Discussion Questions: what is the justification for the mental health model, what public interests does it serve? Can these interests be served through means consistent with human rights?

The mental health model is primarily justified by the public interest of protection against harm. Psychiatric diagnosis and treatment is intended to ensure that hormone and surgical treatment, which can be permanently life altering, is in the patient's best interests. The perversion of the patient-provider relationship, however, undermines the capacity of the mental health model to serve this protective function. Rather, the process may lead not only to ineffective but harmful treatment, implicating the right to health. A report from the United Kingdom indicates that lack of knowledge and understanding by general psychiatrists result in transgender persons receiving inappropriate treatment.[66]

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[59] *Lev,* at p. 79.
[60] *Goodwin,* at para. 81.
[61] *Van Kück,* at para 81 and 82.
[62] *Van Kück,* at para 81.
[63] In the DSM-V proposed revision, discrepancy between experienced/expressed gender (male, female, in-between or otherwise) and assigned gender (male or female) replaces cross-gender identification.
[64] See D. Spade. "Resisting Medicine, Re/modeling Gender" (2003) 18 *Berkeley Women's Law Journal* 15 at p. 24.
[65] *Yogyakarta Principles,* at Principle 3
[66] *Scottish Transgender Alliance,* at p. 18.

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The precondition of psychiatric diagnosis is also an access barrier to appropriate gender-affirming medical treatment. Many individuals, for example, cannot access psychiatrists or other mental health professionals necessary to obtain a diagnosis for financial reason or because of geographic distribution, e.g. restricted availability to large urban centers. Other individuals, who disagree and refuse to comply with the mental health model or become frustrated by it, may seek treatment through other channels.[67] Natalie considered buying hormones on the black market and self-administering. Hormone therapy carries serious physical and psychological health risks, including inappropriate dosage, liver and nerve damage, drug-to-drug interactions, and HIV and hepatitis infection resulting from injecting without medical supervision or clean needles.[68]

Harm reduction and support in gender role transition are both important public interest objectives. There are, however, means to achieve these objectives that are consistent with human rights. The traditional "gatekeeping" role of medical health professionals can be transformed. Given the real distress and disability experienced by many transgender persons, mental health care can offer significant support in acceptance and management of a gender role transition. Natalie acknowledges this aspect of the treatment. She found her counseling sessions sometimes helpful.

By recognizing a transsexual person as a healthy, functional individual, safe and effective access to gender-affirming medical treatment can be secured by facilitating free and informed decision-making. The objective should be to design assessment processes to empower individuals in their decision-making.[69] To assess whether treatment is in an individual's best interests, a mental health professional must have an understanding of what health and well-being are for that individual. Based on the nature of the medical treatment, for example, counseling sessions may expressly address expectations for and limitations of a treatment, available alternative treatments and their respective advantages and disadvantages. This is the requirement of free and informed decision-making for most invasive medical treatments. These sessions may also be helpful to identify and address other mental health concerns, such as personality disorders, addiction, and emotional or psychosocial instabilities, that may impact the capacity for decision-making.[70] Mental health services can be provided in ways that respect and encourage individual expression and actualization rather than conformity to a set of external standards unrelated to the individual's needs and aspirations.

III. HEALTH INSURANCE COVERAGE OF GENDER-AFFIRMING MEDICAL TREATMENT

- A. Medical Necessity as the Basis of Exclusion
- B. Justification for Exclusion of Treatment Based on Medical Necessity
- C. Challenge to Exclusion of Treatment Based on Medical Necessity

Once eligible and referred for treatment, transsexual persons experience an additional access barrier: affordability. Economic accessibility is an essential and interrelated feature of the right to health.[71] Discrimination in access to health care as well as to means and entitlements for their procurement, including insurance, is prohibited on grounds of health status and gender identity.[72]

Gender-conforming medical treatment is routinely excluded from health insurance coverage, prohibiting access to medical treatment for transgender persons, many of whom are socially and economically marginalized. A claims manager informed Natalie that hormone and surgical treatment were excluded from coverage on the basis of medical necessity.

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[67] *Lev,* at p. 81.
[68] N. Kammerer et al. "Transgender Health and Social Service Needs in the Context of HIV Risk" in *Transgender and HIV: Risks, Prevention and Care* (2001) at p. 41.
[69] *Lev,* at p. 77.
[70] *Lev,* at p. 78.
[71] *CESCR General Comment No. 14,* at para 12.
[72] *CESCR General Comment No. 14,* at para 18.

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A. Medical Necessity as the Basis of Exclusion

Discussion Question: How is the mental health model, namely psychiatric diagnosis, implicated in the exclusion of hormone and surgical treatment from health insurance coverage?

While recognizing the human right harms of a mental health model, many advocates caution against de-pathologization (i.e. removal from the DSM and ICD) on the basis that psychiatric diagnosis establishes a "medical need" for gender-affirming medical treatment.[73] Without this diagnosis, the treatment may be excluded from health insurance as elective treatment undertaken for cosmetic or lifestyle reasons. The claims manager tells Natalie she is "lucky to have the diagnosis." To preserve this benefit of diagnosis, some advocates have argued for its reform rather than removal.[74]

B. Justification for Exclusion of Treatment Based on Medical Necessity

Discussion Question: what are the rationales for exclusion of hormone and surgical treatment on the basis of medical necessity, even with psychiatric diagnosis of GID or transsexualism?

Psychiatric diagnosis may be insufficient if not counterproductive to qualification of hormone and surgical treatment as medically necessary. Necessity or need may not be defined by current health status: the fact of having a mental disorder. Rather, medical necessity may refer to *that which is needed*: improvement in health status through medical intervention. In other words, there can only be a "need" for medical treatment if there is reason to believe the treatment will enhance health or prevent further deterioration. The necessity of medical treatment is assessed by its capacity to benefit the individual: a change in health status over time with and without care.[75]

The claims manager justifies the exclusion of hormone and surgical treatment on the basis that, contrary to psychotherapy, the treatment is not directed to changing the individual's health status, defined by the presence, absence, or relative severity of the mental disorder, a gender identity which gives rise to significant distress or impairment. The claims manager informs Natalie that there is no medical evidence that hormone or surgical treatments "cure the mental disorder." On the contrary, it is often claimed that surgical treatment, for example, destroys normal organs for which there is no medical necessity because of underlying disease or pathology in the organ. Insurance covers psychotherapy, behavioral therapy, and psychotropic medication on the assumed rationale that they are intended to cure transsexuality, the pathologized mental state.[76]

It is worthwhile to note that insurance policies often cover these same hormone and surgical treatments for persons who seek them on medical diagnoses other that GID or transsexualism. For example, hormone treatment for women to eliminate hair growth considered gender-inappropriate (hirsutism), chest surgery for men with excessive breast tissue growth (gynecomastia), and surgical treatment for intersex persons (persons with congenital intermediate or atypical combinations of sex characteristics). These treatments remove organs and affect change in body systems that are not otherwise strictly unhealthy to satisfy social norms or address related mental health effects.[77] The distinction in refusing coverage of this treatment to transgender persons is thus based solely on the diagnosis.

A second justification for the exclusion of hormone and surgical treatment is that neither is the sole medical treatment for transsexuality, nor the form of treatment universally recommended. It may be argued that surgical treatment is not medically necessary precisely because for many individuals, hormone therapy is sufficient to complete transition.[78] Such an interpretation might require that individuals prove other available treatments, such as psychotherapy, are ineffective.

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[73] See e.g. *COE HR Commissioner Report,* at p. 25.
[74] *Bockting,* at p. 58. See also Footnote 4.
[75] See e.g. A.J. Culyer. "Equity – some theory and its policy implications." (2001) 27 *Journal of Medical Ethics* 275-283
[76] For a formulation of this argument, see *Van Kück*, at para 22.
[77] *See* N. Ben-Asher. "The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties" (2006) 29 Harv. J.L. & Gender 51.
[78] For a formulation of this argument, see *L v. Lithuania,* at para 41.

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C. Challenge to Exclusion of Treatment Based on Medical Necessity

Discussion Question: can these rationales be challenged? On what basis? What human rights are violated by requirements for curative and exclusive treatment?

Both rationales for exclusion of gender-affirming mental treatment can be challenged on human rights grounds.[79]

First, acceptability and quality, key dimensions of the right to health, require that health services be designed to improve the health status of those concerned, and must be scientifically and medically appropriate.[80] The treatment objective of altering gender identity is discredited as ineffective. There is no convincing literature to support the idea that gender identity can be manipulated by known techniques.[81] Rather, evidence suggests that efforts to "cure" transgender persons of their "disorder" often lead to further distress and dysfunction. More importantly, given that gender identity is an aspect of one's private life protected by human rights law, conditioning health insurance coverage on its manipulation violates the right to respect for private life.

Taking the definition of medical necessity as that which is needed to improve health status, all medical treatment intended to facilitate acceptance and management of gender transition and reduce related distress and dysfunction – to affirm gender identity – should qualify as medically necessary. Widespread evidence indicates the effectiveness of hormone and surgical treatment in this regard. Access to treatment facilitates individuals' full and meaningful participation in social and economic life, not least because it allows for change of registered sex on identity documents. A number of studies report extremely high patient satisfaction with surgical intervention, defined by criteria such as subjective satisfaction, mental stability, partnership and sexual experience, and social-economic functioning.[82] Many negative health outcomes, depression, anxiety, addiction, and suicidality are significantly reduced with access to treatment. Lack of access to this treatment, in contrast, can lead to serious adverse health consequences. Gender-affirming medical treatment thus has a significant capacity to benefit the individual, measured by a change in health status over time with and without care.

In *Van Kück*, the European Court rejected the claim that "[h]ealth insurance had to bear only costs of treatment suitable to cure a disease … [and] that gender reassignment measures could not be expected to cure the applicant's transsexuality, but at best to improve her psycho-social situation."[83] The Court relied on its previous statement in *Goodwin* that rather than identifying a cause of transsexualism to be remedied, it is more significant "that transsexualism has wide international recognition as a medical condition for which treatment is provided in order to afford relief." [84] The Court eschewed a narrow and formalistic application of medical necessity. Acknowleding the value of treatment to the health and lives of transsexual persons who desire and need it, the Court in *Van Kück* concludes that ["t]he burden placed on a person in such a situation to prove the medical necessity of treatment … in one of the most intimate areas of private life, appears disproportionate."[85] This approach to gender-affirming treatment reflects the broader human rights standard that "[e]very human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[86]

Second, gender-affirming medical treatment must be individualized, reflecting the wishes and needs of the individual. There is no universal, best treatment. A requirement that a treatment be recommended in all cases to be classified as medically necessary misunderstands the nature of gender-affirming medical treatment and disregards that identical treatment may be detrimental to

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[79] For analysis in U.S. context, see: *Gehi & Arkles*.
[80] *CESCR General Comment No. 14*, at para 12.
[81] *Feldman & Safer*, at p. 149.
[82] See e.g. S. Monstrey, H. Vercruysse Jr., & G. De Cuypere. "Is Gender Reassignment Surgery Evidence Based? Recommendation for the Seventh Version of the WPATH Standards of Care" (2009) 11(3) International Journal of Transgenderism 206-214.
[83] *Van Kück*, at para. 22.
[84] *Goodwin*, at para 81, *Van Kück*, at para 54.
[85] *Van Kück*, at para 82.
[86] *CESCR General Comment No. 14, at para 1.*

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health. There are several reasons transgender persons may not undergo a particular form of treatment (see discussion above). Some persons desire only certain treatments; others are not appropriate candidates for treatment. The WPATH-SOC recognizes that clinical departures from the guidelines may come about because of a patient's unique anatomic, social, or psychological situation.[87] "[I]n considering the necessity of an operation [one] should take into account, as one of the decisive factors, the wishes of the transsexual."[88]

[87] Meyer, at p. 3.
[88] *Van Kück, concurring opinion,* at para 4.

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SUPPLEMENTAL STUDY OF ETHICS ISSUES

Transgender Persons, Access to Healthcare, and Legal Identity Change
Josephine Johnston, The Hastings Center

First part of case:

Natalie was born a biological male, and assigned the sex of male. From an early age, however, she identified as female rather than male. Puberty was especially difficult. "I was horrified by the growth of hair on my body and the deepening of my voice. Everything felt wrong, seeing myself in the mirror as a man." In her twenties, Natalie disclosed to her family that she identified as female, not male. Some family members could not understand. Others reacted with disgust or hostility. Natalie became distant from her family, and moved away from her home town. She began to experiment with her dress, body language and voice. She referred to herself and requested that others call her "Natalie." "I could no longer bear presenting myself as a man in the world. I felt like a fraud."

Discussion questions on first part of case:

1. Why is it important to Natalie that she be able to express her transgender identity?
2. Who should respect Natalie's transgender identity and why?

Ethics commentary on first part of case:

This case study describes a transgender individual, Natalie, who struggles to be accepted and respected in a number of different realms. Natalie recognized as an adolescent that her biological sex—male—did not match her self-perception—she identified as female. Later, she began to refer to herself by a woman's name and to dress in typical women's clothing. One term for individuals whose biological sex does not correspond to their gender identities (to how they see and understand themselves) is "transgender."[i] Although Natalie has been able to accept her identity as a transgender person, some members of her family have not.

Like gay, lesbian, bisexual, and intersex individuals, transgender persons challenge traditional notions of gender and sexuality. We may take for granted that genitalia and other biological markers that are used to construct binary biological categories of male and female are the same as gender identity; that is, that a person's sex organs tell us whether that individual will see him or herself as, and seek to function in society as, a male or female.[ii] We expect individuals with female sex organs to dress the way society expects "women" to dress, to speak and move like "women," and to carry out particular roles in social and family life. The same can be said of individuals with male sex organs.

Individuals who are transgender do not conform to these assumptions. Their individual identities—how they understand and perceive themselves—do not match societal expectations for behaviors that align with genitalia and other biological markers of societal definitions of "male" and "female." When they change their appearances (medically or by other means) to better reflect how they identify themselves, they often encounter hostility, including from family members and close friends as well as from employers, government bureaucrats, and health professionals. Why is this? A negative reaction to a transgender person may be due to ignorance (many people do not know anyone who is transgender) or belief in negative stereotypes (transgender persons are sometimes portrayed as comic figures in film and television).

Some scholars have also argued that because transgender persons challenge the idea that the categories of "male" and "female" are biologically fixed and clearly demarcated, negative reactions are an expression of unease or discomfort at category blurring (even though scientific research shows that in animals the biological categories "male" and "female" are not as discrete as commonly assumed[iii]). Binary sex and gender categories have been described as "so fundamental to the organization of social life" that "the challenge presented to them by various transgender

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phenomena is widely felt to be deeply threatening."[iv] Indeed, individuals who are transgender are frequently subjected to violence and discrimination.[v] "Transgendered people of every stripe still routinely confront forms of violence, abjection, and marginalization that seem largely invisible to many of the non-transgendered."[vi]

Individuals may have a number of identities. A person might describe herself as a woman, mother, sister, daughter, teacher, Catholic, teacher, and community volunteer. These identities begin to describe who she is and how she functions in society; they help the individual and those around her make sense of the world and her place in it. Many of these identities cannot simply be claimed, they must also be negotiated.[vii] It is not usually enough for an individual to assert a specific identity; to be sustainable her identity must also be accepted and affirmed by others, including family, friends, and co-workers as well as by social institutions, and she must be able to live according to that identity. Gender is currently a fundamental identity in most human societies (one can imagine a society that did not use gender categories, but it would be different in many ways from ours; for example, all public toilets would be unisex, wearing a dress would signify nothing about gender, legal documents such as driver's licenses and passports would not carry a sex designation, all first names would be unisex, and so forth). Living according to one's gender identity is therefore arguably key to an authentic, rewarding life. For some transgender persons to thrive in society—for them to "live out" their gender identities—it may be necessary for them to be "seen" by others as female or male and be able to occupy typical female or male social roles. Other transgender persons may not seek to occupy traditional male or female social roles, but may nonetheless need those around them to affirm their transgender identity as valid and acceptable.

It can be helpful to understand our response to transgender individuals as grounded in ethical principles, specifically in the principle of respect for persons. This principle, which is a central concept of many ethical theories, can be formulated in a variety of ways, but essentially requires that we treat other humans as unique, autonomous and free individuals (or, as the German philosopher Emmanuel Kant put it, as ends in themselves).[viii] This principle has been well developed in biomedicine[ix] but also applies to other realms of human life. However, its precise terms are somewhat contested. To some philosophers, respect for persons creates a negative right or a right to be left alone; respecting persons involves "refraining from regarding or treating persons … as if they were worthless … we ought not to violate their basic moral rights, or interfere with their efforts to make their own decisions and govern their own conduct, or humiliate them, or treat them in ways that flout their nature and worth as persons."[x] To others, the principle generates positive duties so that respecting transgender persons would require that individuals and social institutions take steps to help transgender persons live lives that are meaningful to them.

In Natalie's case, the principle of respect for persons requires that, at a minimum, she not be discriminated against or subjected to physical violence or humiliation on account of her transgender identity. Indeed, many actors, including health care providers, will likely be legally—and morally—obligated *not* to deny Natalie services merely on account of her transgender identity. If we accept that the principle also creates some positive duties, we can argue that her family and friends should try to accept her transgender identity. Equally importantly, a positive interpretation of the principle of respect for persons demands that various other actors, such as employers, medical practitioners, insurance companies, and state institutions, actively help Natalie live according to her transgender identify (more on this obligation below).

Second part of case:

Natalie has suffered from depression throughout her life. Natalie began psychiatric treatment and was later diagnosed with "gender identity disorder." (The ICD-10, in use in most European countries, uses the diagnosis of "transsexualism.") This mental disorder describes persons who experience significant gender dysphoria: discontent with their biological sex assigned at birth. Natalie initially sought psychiatric care precisely for this diagnosis. Her physician would not prescribe hormone replacement therapy without it. "I was eager to change the appearance of my body. I was desperate and willing to do anything." Natalie was reluctant to visit another doctor, having had many negative

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experiences in the health system. She considered buying the hormones on the black market and self-administering to avoid further mistreatment. "I don't mind the psychiatrist too much. She has a set story about the transgender experience. Only one seems acceptable. I try to live up to it, so she will sign off on my other medical care."

Discussion questions on second part of case:

1. What are the pros and cons of understanding individuals who are transgender as suffering from a mental disorder?
2. What should be the goals of psychiatric care for "transsexuals"?

Ethics commentary on second part of case:

In 1977, "transsexualism" was included in edition 9 of the International Statistical Classification of Diseases and Related Health Problems (ICD), which is published by the World Health Organization and used in many European countries. In 1980 the American Psychiatric Association for the first time listed "transsexualism" as a mental disorder in the third edition of its Diagnostic and Statistical Manual (DSM). This term was replaced by "gender identity disorder" in the fourth version of the manual (DSM IV), published in 1994. In many health care systems, a diagnosis of transsexualism or gender identity disorder based on the criteria laid out in these manuals is needed before a transgender person can access hormone or surgical treatments.

Mental disorders are predictable clusters of moods and behaviors that cause distress or disability.[xi] A clinician makes a diagnosis after observing the individual and considering reports of symptoms and impairment from the individual him or herself and possibly from his or her caregivers. There are not yet any biomarkers, such as blood tests or brain scans, to help diagnose mental disorders. To a certain extent, clinicians must rely on their judgment; bright lines do not separate an individual who is, for example, sad from one with major depressive disorder.[xii] To further complicate matters, specific diagnoses are contested in their entirety.

The question whether transgenderism is a mental illness is debated within the transgender community and the medical profession. As scholar Susan Stryker noted: "There is a long history of ambivalent feeling among many transsexuals towards the professionals who offer them access to reembodiment technologies only by pathologizing their desires and stigmatizing their lives."[xiii] This ambivalence is understandable; even if being diagnosed with a mental disorder becomes little more than a bureaucratic hurdle on the path to sex-reassignment treatment, it is still a label that categorizes all transgender individuals as mentally ill, thereby exposing them to (still more) stigma and discrimination. Classifying the mismatch between biological sex and gender identity as something other than a mental disorder would be one way to avoid the stigma that a mental disorder diagnosis can bring (another approach, of course, is to combat the general stigma associated with mental disorders).

Indeed, one view is that being transgender is not a mental disorder but is simply an example of normal human variation, like being left-handed, short, or shy. On this view, the suffering of transgender individuals is not inherent in the identity itself but is due to their inability to access the means to alter their appearances and/or the inability of other people to accept the transgender identity as legitimate and to treat individuals who are transgender as full persons. Parallels are often made with homosexuality, which was once classified as a mental disorder but was removed from DSM in 1974 and from ICD in 1990 after medical research failed to support the idea that it was a disorder rather than a form of normal human variation. Homosexual men and women are still discriminated against, humiliated, and hurt today simply because of their sexuality, and many are still not able to live openly, but this suffering is not understood as evidence that anything is wrong with their mental health.

However, unlike homosexuals, some transgender persons seek access to medical procedures in order to live in accordance with their identities, so they must interact with the medical community. Health professionals want criteria to assess whether an individual is transgender before moving to consider provision of sex reassignment treatments (see further discussion below).

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Currently, these criteria are found in the diagnoses of transsexualism and gender identity disorder.

Within the limits of the current system, mental health professionals assessing and treating transgender persons must remember that no two individuals are exactly alike. In particular, each person's story—how they describe the development of their gender identity, how they currently function, and how they seek to function, including which, if any, particular interventions they seek—will be different.[xiv] Scholarship has documented a tendency for particular stories to dominate professional understandings of illness. "The dominant narratives are the stories that are told to explain a culture, sub-culture, or an individual. Within the dominant narratives, there are the messages of how people should behave and what has been historically relevant."[xv] One problem with this tendency is that clinicians can develop rigid expectations about what a transgender patient will say, how she will look, and what she will want. Patients may then "learn" the dominant narrative and present themselves accordingly, even if their personal story actually differs. Clinicians must respect the individuality of patients and encourage honesty in the doctor-patient relationship by being open to transgender patients breaking with dominant narratives in all aspects of their care (patient history, description of symptoms, and treatment preferences).

Given current understandings of transgenderism, psychiatric care should not seek to change the mind of a transgender individual about wanting to live as his or her preferred identity (more on the standard of care for gender identity disorder/transsexualism below). In addition to psychoeducation (explaining psychiatry's understanding of transgenderism, discussing treatment options, and sharing available data about risks and benefits), psychiatrists may need to help their transgender patients with other disorders. In this case, Natalie suffers from depression. Bearing in mind the possible connection between Natalie's depression and her struggles to live as her preferred gender (were Natalie able to access interventions, she might no longer be depressed), her psychiatrist should work with Natalie to relieve the condition.

Individuals who are transgender will not only call on medicine to help them change their appearances; they also need access to the usual range of medical and mental health services available to nontransgender persons. Unfortunately, some transgender individuals have reported difficulties accessing, or a reluctance to use, standard medical services.[xvi] "Health care service providers have found that helping transgender individuals obtain the services they need (e.g., substance use treatment, housing, health care) is difficult because other service providers may not want to work with transgender clients. Furthermore, lack of sensitivity on the part of health care providers who do not respect the expressed gender identity of transgender persons can adversely influence whether these individuals will access and stay in treatment."[xvii] For example, transgender men have been refused access to gynecological services even though they still have female sex organs.[xviii] This discrimination clearly breaches the ethical obligations of medical professionals to help patients (sometimes called the duty of beneficence) and to treat all patients with respect. Whatever an individual physician's personal views on transgenderism, and whatever discomfort he or she may feel about treating a transgender person or concerns he or she may have about how other patients will react to the presence of a transgender person in a waiting room or a hospital ward, the health needs of the transgender patient must be served.

Third part of case:

Natalie's transition continues to be difficult. She suffers from verbal abuse and harassment, and fears violent attacks. Her registered sex as "male" on identity documents is a painful reminder of a lifetime of being mislabeled, and a daily source of humiliation and mistreatment. Every time she uses her health insurance card, driving license or education certificate, Natalie endures this experience. "I try to avoid these situations. I won't travel internationally because I hate to show my passport. I discriminate against myself."

Natalie has decided to seek legal recognition of her gender identity by changing her registered sex to female. She visits the government bureau to file an application. The clerk informs Natalie there are eligibility requirements she must satisfy. An individual must follow a process of gender reassignment under medical supervision, undergo genital reassignment surgery, and be rendered surgically

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irreversibly infertile. "You must bring this evidence before an expert panel. There needs to be a clear cut point," the Clerk explains. "You can't simply choose."

Discussion question on third part of case:

1. What are the arguments for and against jurisdictions setting specific requirements for individuals who seek to change their legally registered sex?

Ethics commentary on third part of case:

Some jurisdictions allow an individual to change his or her legally registered sex on the basis of personal request, proof that the individual has been diagnosed with transsexualism or gender identity disorder, and proof that the individual has completed some hormone treatment.[xix] Others stipulate that the he or she must first complete surgical treatments, be sterilized, have lived as the preferred gender for a specific period of time, and/or have divorced any spouse.

Although there is not yet international uniformity or agreement about what ought to be the prerequisites for legal sex change, many of these criteria have been criticized as unreasonable, unnecessary, possibly dangerous, discriminatory, and in violation of human rights.[xx] Requirements for specific treatments, whether pharmacological or surgical, risk subjecting transgender individuals to medical interventions they may not want, cannot afford, or are too risky in their particular case. All treatments carry risks, many are expensive, and some are simply not desired by particular individuals. (For example, some female to male transsexuals may seek access to mastectomies, but not hysterectomies or genital surgeries.) We generally respect patient autonomy by allowing patients to refuse medical treatments. A legal requirement to undergo particular treatments before an individual can change his or her legally registered sex can conflict with respect for patient autonomy, a fundamental commitment in medical ethics that is grounded in respect for persons.[xxi,xxii]

Sterilization requirements deprive transgender individuals of the ability to procreate, and requirements to divorce a partner force transgender individuals to choose between their gender identity and their spouse. Both requirements threaten fundamental human rights—the right to marry and the right to procreate—and are arguably irrelevant to establishing individual gender or legally registered sex. Requirements that a transgender individual live for a specified length of time as their preferred identity can, depending on the society in which he or she lives, put that individual at risk for violent attack.

If a person's sex as listed on official documents, like her driver license and passport, does not match her gender, the authenticity of these documents may be questioned by law enforcement and other officials.[xxiii] To avoid situations in which their apparent gender does not match their listed sex, transgender individuals may avoid driving, travel, and other situations in which they must use official identity documents. Difficulty changing legally registered sex can therefore effectively deprive a transgender person of the ability to travel and may inhibit her ability to seek the assistance of law enforcement or access social services to which she is legally entitled. Inability to change legally registered sex can affect marital rights and social security entitlements.

It is possible to imagine a jurisdiction in which sex is irrelevant, or largely irrelevant, to the state. Indeed, it is already seldom clear why sex is a required data point on forms or identity documents, particularly as the latter now increasingly include sophisticated biometric identifiers. Thus, rather than asking why an individual should be allowed to easily change her legally registered sex, one might ask why she should not (what state interest is served in preventing her from legally changing her sex). Given the practical difficulties and psychological pain that not being able to change legally registered sex to match preferred gender creates for transgender individuals and the arguable irrelevance of sex for bureaucratic purposes, the onus would then be on the state to show why it has a compelling interest in transgender individuals fulfilling particular requirements before a legal sex change will be granted. When these requirements are expensive, irrelevant to establishing a gender identity, risk placing the individual's health or safety at risk, or threaten other fundamental rights, they ought to be reconsidered. Further, we may legitimately

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ask states to consider whether they really need to continue to use sex categories at all in their identity documents and in other forms and policies.

Individual health professionals and their institutions can have an impact on national policy. They may also see firsthand some of the damage done to transgender individuals by stringent requirements for legal change of sex, as well as by the continued use of binary sex categories in official forms and documents. A concern for patient welfare and respect for patient autonomy might, therefore, lead individual health professionals, their institutions, or their professional groups to lobby governments for less restrictive laws regarding change of legally registered sex and for reduction in the use of, or elimination of, binary sex categories in official forms, documents, and policies.

Fourth part of case:

Natalie is frustrated. She desires genital reassignment surgery but cannot afford it without health insurance funding. Natalie calls to inquire. A representative informs Natalie the insurance plan will not cover the costs of surgery. Natalie has already paid substantial costs out-of-pocket for her hormone treatment. The representative explainst, "We only cover medically necessary treatment. These treatments do not qualify under this general condition. There is no medical evidence either treatment relieves the condition of gender identity disorder. You are lucky to have the diagnosis. With that, we can cover more extensive psychiatric care."

Discussion question on fourth part of case:

1. Which medical treatments should insurance plans and states provide to transgender individuals, and why?

Ethics commentary on fourth part of case:

One advantage for transgender individuals of a mental disorder diagnosis is that it brings them into the medical realm, and therefore a step closer to accessing sex reassignment treatments. Generally, health insurance plans will not cover medical costs unless they are for diagnosis and treatment of a recognized illness or disease. Even if insurers recognize transgender persons as suffering from a mental health disorder, they may place limits on the treatments they will cover.[xxiv] In determining coverage, plans may look to published standards of care for the treatment of gender identity disorder or transsexualism, which include guidance on diagnosis and treatment. One particular standard of care document, published by the World Professional Association for Transgender Health (WPATH—formerly the Harry Benjamin International Gender Dysphoria Association), is currently particularly influential, although it has been criticized and alternative standards of care have been proposed.

WPATH's Standards of Care for Gender Identity Disorders[xxv] include eligibility criteria for sex reassignment treatments, including hormones and surgeries. WPATH clearly states that "sex reassignment is effective and medically indicated in severe gender identity disorder" and "is not 'experimental,' 'investigational,' 'elective,' 'cosmetic,' or optional in any meaningful sense." Generally, to access hormone treatment the patient must be 18 years old, demonstrate knowledge of what hormones medically can and cannot do and of their social benefits and risks, and either show "real-life experience" (living in the preferred gender) of at least three months or a period of psychotherapy (usually a minimum of three months). It recommends eligibility criteria for the various surgeries, stating that for genital surgery the patient should have completed 12 months or of hormone therapy and 12 months of "real-life experience." Alternative standards of care, such as those promulgated by the International Conference on Transgender Law and Employment Policy (ICTLEP), set far less stringent requirements for access to hormone and surgical treatments.[xxvi]

Bioethicist and philosopher James L Nelson has noted that the WPATH standards, which were drafted primarily by medical professionals, and the ICTLEP standards, which were drafted by a group that includes many transgender individuals, display different notions of the purpose of

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biomedicine and the reasons why transgender individuals might seek medical assistance. "The Benjamin Standards license the exercise of medical power according to internal medical norms, partly defuse the social deviancy of 'sex change,' and morally disenfranchise 'sufferers.' The [ICTLEP standards] represent an objection to each of these functions. They embrace a political conception of gender shifting and invest decision-making authority in the people who want the procedures rather than in the professionals who perform them."[xxvii]

Nelson explains that bioethics recognizes two forms of authority for physicians to intervene in the bodies of patients: professional authority, which requires a diagnosis and some chance that the planned intervention will benefit the patients, and patient-centered authority, which requires that patients give free and informed consent to treatments and that clinicians try to enhance the agency of their patients. Nelson notes that bioethicists "...have consistently urged health care providers to see patients as persons capable of some significant understanding of the world and how it interacts with what they value and of how they might act in ways that increase the fit between those values and resulting states of affairs."

Nelson interprets the WPATH standards as drawing heavily on physician autonomy and the medical ethics principle "first do no harm," but argues they can have the effect of forcing transgender individuals who seek surgeries into a "sick role." "What one says and does are taken to be not expressions of a responsible moral agent but potential symptoms of a disease." The WPATH standards do not acknowledge or make room for the moral authority of the individual seeking the interventions. The ICTLEP standards, on the other hand, are more focused on respect for patient autonomy. However, Nelson criticizes these standards for marginalizing "the agency of service providers," pointing out that patients' right to refuse medical treatment does not create a right to demand it.

Despite their differences, both standards of care do agree that hormone and surgical treatments can be appropriate interventions for transgender individuals. Plans that do not cover these services can therefore legitimately be criticized for being out of date and, because they likely cover similarly effective interventions for other medical and mental health problems, as unfairly discriminating against transgender individuals.

Assuming Natalie's insurance plan is altered to include access to sex reassignment treatments, physicians working under the plan should be aware that, as noted above, each patient is an individual and should be assisted to develop a treatment plan that fits his or her individual needs and circumstances. Natalie's physician should help her consider the range of treatment options, including the possibility of no treatment, and should discuss with Natalie what is currently known about the post treatment experiences of transgender individuals. Physicians unfamiliar with the data on transgenderism and sex reassignment treatments are obliged to educate themselves before treating transgender patients so that they are able to provide their patients with appropriate treatment options and help them to make informed choices.

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[i] Note however, that transgender is "an expansive and complicated social category," Currah P, Juang RM, Minter SP (eds), *Transgender Rights*, Minnesota: University of Minnesota Press, 2006, xv.
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[iii] Roughgarden J, *Evolution's rainbow: Diversity, gender, and sexuality in nature and people*. Berkeley: University of California Press, 2004.
[iv] Nelson JL, "The silence of bioethicists: Ethical and political aspects of managing gender dysphoria," *GLQ* 1998; 4(2): 213-230 at 213.
[v] Lombardi EL, Wilchins RA, Priesing D, et al., "Gender violence: Transgender experiences with violence and discrimination," *Journal of Homosexuality* 2002; 42(1): 89 – 101.
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[vii] Swann WB, "Identity negotiation: Where two roads meet," *Journal of Personality and Social Psychology* 1987; 53(6): 1038-1051
[viii] Kant I, *Groundwork for the Metaphysics of Morals*, Herbert J Paton (translator), New York: Harper Torchbooks, 1965.
[ix] Beauchamp TL, Childress JF, *Principles of biomedical ethics, 6th ed.*, New York: Oxford University Press, 2009.
[x] Dillon RS, "Respect," in Zalta EN (ed.), *The Stanford Encyclopedia of Philosophy,* online http://plato.stanford.edu/archives/win2009/entries/respect/>.
[xi] American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders Washington, DC: American Psychiatric Association 2004. ICD-10 does not define mental disorder.
[xii] Parens E, Johnston J, "Understanding the agreements and controversies surrounding childhood psychopharmacology," *Child and Adolescent Psychiatry and Mental Health* 2008; 2:5; www.capmh.com/content/2/1/5.
[xiii] Supra note 6 at 146
[xiv] Lombardi E, "Enhancing Transgender Health Care," *American Journal of Public Health* 2001; 91(6): 869-72.
[xv] Piper J, Mannino M, "Identity Formation for Transsexual Individuals in Transition," *Journal of GLBT Family Studies* 2008; 4(1): 75- 93 at 84-85.
[xvi] JSI Research and Training Institute Inc. *Access to Health Care for Transgendered Persons in Greater Boston*. Boston, Mass: Gay, Lesbian, Bisexual, and Transgender Health Access Project; 2000.
[xvii] Supra note 14.
[xviii] See for example the story of a transgendered man who was unable to access treatment for uterine cancer, as told in the 2001 documentary "Southern Comfort," directed by Kate Davis. Also, Feinberg L, "Trans health crisis: for us it's life or death," *American Journal of Public Health* 2001; 91(6):897-900.
[xix] See for example the law in Spain, which allows change of sex on all public documents, provided the individual can show a gender disorder diagnosis and two years of hormone treatment.
[xx] Gehi PS, Arkles G, "Unraveling injustice: Race and class impact of Medicaid exclusions of transition-related health care for transgender people," *Sexuality Research & Social Policy* 2007; 4(4): 7-35.
[xxi] Supra note 9.
[xxii] Frye PR, "Genital surgery not required for legal change of sex: Freedom from the "have-to" of the scalpel," *National Journal of Sexual Orientation Law* 1997; 3(1): 30-36.
[xxiii] Supra note 20.
[xxiv] For discussion of coverage in the US under Medicaid, see ibid.

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[xxvii] Supra note 4.

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