PATERNALISM AND COMPETENT PATIENT CHOICE IN THE
STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL,
TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE

by

Kevin Pigeau

A thesis submitted to the Department of Philosophy
In conformity with the requirements for
the degree of Master of Arts

Queen’s University
Kingston, Ontario, Canada
(October, 2016)

Copyright © Kevin Pigeau, 2016
Abstract

In 2016 physicians in Ontario will be granted the authority to refer patients with gender dysphoria for sex reassignment surgery. In order to be granted this authority physicians must be trained in the World Professional Association for Transgender Health’s *Standards of Care*, which outlines healthcare procedures for the treatment of gender dysphoria and provides background information concerning transgender health. The *Standards of Care* require that patients undergo a process of 12 months of continuous living in a gender role that is congruent with their gender identity prior to being given access to sex reassignment surgery. While this requirement can sometimes be helpful it can also cause more harm than benefit. This paper argues that the requirement is strongly paternalistic in its current form and should no longer be mandatory in most cases.
Acknowledgements

I would like to thank Udo Schuklenk for taking time out of his own projects to offer extensive feedback on this paper. My arguments would be far less coherent and presentable without his guidance. I would also like to offer my gratitude to the staff, students, and faculty of the Philosophy Department at Queen’s University for providing a friendly, productive, and mentally stimulating environment throughout my year here. Finally, I would like to thank my family for their support throughout this process—especially Marina Pogosyan, whose support and encouragement has been vital to my success.
# Table of Contents

Abstract ......................................................................................................................................................... ii  
Acknowledgements ........................................................................................................................................ iii  
List of Abbreviations .................................................................................................................................... v  
Chapter 1 Introduction ................................................................................................................................. 1  
Chapter 2 Gender Nonconformity, Gender Dysphoria, and Treatments ...................................................... 8  
Chapter 3 The Gender Role Experience ..................................................................................................... 27  
Chapter 4 Paternalism and Competent Patient Choice .............................................................................. 38  
Chapter 5 Recommendations for the SOC and Healthcare Providers ...................................................... 61
List of Abbreviations

CAMH – Centre for Addiction and Mental Health

GRE – Gender Role Experience

HRT – Hormone Replacement Therapy

SOC- Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People

SRS – Sex Reassignment Surgery

WPATH – World Professional Association for Transgender Health
Chapter 1

Introduction

Beginning in 2016 all Ontario physicians who undergo appropriate training will be granted the authority to refer patients with gender dysphoria for sex reassignment surgery (SRS), (Service Ontario, 2015). Gender dysphoria is the distress that can result when one’s gender identity is incongruent with the sex that they were assigned at birth, (World Professional Association for Transgender Health [WPATH], 2012, p. 5).\(^1\) SRS continues to be the best available medical treatment for many patients presenting with gender dysphoria, (Gijs & Brewaeys, 2012). Prior to changes in Ontario’s Health Insurance Act in 2015, only the Centre for Addiction and Mental Health (CAMH) based in Toronto had the authority to grant access to sex reassignment surgery for people in Ontario, (Service Ontario, 2015). As of 2015, CAMH had a waiting list of over one thousand patients seeking SRS, (Csanady, 2015). These patients can now avoid extensive travel time and the CAMH’s lengthy waiting list (which averages around two years just for a first appointment) (CAMH, 2016), since they can now request treatment from any willing local physicians. This change represents a significant step forward in the availability of medical treatment for those with gender dysphoria.

In order for physicians to gain the authority to provide referrals for SRS, they must first receive training in the World Professional Association for Transgender Health’s (WPATH) *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (commonly referred to as the *SOC*), (Service Ontario, 2015).

---

\(^1\) Where ‘sex assigned at birth’ is the process in which a male or female sex designation is assigned to a neonate due to the appearance of external genitalia, (WPATH, 2012, p. 97).
2015). WPATH is an educational organization that seeks to “promote evidence based care, education, research, advocacy, public policy, and respect in transgender health,” (WPATH, 2016). It provides an international standard for the healthcare of individuals who are transgender. While the SOC has an excellent track record in terms of providing increasingly good surgical outcomes for patients undergoing surgery (WPATH, 2012, p. 107) there are elements of the SOC that impose daunting requirements that patients must meet in order to be approved for surgery. Prior to being approved for SRS involving the genitals patients must “live continuously for at least 12 months in the gender role that is congruent with their gender identity,” (WPATH, 2012, p. 21). For example, one who identifies with a traditional female gender role but who was assigned a male gender at birth would be required to publicly express a feminine gender role for one year prior to being referred for surgery. The reasoning for this requirement is to “[test] the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports,” (Harry Benjamin International Gender Dysphoria Association, 2001, p. 1) and “is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery,” (WPATH, 2012, p. 106). This requirement does not have a name in the SOC but is referred to as the “gender role experience” (GRE) by Toronto’s CAMH. I will refer to this requirement as the GRE, although, it should be noted that the naming of this requirement has been contested a number of times in the past, which is why the name no longer appears in the SOC, (Levine, 2009, p. 190).
Undergoing the GRE can be very difficult for patients and presents a number of social, psychological, and physical challenges, (WPATH, 2012, p. 30). However, the requirement is mandatory according to the SOC, (WPATH, 2012, p. 58). It is often argued that the GRE prepares patients for surgery, improves surgical outcomes, and leads to fewer post-surgical regrets (Bockting, 2008; Levine, 2009 p. 191). However, despite the GRE having been a requirement for SRS for roughly 50 years there is no published empirical evidence to suggest that it improves surgical outcomes or lowers the incidence of post-surgical regret, (Cascio, 2003; Lawrence, 2001; WPATH, 2012, p. 106). The GRE has persisted as a tradition in many treatment models for SRS, including those outlined in the SOC, despite this lack of data, (Levine, 2009, p. 187). In fact, limited data has been published to suggest that the year-long GRE does not reduce regret in patients and can actually be harmful, (Lawrence, 2001). Lawrence (2001) has found in two small studies including 18 and 13 patients that GREs of shorter lengths (including no GRE at all) have not led to post-surgical regret. Additionally, the survey participants noted several benefits of avoiding the GRE, including “sustaining needed employment; reducing fear of physical harm; pursuing significant relationships; and perhaps most important of all, achieving personal comfort,” (ibid.). The GRE can be a trying experience for patients, which is often more difficult than the physical obstacles of the surgery itself (WPATH, 2012, p. 30).

Given the recent changes to the Health Insurance Act in Ontario many new physicians will soon be trained in the SOC, which will act as an outline for the requirements necessary to receive funding for SRS, (Service Ontario, 2015). This

---

2 The requirements of the SOC are said to be flexible, (Ehrbar & Gorton, 2010 ; WPATH, 2012, p. 2). However, the GRE requirement in particular is mandatory. This is discussed further in Chapter 5.
potential influx of newly trained physicians capable of referral, along with the increasing number of patients who are seeking SRS every year (Grant, 2015), has made it especially important to address any ethical issues that arise in the SOC. This paper focuses on the ethical implications of the GRE requirement for sex reassignment surgery as it is outlined in the SOC. The GRE is a strongly paternalistic requirement in that it is forced upon competent patients who might reasonably choose to avoid it. The GRE is intended as a measure to reduce the harm done to patients through SRS and to maximize surgical outcomes. However, if the GRE does not significantly increase overall utility\(^3\) for patients with gender dysphoria (either through the reduction of harm caused by SRS or by easing gender role transitions) then it presents an ethical problem for healthcare providers and their patients. Since there is no reason to believe that patients with gender dysphoria are incompetent when it comes to medical decision-making, paternalistic measures such as the GRE require justification in order to override patient autonomy. In this paper I will demonstrate that the GRE currently lacks sufficient justification to override competent patient choice. This is because the GRE often fails as a measure to reduce harm (in that it could cause a good deal more harm than it prevents) and because there is a lack of empirical evidence to suggest that the GRE either improves surgical outcomes or reduces post-surgical regret.

I will argue that the GRE is strongly paternalistic and lacks the required justification to override the choice of competent patients. As a result, I will suggest that future versions of the SOC offer alternative treatment models that make the GRE

\(^3\) Utility is used here in the classical sense of maximizing pleasure and minimizing pain and is manifested through concerns about non malfeasance and beneficence—although, the GRE would also be suspect under alternative conceptions of utility, especially preference satisfaction.
available on a voluntary basis for competent patients. I will also suggest that referring physicians who are trained in the SOC consider whether or not the GRE is suitable on a case-by-case basis and encourage them to negotiate the length of the GRE with their patients—up to, and including, a complete removal of the GRE requirement for competent patients who either do not wish to pursue the GRE or for patients who might not benefit from the GRE given their situation. Unfortunately, since the Health Insurance Act will not provide funding for SRS unless physicians adhere to the current version of the SOC, funding could be threatened for patients who do not undergo at least some version of the GRE. As a result, until further changes are made to the SOC or the Health Insurance Act, considerations concerning how physicians should proceed with the GRE must be balanced with the need to meet funding requirements for SRS in Ontario.

Chapter 2 will provide background information concerning gender nonconformity, gender dysphoria, typical forms of treatment for gender dysphoria, types of treatment models, and gender paradigms. This chapter will provide the context for the GRE by outlining patient needs and experiences in relation to their treatment for gender dysphoria and by exploring concepts of gender as well as different approaches to treatment.

Chapter 3 will focus on the GRE requirement for SRS. It will discuss the intended purpose and benefits of the GRE and point out some of the conceptual problems with the requirement. While the mandatory requirement for the GRE can cause unnecessary harm to some patients it is possible that the GRE will be useful for others. Arguments in favour of the GRE often include concerns about non malfeasance, adequately informed consent, reducing the incidence of post-surgical regret, and the argument from better surgical
outcomes (Bockting, 2008; CAMH, 2015; Levine, 2009 p. 191). The argument from non malfeasance suggests that it is better to hold off on surgery in order to avoid causing harm to the patient. Not only does SRS present a significant risk to patients in terms of complications but it makes irreversible changes to their bodies, (WPATH, 2012, p. 63). Thus, proceeding with SRS is not a decision that should be taken lightly. The GRE is meant to help patients fully understand the implications of a change in gender role and thus, contribute to informed consent for surgery, (CAMH, 2015). Since the development of the SOC surgical outcomes have significantly improved, (WPATH, 2012, p. 107). This has been partly attributed to the GRE and continues to serve as a reason for its support. Each of these claims will be challenged in this chapter.

In chapter 4 I will argue that the GRE is strongly paternalistic and requires justification if it is to override competent patient choice. The GRE is said to be justified because it improves surgical outcomes as part of the SOC and because it ensures non malfeasance in the pursuit of SRS. I will demonstrate that there is insufficient evidence to support the claim that the GRE improves surgical outcomes and that the GRE often fails as a measure to ensure non malfeasance. Consequently, the SOC is not justified in enforcing the GRE as a mandatory requirement for SRS. Some of the major obstacles that the GRE could create for patients are: delayed surgical intervention, invasion of privacy, a breakdown of trust between patients and their healthcare providers due to the gatekeeper role of physicians, irreversible damage to relationships and careers, and increased chance of exposure to violence and discrimination. I will conclude that, in many cases, the GRE is more harmful than beneficial and thus it cannot be justified in overriding competent patient choice.
Finally, Chapter 5 will offer recommendations for the next version of the SOC. It will discuss the flexibility of the SOC and suggest that the GRE be removed as a mandatory requirement for competent patients who wish to pursue SRS. The applicability of the GRE to those who volunteer for it as well as for non competent patients will be discussed.
Chapter 2

Gender Nonconformity, Gender Dysphoria, and Treatments

In order to make judgments about whether or not the GRE portion of the SOC is justified as a strongly paternalistic measure some background information about gender dysphoria and its treatments is necessary. While there no longer seems to be any serious debate in the academic literature concerning the necessity of medical treatment for gender dysphoria or concerning the general form that such treatment takes—aside from concerns about the GRE, which is the focus of this paper—there remains a great deal of confusion among the general public and even among healthcare professionals concerning gender nonconformity and gender dysphoria. As a result, some time will be spent defining these terms. It will also be necessary to review some common forms of treatment as well as the concepts of gender and gender dysphoria that inform various treatment models.

Those who are gender nonconforming have a gender identity or gender role that is incongruent with the gender identity/role that they were assigned at birth. A gender identity is the sex or gender that one best identifies with and need not conform to the traditional gender binary of male or female. One may identify as male, female, transgender, genderqueer, etc. regardless of the sex that was assigned to that person at birth. A gender role is the “characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine,” (WPATH,

---

4 This is indicated by social stigma in the general public and within healthcare systems toward those who are gender nonconforming and has been reported in studies such as the Trans Pulse survey of 2010.

5 A treatment model is a term used by Ehrbar and Gorton (2010) and is intended to indicate that physicians will develop different ways to treat patients based upon their interpretation of the SOC, local culture, patient needs, the way the physician understands gender nonconformity and dysphoria, as well as other criteria, (p. 203).
2012, p. 96). One can have a certain gender identity and yet not express it through its corresponding gender role. For example, one who was assigned a female sex at birth could have a masculine gender identity and yet express themselves in a female gender role. This is common when those who are gender nonconforming have not yet “come out” and are attempting to conceal their gender identity due to cultural and social expectations, (Bockting, 2008, p. 215). The SOC claims that gender nonconformity is a matter of diversity and not pathology, (WPATH, 2012, p. 4). Gender nonconformity is not an illness but rather a normal expression of gender identity along a continuum of possible gender identities and roles, (Hage & Karim, 2000, p. 1222).

In previous years there was debate concerning whether or not people who were gender nonconforming were ill, (ibid., p. 1224). Pathologizing those who were gender nonconforming had some significant benefits—namely, increased access to medical care that would aid patients in achieving a gender role that is congruent with their gender identity. Additionally, viewing gender nonconformity as an illness was thought to relieve social stigma by inciting compassion rather than rejection, (ibid.). However, it is unlikely that this is the case. Homosexuality was pathologized for similar reasons but instead of relieving social stigma this served only to harm those who were homosexual by encouraging unnecessary medical treatments, job discrimination, and continued social stigma, (Perone, 2014). Gender nonconformity is common across a variety of cultures and can exist in individuals with no noticeably negative effects, (WPATH, 2012, p. 4).

---

6 Magnus Hirschfeld argued in 1910 that transvestitism was due to illness. His intent was to generate greater social acceptance of those who were gender nonconforming, (Hage, Karim, 2000, p. 1224). However, it is unlikely that pathologizing gender non-conformity reduced social stigma and may have actually caused it to increase.
As a result, gender nonconformity has been distinguished from the negative effects of social stigma and gender dysphoria in the SOC.

Gender dysphoria is specifically the distress that occurs in some people who do not identify with the sex that they were assigned at birth. Those who are gender nonconforming may or may not experience gender dysphoria at some point in their lives, (WPATH, 2012, p. 4). Many people who are gender nonconforming neither experience significant distress as a result of their gender roles and gender identities, nor do they wish for medical interventions. Thus, distinguishing between those who are gender nonconforming and those who experience gender dysphoria makes room for people who require medical treatment without pathologizing gender nonconformity.

It is possible that gender dysphoria should also be excluded from being pathologized since it seems to be largely socially and culturally generated. That is, the distress that often accompanies gender nonconformity could be largely relieved in a culture that is accepting of alternate or fluid gender expressions. Thus, the sources of distress might not lie with those who are experiencing the dysphoria. Anyone experiencing severe social stigma would be similarly likely to develop an associated level of distress. Other sources of distress could relate to embodiment but it is not clear how much of this is culturally generated if our very ideas of gender role and identity are culturally formed. If this is the case then we might have to accept that some individuals who are gender nonconforming require urgent medical intervention as a way to improve quality of life even though they show no signs of illness, (Purdy, 2015, p. 9).

Gender dysphoria is medically relevant whether or not it is considered to be an illness. This is for two reasons. First, those with gender dysphoria often require medical
assistance to cope with their distress (although, this is not always the case). Second, those who wish to make bodily changes such that their body image matches their gender identity need to undergo procedures (prescriptions and surgeries) that are best described as medical and thus, are best supervised by medical practitioners or similarly qualified healthcare providers.

As it stands, only those gender nonconforming people who experience gender dysphoria are eligible for medical treatments impacting the body. Therefore, people who are gender nonconforming may wish to make bodily alterations but they will not be allowed to take the risks associated with medical treatment unless they are experiencing significant and continuous distress. I will not spend much time addressing this issue but it seems to be significant. Desire without distress is thought to be inadequate justification for medical intervention. This could be suspect because a lack of distress does not necessarily mean that quality of life cannot be improved through medical treatment. However, priority should certainly be given to those whose suffering can be relieved through medical intervention since it will likely result in a greater overall increase in quality of life. Additionally, many people are still coming to grips with the idea that medical intervention that is gender confirming (i.e., treatment that changes the bodies of patients to be confirming of gender identity) should be allowed even for those with severe gender dysphoria. Unfortunately, this has created a situation where those without gender dysphoria might claim to have distress (when in fact they do not) in order to gain access to medical treatment, which would undermine trust in patient-physician relationships. The impact on the patient-physician relationship is discussed further in chapter 4.
The term transgender is an umbrella term that appears often in the literature and is probably more prominent than the term “gender nonconforming,” (Hage & Karim, 2000, p. 1222). It includes anyone who does not neatly identify with the sex and gender that they were assigned at birth. This includes those who alter their gender roles (feminine men or masculine women), people who wish to transition their traditional gender role from male to female or vice-versa, those who make physical changes to their bodies to transition gender roles (transsexuals), those who are gender-fluid, multi-gendered, agendered, intersexed, two-spirited, androgynous, genderqueer, and others. The term transgender seems to be synonymous with what the SOC refers to as gender nonconforming—although, the latter specifically refers to a deviation from cultural norms concerning gender that are relative to a time and place, (WPATH, 2012, p. 5). I will continue to use the term ‘transgender’ interchangeably with the term ‘gender nonconforming’ throughout this paper, although I believe the term gender nonconforming to be problematic. The SOC has begun using the term gender nonconforming often in place of the umbrella term transgender. However, the term gender nonconforming is misleading since many transgender people do indeed wish to conform to a traditionally defined gender—just not the one they were assigned at birth. This oversight is due to a shift in gender paradigm that has occurred in the literature that, while useful, seems to be misinterpreted to suggest that traditional genders are to be excluded from the gender transition process, (Bockting, 2008).
The Impact of Social Stigma and Gender Dysphoria

Until this point not much has been said concerning the seriousness of gender dysphoria. I will draw attention to this point because the distress of gender dysphoria can be severe and is often underestimated. The severity of gender dysphoria also provides a major form of justification for medical intervention. Since many of the available treatments for gender dysphoria involve bodily changes that are risky and could cause harm they must be justified by providing an overall increase in the quality of life for patients. The most obvious way that they can do this is by relieving patients of gender dysphoria. This means that in order to be justified (in this way) a proposed medical intervention must cause significantly less harm than that which is caused by gender dysphoria. The severity of gender dysphoria that patients present with is also one of the motivating factors for physicians who decide to undergo the necessary training in order to provide treatment, (Ettner, 2007; Wheeler, 1999 as cited in Ehrbar & Gorton, 2010, p. 208).

A number of studies have documented the quality of life of those with gender dysphoria. In 2010 an organization called Trans Pulse was funded to survey transgender people in Ontario in order to determine the “impact of social exclusion and discrimination on the health of trans people in Ontario, Canada,” (Trans Pulse, 2012). The 2010 Trans Pulse survey had 433 transgender participants from Ontario. The results of the 87-page survey were published in a number of smaller bulletins and articles in the

---

7 I have already suggested that medical intervention could be appropriate even absent gender dysphoria since it can improve the quality of life for those who are gender nonconforming. However, resources available in Ontario are already overwhelmed serving those with gender dysphoria alone, at least in terms of the availability of surgery. Hormone replacement therapy could potentially be offered to those without gender dysphoria who may experience an increase in the quality of life as a result and who are willing to accept the associated risks.
following years. One article, “Ontario’s Trans Communities and Suicide: Transphobia is Bad for Our Health,” suggests that 77% of the survey participants had considered suicide at some point in their lives and 43% had attempted to commit suicide at least once, (Trans Pulse, 2010). Of course, these statistics do not include transgender people who have successfully committed suicide, which suggests that these numbers are even higher.

For comparison, attempted suicide rates in the general population of the United States were roughly 0.6% in 2015, (CDC, 2015). This is perhaps the most shocking result of the Trans Pulse study and it points to the severity of distress that people with gender dysphoria often experience. Other problems that the Trans Pulse study has revealed are low levels of income (50% of transgender Ontarians earn less than $15000 per year) and high levels of unemployment (20%) among people who are transgender despite their possessing abnormally high levels of education (44% of those surveyed had at least one university degree), (Trans Pulse, 2011). Also, the majority of participants reported fear of public places (Trans Pulse, 2014) as well as fear in accessing healthcare, (Bauer, 2013). Additionally, 26% of survey respondents reported being physically assaulted due to their gender nonconformity, (Trans Pulse, 2013). Many of these problems seem to stem from a lack of acceptance of transgender people among the general public, i.e. the transphobia that the aforementioned article title refers to, (Trans Pulse, 2011; Trans Pulse, 2013).

Given that many gender nonconforming people experience significant distress, medical treatments that are capable of relieving gender dysphoria are often justified even in cases where they present risk of harm.

---

8 Statistics concerning suicide rates in the general population were unavailable for Ontario, Canada.
Since a good deal of the distress of gender dysphoria is socially based it might seem more appropriate to work towards a greater social acceptance of gender nonconformity than to proceed with risky medical treatments. However, despite progress that has been made in greater social acceptance of those who are gender nonconforming a great deal of work remains to be done. The Trans Pulse survey shows that as little as five years ago Ontario has proven to be a fairly hostile place for those who are gender nonconforming. If there are medical treatments that can relieve gender dysphoria for patients now then it is reasonable to pursue these options since waiting for social change will take too long to prevent significant harm to those who are experiencing gender dysphoria. There are also causes for distress that are not socially based and that can be relieved through medical intervention. For example, social change will not help resolve issues of embodiment, where some patients feel as if their gender identity does not correspond with their bodies but medical treatments can help to resolve these issues by physically changing the bodies of patients such that they are more congruent with their gender identities, (Lawrence, 2001).

**Attempts to ‘Correct’ Gender Nonconformity**

Initial attempts to perform sex reassignment surgeries in the 1930s were controversial because gender nonconformity was considered to be an illness. As a result, surgeries seemed to reinforce what many believed to be psychiatric illness, (Gijs & Brewaeys, 2012, p. 215). A form of treatment that involved realigning the gender identity of those who are gender nonconforming with the gender that they were assigned at birth has been attempted and has been largely unsuccessful, (Cohen-Kettenis & Kuiper, 1984;

Treatments that attempted to realign the gender identity of those who are gender nonconforming with the gender that they were assigned at birth are now considered to be unethical, (WPATH, 2012, p. 16). The SOC claims that treatments of this kind are unethical but it does not offer an explanation why this is the case. It does seem to be the position of some authors that if gender identity could be successfully re-aligned with the gender assigned at birth that this form of treatment would be preferable to our current treatment models, (Blanchard & Fedoroff, 2000). Some authors reluctantly support SRS and other gender confirming treatments merely as the best available alternative. As a result, it is worth considering what is unethical about treatments that attempt to change gender identity. We might consider treatments that attempt to alter gender identity to be ethically problematic regardless of whether or not they are effective. This would be the case if we accept that all gender identities are valid, regardless of whether or not they conform to traditional gender identities or whether or not a particular person’s gender identity conforms to the gender assigned at birth. If we view such identities as valid then there would be no reason to treat them differently than we treat the gender identities of people whose identity conforms to the gender assigned at birth. As a result, treatments purposely attempting to change the gender identity of individuals would be unfairly targeted at those who are gender nonconforming. Failing to respect gender identity as a whole would also undermine the self-determination of patients (while gender identity is doubtlessly formed in significant part by cultural contribution individuals can reasonably
choose how they wish to relate to gender expectations inasmuch as they are aware of them). If we do not consider gender identities that diverge from tradition to be valid then we are stuck with explaining why that might be the case. However, those who would like to change gender identity as a form of treatment if it were possible do not seem to be motivated by adherence to traditional gender roles but rather by the desire to reduce the amount of harm done to patients through medical treatment. They assume that changing gender identity (if it could easily be done) would be a significantly less harmful way to resolve gender dysphoria than the treatments that are currently available. However, forcefully changing gender identity could be harmful on its own regardless of how easily it might be accomplished.

**Contemporary Treatments for Gender Dysphoria**

Contemporary treatments of gender dysphoria begin with methods that cause the least amount of harm and are the most easily reversible. However, treatments can progress to forms that create a higher risk of harm and introduce irreversible changes in the body. Treatment of gender dysphoria usually begins with assessment and/or psychotherapy. This is intended to encourage patients to explore gender roles and to take on a role that aligns with their gender identity. Healthcare professionals assist patients with exploring alternate gender roles, overcoming social stigma and internalized transphobia, coming out to friends and family, outlining any goals related to gender transitions, and accepting their gender identity in such a way that relieves the distress experienced by the patient (Ehrbar & Gorton, 2010, p. 205; WPATH, 2012, p. 8-10, 29). Through psychotherapy some patients find a comfortable way to express their gender role
that is more in line with their gender identity and this reduces gender dysphoria to more comfortable degree, (ibid.).

For other people changes made in gender role are not enough to relieve gender dysphoria. More aggressive treatment involves the use of hormone replacement therapy (HRT). This is often a combination of medications that block sex hormones in a variety of ways (by reducing hormonal levels or activity) along with the introduction of new sex hormones, (WPATH, 2012, p. 48-50). This creates a number of physical bodily changes, which allow people with gender dysphoria to more adequately take on their desired gender identity. For example, a transgender woman who was assigned a male sex and gender at birth but has a traditionally female gender identity could take medications that block the production or binding of testosterone (anti-androgens) and introduce female sex hormones (estrogen and/or progestins), (WPATH, 2012, p. 48-49). This creates a number of bodily changes such as finer and less apparent body hair, development of the breasts, changes in fat and muscle ratios and distribution, less oily skin, shrinking of the penis and testicles, etc, (WPATH, 2012, p. 36-38). HRT that is intended to masculinize works in much the same way but introduces thicker body and facial hair, encourages the development of more muscle tissue, enlarges the clitoris, halts menstruation, causes atrophy of the vagina, and lowers the pitch of voice, (ibid.). These changes can aid significantly in allowing patients to express their gender identities. Both forms of HRT have distinct but serious risks and side effects—although these problems can be managed with careful monitoring and minimization of risk factors based upon lifestyle choices such as smoking, (WPATH, 2012, p. 39-40, 44-45). Many patients with gender dysphoria cease their treatment at this point either because their distress has been relieved to an
adequate degree or because they do not wish to proceed with further treatments that involve surgery, (WPATH, 2012, p. 54).

For patients who continue to experience distress related to gender nonconformity after HRT there is the option of sex reassignment surgery (SRS). There are a large number of possible surgeries that patients can undergo in order to adapt their bodily features to match their gender identities, the most obvious of which is genital reconstruction surgery. However, there are a number of other surgeries that can be even more helpful in terms of presenting in a particular gender role. Breast reduction and chest contouring are common surgeries for those wishing to appear more masculine, whereas breast augmentation and facial feminization surgery are more common surgeries for those wish to take on a more feminine appearance. Although some of these surgeries are more effective at producing an outward appearance that conforms to a desired gender identity, much of the SOC focuses on genital surgeries, (WPATH, 2012, p. 107-9). Curiously, the SOC specifically avoids outlining criteria for facial feminization/masculinization surgeries and does not offer reasoning for this exclusion, (WPATH, 2012, p. 27). Nonetheless, the SOC claims that surgeries which are normally considered to be aesthetic “can be considered medically necessary” for some people with gender dysphoria, (WPATH, 2012, p. 64). Only a select number of these surgeries are funded by the Ontario government. Notably, facial feminization/masculinization surgery is not covered by the Ontario Health Insurance Plan, which leaves this option unavailable for many
patients. However, funding is now available for breast augmentation for select individuals, (Ontario Ministry of Health and Long-Term Care, 2016).

Sex reassignment surgery involving genital reconstruction is usually the final step in the treatment process and has been shown to significantly improve the quality of life for people with otherwise unresolved gender dysphoria, (WPATH, 2012, p. 54, 107). This is primarily why SRS remains the best treatment available for gender dysphoria, despite its complications, (Gijs & Brewaeys 2012, p. 215; Tom Waddell Health Center, 2013, p. 6; WPATH, 2012, p. 8, 107). Surgeons might find SRS to be ethically problematic since it involves damaging and removing otherwise healthy anatomical structures, (Brownstein 2009, p. 220; WPATH, 2012, p. 55). However, the general consensus is that this harm is outweighed by the benefit of relieving gender dysphoria, (Blanchard & Fedoroff, 2000). The SOC states: “the resistance against performing surgery on the ethical basis of ‘above all do no harm’ should be respected, discussed, and met with the opportunity to learn from patients themselves about the about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments,” (WPATH, 2012, p. 55). Surgical procedures involving the reproductive system that are intended to feminize the body “include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty,” (WPATH, 2012, p. 62). Surgeries that are intended to masculinize “include hysterectomy, salpingooophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of

---

9 While I will not dwell upon it here, I will note that in some cases funding these surgeries may be far more cost-effective than funding genital reconstruction surgery. Many patients do not require or desire genital surgery either for its own sake or due to the risk involved and the potential complications that follow. Additionally, some patients reasonably prefer surgeries that maximize the femininity/masculinity of their outward appearance in order to ensure that they “pass” more successfully in their desired gender roles.
testicular prostheses, and phalloplasty,” (WPATH, 2012, p. 63). Each of these surgeries carries significant risk for the patient, (WPATH, 2012, p. 62-63). However, patients rarely regret undergoing these surgeries even when there are severe complications (WPATH, 2012, p. 63) and the majority of studies following up on surgery show improved “postoperative outcomes such as subjective well being, cosmesis, and sexual function,” (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009; as cited in WPATH, 2012, p. 107).

According to the SOC patients must undergo a year-long gender role experience in order to be considered for SRS involving the genitals. The GRE requires that patients live full-time in a gender role that is congruent with their gender identity for one year prior to being approved for surgery. This requirement must be met to secure funding for SRS in Ontario.

The use of counseling and psychotherapy followed by hormone replacement therapy and finally sex reassignment surgeries is the general course of treatment. The kinds of treatments that are pursued and the order in which they are provided can be somewhat variable. This is because the large variety of differences in patient needs calls for different forms of treatment, (WPATH, 2012, p. 8-9). However, any surgery involving the gonads, external genitalia, or breast augmentation requires one year of hormone replacement therapy beforehand. This is because hormone replacement therapy can prepare the body for the hormone suppression that will come with the removal of gonads, and because hormone supplementation can produce breast growth without the need for surgical augmentation, (WPATH, 2012, p. 60, 106). This requirement is not mandatory and can be skipped if HRT is not clinically appropriate for a patient. Breast
augmentation is only funded by the Ontario Health Insurance Plan (OHIP) if 12 months of HRT has not resulted in breast development, so this option is more limited for Ontarians, (Ontario Ministry of Health and Long-Term Care, 2016).

**Treatment of Gender Dysphoria in Children and Adolescents**

The forms of treatment that have been outlined so far are targeted towards adults. The SOC does outline standards for the treatment of children that differ significantly. Children presenting with gender nonconformity or gender dysphoria do not often continue to experience this into adolescence, (WPATH, 2012, p. 11). However, as many as a quarter of these children will have dysphoria or nonconformity that persists, (ibid.). Adolescents, on the other hand, are far more likely to have gender dysphoria that persists into adulthood, (WPATH, 2012, p. 12). Counseling and psychotherapy is made available in much the same way that it is for adults, although family members are often included in this process. The SOC also draws attention to the influence that parents can have on their children. For example, children are explicitly made aware that they do not need to continue gender role exploration as it has been found that some children were afraid to reverse the process after so much had been invested, (WPATH, 2012, p. 17). Medications that suppress sex hormones and thus prevent the onset of the physical changes of puberty can be made available to adolescents, (WPATH, 2012, p. 18, 19). However, full hormone replacement therapy is often delayed. SRS is reserved for those who are capable of providing informed consent (generally at the age of 16) and who have completed a year-long GRE. The entire process focuses on taking seriously the need for children and adolescents with gender dysphoria to begin transitioning prior to irreversible changes.
brought about by the onset of puberty while keeping as many options open as possible by delaying irreversible treatments. Much of the argument that will be made concerning the ethical implications of the GRE will not to apply to the case of treating children and adolescents, as adolescents have ample opportunity to undergo a GRE prior to the availability of surgery, which means there will be no potentially unnecessary delay that prolongs gender dysphoria. The GRE is also appropriate for adolescents because they are less likely to have the experience necessary to make informed choices about surgery without it. As a result they might not be considered competent to make medical decisions and thus a paternalistic approach would be justified.

**Treatment Models and Gender Paradigms**

Ehrbar and Gorton (2010) have referred to the varying forms that treatments take as *treatment models*. While the standard forms of treatment are described above, physicians can make a number of alterations to suit their needs and the needs of their patients. Ehrbar & Gorton (2010) distinguish between conservative and liberal treatment models as well as treatment models that are narrow or broad, (p. 200). Although Ehrbar and Gorton do not explicitly define what they mean by conservative or liberal treatment models, they seem to imply that conservative models are heavier on psychotherapy and are less likely to allow risky treatments until they are deemed fully necessary. Liberal treatment models on the other hand, provide a more egalitarian relationship between patients and physicians and focus more on informed consent as the basis for proceeding with riskier treatments, (*ibid.*). Narrow treatment models attempt to enforce a rigid form of treatment on all patients (regardless of whether or not the treatment model is
considered liberal or conservative), whereas broad treatment models are flexible and can be adapted based upon individual patient need, (ibid.). Ehrbar and Gorton (2010) indicate that countries with publicly funded healthcare are more likely to support narrow or conservative treatment plans, (ibid., p. 202). This seems to be the case in Ontario where access to SRS has been tightly controlled by CAMH in the past and where access to SRS is currently determined by the requirements laid out in SOC. Treatment models can be shaped by “(a) provider values, (b) practice context, (c) understanding of transgenderism, (d) level of experience, and (e) understanding of the SOC,” (ibid., p. 199).

Understandings of transgenderism have changed over the last decade and this has had a notable impact on the way that healthcare providers approach treatment, (Bockting, 2008).

Treatment models were once informed by a binary gender paradigm, (WPATH, 2012, p. 8). For example, if one was assigned a female sex at birth and came to a physician with gender dysphoria, treatment would aim to make the patient’s gender role and body match a traditionally male gender role and identity. Patients could transition to become male or female and nothing in between, (Hage & Karim, 2000, p. 1222-3). There was also an expectation that postoperative patients would be heterosexual, (ibid.). However, treatment models rarely follow this paradigm anymore. Instead, the goal of treatment is to help patients adopt a gender role and body image that is congruent with their gender identities, whatever they may be. The idea that gender is fluid and exists on a continuum instead of existing in a binary configuration has changed the way that treatment is pursued, (Hage & Karim, 2000, p. 1222). This is why patients often stop treatment after psychotherapy or hormone replacement surgery—because they find a
gender expression that is suitable for them, even if this expression does not match traditional gender roles. Physicians no longer expect that all patients with gender dysphoria can have their distress resolved only with a full transition in sex and gender. This gender paradigm has created more realistic treatment plans, where the goal of assisting someone in their gender transition is to help them masculinize or feminize without the expectation of a full transition, (Bockting, 2008, p. 216). However, this paradigm could be problematic because it fails to take seriously the desire of some people to transition into a traditional gender role.

In the article “Psychotherapy and the real-life experience: From gender dichotomy to gender diversity,” Bockting (2008) states: “the wish to have been assigned the other sex and the desire to change sex fully is common, however, in reality, changing sex in such a binary way is neither attainable nor fulfilling,” (p.216). Since available treatments can be inadequate to allow for a completely convincing gender role transition, this view may provide patients with more realistic expectations concerning the outcome of their treatment. However, the fluid gender paradigm does not require that patients abandon traditional gender identities. It should be up to the patient whether or not they wish to attempt to transition into a traditional gender role despite its challenges. In other words, traditional gender roles and identities should be considered valid roles and identities. Some people strongly desire to achieve a gender role and identity that is roughly traditional, (Factor & Rothblum, 2008 as cited in WPATH, 2012, p. 34). Such results are clearly possible in at least some cases. One does not need to look far to find images of people who have transitioned into a traditional gender role and who appear to match our cultural expectations of that role completely (at least in regards to outward
appearances). The fluid gender paradigm is capable of accommodating traditional gender roles while still validating gender identities and roles that are non-binary in nature. As a result, treatment models should be informed by a fluid gender paradigm that is still accepting of traditional gender roles. Different routes through treatment and different understandings of gender, gender dysphoria, and gender nonconformity all impact on whether or not the GRE is seen as valuable.
Chapter 3

The Gender Role Experience

What I have been referring to as the GRE is a requirement found in the SOC for anyone who wishes to have sex reassignment surgeries involving the external reproductive organs. The SOC requires that patients “live continuously for at least 12 months in the gender role that is congruent with their gender identity” prior to approval for surgery, (WPATH, 2012, p. 21). This requirement was once referred to as the Real-Life Test (RLT), (Cascio, 2003). This name reflects the original intent of the GRE, which was intended to help patients develop the resilience required to deal with the social and psychological obstacles that can be involved with changing gender roles. It also acted as a test for patients to see if they were willing to proceed with treatment by allowing them to compare the pleasures of enacting their desired gendered role with the challenges of engaging in a social gender transition, (Levine, 2009, p. 188). Additionally, it allowed physicians to evaluate the readiness of patients prior to hormone therapy or surgery. Subsequent versions of the SOC referred to this requirement as the Real-Life Experience (RLE). What this name was intended to suggest is that patients have some ideal vision of their lives in a new gender role that needs to be tested in reality, (Bockting, 2008, p. 211; Cascio, 2003). In the latest version of the SOC (version 7), this requirement no longer has a name—likely because of the negative connotations that were associated with previous names, (Levine, 2009, p. 190). Despite its lack of name this requirement continues to be a major part of the SOC. The CAMH helpfully refers to this requirement as the Gender Role Experience (GRE), which is a term that accurately describes the process, (CAMH,
The term GRE is helpful as a signpost to refer to this requirement, although it should be kept in mind that this term appears nowhere within the SOC itself.

Patients were required to spend a year, sometimes two years, testing their resolve, building up resilience to social and psychological obstacles, gathering social support for their gender role transitions, and testing their ideal perceptions of gender roles against reality prior to being given access to surgery, (Levine, 2009, p. 188). By resilience to social and psychological obstacles it is meant that patients must learn how to adapt to both external and internalized transphobia. It is likely that people undergoing a gender role transition will not blend seamlessly into their desired gender role, especially early on in the process. As a result, the transition process can be publicly visible which, if the Trans Pulse studies referred to in the previous chapter are any indication, can lead to negative social stigma. This transphobia can also become internalized, leading to thoughts of self-hatred that must be contended with, (Bockting, 2008, p. 216). Levine (2009) states that “the objective aspects that both the patient and the professional should evaluate include the quality of function at work or in school and how the patient has dealt with old friendships, new friendships, spouses, children, parents, siblings, community involvements, health maintenance activities, and recreational pursuits,” (p. 190). The rationale here is that SRS demands a gender role transition and that this transition could be harmful to the patient if it is not pursued carefully—specifically, it can be harmful concerning the ‘objective aspects’ listed above. The GRE allows patients to test whether or not they will be comfortable with this transition prior to undergoing irreversible surgery.
Duration of the GRE

The length of the GRE is currently one year. The SOC offers the following justification for this duration:

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role, (WPATH, 2012, p. 60).

By taking place over the period of a full year the GRE ensures that patients meet challenges in many of the objective aspects that Levine (2009) lists. However, this reasoning might seem weak to those who already feel prepared for surgery. Novel events such as “family events, holidays, [and] vacations,” (ibid.) are likely to persist throughout one’s entire life. The longer one undergoes the GRE the more likely that a wide range of possible challenges will be encountered. By this reasoning we might demand that the GRE persist for longer than one year in order to prepare patients for various long term phases of life. For example, perhaps patients who intend to have children should not pursue SRS before having experienced the challenges of child rearing after a gender role transition. Undoubtedly, extending the length of the GRE will allow patients to develop resilience in the face of new obstacles but at some point patients will have to take an informed risk and proceed with treatment. Furthermore, a lengthy GRE may have a number of harmful effects including the prolonging of gender dysphoria. Suggestions about how long the GRE should last vary from no time to two years, (Levine, 2009, p.
However, there is little evidence available to support durations of any length. (Gijs & Brewaeys, 2012, p.216).

The GRE and the Irreversibility of SRS

The SOC states that the GRE “is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery,” (WPATH, 2012, p. 60). The SOC roughly orders the progression of treatment based upon its reversibility. Since SRS is considered to be the most irreversible and risky procedure, its requirements are the most daunting. The GRE ensures that patients really do want to proceed with a gender role transition before they undergo SRS because it cannot be undone. However, many of the other procedures produce irreversible or partially irreversible changes so it is not clear why SRS has been singled out. For example, hormone replacement therapy creates significant irreversible changes, not the least of which are changes to the genitals that make sexual reproduction very unlikely to be successful in the future, (WPATH, 2012, p. 50). Making the decision to undergo hormone replacement therapy is often also a decision to sacrifice reproductive capabilities. Patients are advised to cryopreserve sperm or oocytes prior to HRT in case they wish to raise children that they are genetically related to in the future, (WPATH, 2012, p. 51). Irreversible changes due to HRT are even more prominent in adolescents since such treatments can halt the progression of puberty: “a special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross-gender hormones. At this time there is no technique for preserving function from the gonads of
these individuals,” (WPATH, 2012, p. 51). The SOC orders its treatment for adolescents based upon reversibility but it seems to overlook exactly how significant this change can be. HRT, even for adolescents who risk losing reproductive capability forever with no opportunity for the cryopreservation of gametes, does not require a GRE and yet this procedure clearly produces significant and irreversible change.

Facial feminization surgeries also create irreversible changes to facial structure but the SOC does not offer any treatment guidelines for these surgeries, nor does it require a GRE prior to these surgeries. Breast augmentation and chest contouring surgeries make permanent, irreversible changes to the body but they too do not require a GRE. In fact, even some surgeries involving the reproductive system do not require the GRE. Hysterectomies (removal of the uterus), salpingo-oophorectomies (removal of fallopian tubes and ovaries) and orchietomies (removal of testicles) all do not require the GRE and are obviously irreversibly given our current medical technology, (WPATH, 2012, p. 59-60). Thus, while irreversibility is cited (Bockting, 2008) as the reason why one would be required to undergo the GRE for particular SRS surgeries, this does not seem to be consistent throughout all of the possible procedures. SRS could require special consideration in terms of surgery because it can cause the inability to produce genetically-related offspring, whereas other forms of surgery do not have this problem. However, as already suggested, hormone therapy also has this problem with irreversible infertility and it does not require the GRE.

Furthermore, the GRE causes irreversible changes in a patient’s life. Coming out to family members as having a gender identity that is incongruent with the gender that they have come to expect is an irreversible action with major consequences. Coming out,
which is required by the GRE, also requires exposing that one has severe gender
dysphoria in need of surgical intervention. This is an irreversible revealing of information
that can have lasting implications in the significant relationships in a patient’s life
(Ehrbar & Gorton, 2010, p. 200). Whereas, genital SRS could be potentially hidden in
such a way that it does not affect certain relationships, the GRE requires just the opposite:
a purposeful revealing of gender identity to all of those within one’s life. This may cause
irreversible damage to one’s relationships, especially in localities that are more culturally
conservative. As a result the GRE, which is intended to ensure that patients are ready for
irreversible change, creates irreversible change itself—change that can be even more
noticeable and impactful than surgery.

The Relationship between SRS and a Change in Gender Role

While the risks involved in hormone replacement therapy and SRS are daunting
the SOC suggests that the psychological and social ramifications of a gender transition
tend to be far more troubling, (WPATH, 2012, p. 30). The GRE is intended to prepare
patients for a permanent change in gender role. This assumes that anyone who requires
SRS must also undergo a change in social gender role. However, it is not obvious that
SRS forces patients to make permanent changes to their gender role. While many patients
will seek out SRS in order to reinforce the expression of their gender identity, it is
conceivable that a patient would desire to have SRS without any desire whatsoever for a
change in gender role, (Lawrence, 2001). The fluid gender paradigm that informs most
treatment models today (including those laid out by the SOC) is entirely compatible with
a gender identity that requires SRS but no major change in social gender role. Patients
who would require SRS but no corresponding change in gender role would still be required to undergo a year-long GRE.

This raises questions about how we can even assess a GRE using the fluid gender paradigm. Should we expect that patients who strongly desire vaginoplasty enact a gender role that is feminine? If not (and I think we cannot if we take the fluid gender paradigm seriously), then how will we be able to enforce any kind of GRE? The way the SOC describes the difficulty of the GRE seems to imply that remarkable changes in gender role should occur. If this is the case then there might be a hidden assumption that patients who wish to undergo phalloplasty or vaginoplasty are expected to take on the gender roles that are traditionally associated with these forms of genitalia, which would stand in contrast to the fluid gender paradigm that the SOC espouses. Lawrence (2001) points out: “it may be that in the case of transsexuals, we have paid too much attention to gender role, and too little attention to the dysphoria associated with the sexed body.” Since the SOC never allows the GRE to be jettisoned from a treatment plan it seems that somatic dysphoria—that relating not to gender role but to the body—has been ignored. In cases such as these the GRE is nothing more than “an irrelevant barrier to care,” (Lawrence, 2001).

**Preventing Post-Surgical Regret**

Another benefit of the GRE is said to be that it reduces post-surgical regret, (Bockting, 2008). The history of the GRE has been tracked down to a brochure that attempts to justify a two year long GRE at gender clinics due to two previous cases in which patients who experimented with gender roles prior to surgery ultimately decided
that surgery was not for them, (Cascio, 2003). The GRE seems to have been a test to ensure that patients do not make a decision regarding surgery that they would later regret. The GRE continues to be measured by how much regret patients have after surgery. Since the SOC has been implemented, regret after SRS has been very rare, (WPATH, 2012, p. 107). However, there seems to be no empirical evidence to suggest that the GRE is the cause for this, (Gijs & Brewaeys, 2012, p.216; Lawrence, 2001; Levine, 2009). In fact, there have been studies to suggest that GREs that are less than one year in length do not have any increased incidence of regret, (Lawrence, 1997 & 2001). Some studies also report that patients have expressed regret after surgery even though they have had lengthy GREs, (Kuiper & Cohen-Kettenis, 1998 as cited in Lawrence, 2001). These studies have samples sizes that are likely too small to provide adequate generalizations. However, they do demonstrate the possibility that the GRE does nothing to reduce the incidence of regret.

**Equating the GRE to a Gender Transition**

It has been suggested that the GRE is identical to the process of a gender transition, (Levine, 2009, p.190). A gender role and/or sex transition is a common process in which people who are gender nonconforming adjust to their new sex or gender role as they attempt to make changes such that their gender expression is congruent with their gender identity. The overall process in which one makes bodily changes and gender role changes in order to live in such a way that matches gender identity is colloquially referred to as a transition. This process can include the treatments outlined for gender dysphoria earlier, and often includes “coming out”, *i.e.* notifying friends, family, and
coworkers that a gender transition will take place and adapting to new social expectations that can come along with a change in gender role. Since the transition process is well established among those who are gender nonconforming some have attempted to equate the GRE with transitioning in order to suggest that it is essential, (Levine, 190). The GRE is distinguished from a transition in several ways. First, the GRE only occupies some of the social and psychological aspects of a transition over a limited duration. A gender role transition can be a lengthy process that takes many years and does not necessarily stop at the conclusion of medical treatment. The GRE is also reserved for those who wish to undergo SRS, whereas a gender role transition is open to anyone who is gender nonconforming and need not be associated with medical treatment at all. Second, the GRE is documented, enforced, and judged, whereas a gender role transition in general need not be any of these things. The GRE is imposed upon those who seek medical care. If a patient fails to document the GRE adequately or if they seem to have not engaged in it as seriously as healthcare providers would like, then they can be denied access to care. This is not to say that the GRE is always a bad thing. Patients can voluntarily accept the GRE process and it might benefit them. In some cases the GRE is beneficial even if it is forced upon patients—perhaps for patients who are under-aged. In this case a forced delay in surgery could create more benefit than harm. However, the GRE cannot be equated to the transitioning process as a whole.

**Informed Consent**

Finally, the GRE is said to be necessary to ensure adequate informed consent, (CAMH, 2016). We might need to assume that SRS demands a permanent and immediate
change in gender role in order to understand why this might be the case. The physical complications for SRS can be easily discussed like any other surgical procedure. The GRE in particular is supposed to help patients become informed about the pyschosocial implications of SRS. However, it is not clear that there are such implications. Any changes made in the structure of one’s genitalia can be easily hidden from most others on a day-to-day basis so unless we assume that SRS also forces a change in gender role SRS will only have a psychosocial impact in select circumstances when genitalia are exposed to others. We should not belittle the distress that can be caused in just these instances.

The Trans Pulse survey shows that access to medical care and spaces such as washrooms and change rooms, where exposing of the genitals might be expected to occur, does provide a significant level of distress for many transgender people, (Bauer, 2013; Trans Pulse 2014). However, this distress alone does not warrant a year-long GRE. If we do assume that SRS must be coupled with a significant change in gender role it is still not entirely clear why SRS needs to be the final stop in one’s transition. Why must patients be fully prepared (and thus, require the GRE) at this point of their transition in particular? Again, if the reason is because SRS will cause irreversible changes, then many forms of treatment for gender dysphoria would require the GRE.

It has been suggested by CAMH (2016) that the GRE is a part of the process of informed consent—although, the SOC in particular does not make this claim. Informed consent is intended as a response to paternalism. It is intended to shift power away from physicians in favour of patients. Since informed consent is a part of the process to empower the patient’s decision-making process it seems counter-productive that the GRE, as part of the process for informed consent, would throw up such a significant
barrier blocking treatment that is requested by patients. Rather than being a part of informed consent, the GRE seems to be a form of strong paternalism—it is a requirement that is forced upon competent patients supposedly for their own good. It is not clear why a patient must experience the implications of a gender role change in order to understand what they are giving consent to in terms of a surgical intervention. There may be other benefits of this experience but it does not seem as if informed consent in particular would require this. Rather, a simple education—perhaps over several sessions with ample time for reflection—would provide an adequate stand-in for the GRE in terms of informing patients well enough so that they can make good decisions concerning SRS.
Chapter 4

Paternalism and Competent Patient Choice

It can be more important for individuals to be self-determining than it is for them to do what is medically best for them, (Young, 2009). Normally, it is desirable to achieve the best medical results possible because this ensures good health, which is incredibly important because it helps to minimize suffering and maximize the options available for people to be happy and engage in meaningful activities. Lowry and Schuklenk (2009) state that “nearly every valuable human activity is ultimately supported by health and undermined by illness,” (p. 277). They argue that good health is strongly correlated with happiness, economic prosperity, access to liberties, and equality of opportunity, (ibid.). While the purpose of medicine remains highly debatable it is not unreasonable to suggest as a starting point that its purpose is to minimize suffering as it relates to illness and to “optimize the patient’s chances for a happy and productive life,” (Garrett, et al., 1998 as cited in Collier & Haliburton, 2011, p.65-6). However, it should be kept in mind that inasmuch as pursuing good health is intended to reduce suffering and promote chances for happiness, there could be other pursuits that will better achieve these goals under certain circumstances. As a result, optimal medical outcomes could be generated at an unacceptable cost, for instance when other considerations of value are taken into account, such as self-determination or autonomy, which can be valued to such an extent that they outweigh what is “medically best” for a patient, (Young, 2009).
Autonomy and Competent Patient Choice

Autonomy can be valued intrinsically (whereby having the freedom to make decisions for ourselves is seen as integral to human flourishing) or instrumentally (where the freedom to choose allows us to pursue other objects of value), (Collier & Haliburton, 2011, p. 91). If ensuring that individuals retain their autonomy is vital for their flourishing or if it allows them to pursue other objects of value—perhaps identity formation and expression—then autonomy should be preserved if possible. In the context of healthcare this means that competent patients should be allowed to make their own choices about their bodies and healthcare without having choices made on their behalf without their consent. This includes taking medical risks that might or might not result in improving quality of life, (Mohr, 1987). SRS is one such medical risk that is known to improve the quality of life for some of those who are gender nonconforming. Relieving the distress of gender dysphoria provides the medical justification for SRSs. However, it is also reasonable for patients without the distress of gender dysphoria to make changes to their bodies or gender roles such that they are more congruent with their gender identities. This course of action can be highly desirable for self-determining individuals despite the medical risk it presents.

Paternalism

Paternalism can be justified in medicine when there is strong evidence to suggest that patients will derive a great deal of benefit from choices that are made on their behalf by healthcare professionals. Normally, weak paternalism is required when patients are incapable of understanding the consequences of medical choices—i.e. they are not
competent when it comes to making the relevant medical decisions. As a result, weak paternalism is required in order to make decisions on behalf of the patient that will produce the best medical outcomes for them because this will be the most likely way to ensure that no harm comes to the patient. The assumption here is, of course, that there are objective best patient interests that can be so satisfied.

On the other hand, a patient who is competent will be able to consider what is medically best for them, and balance this against other considerations of value, which suggests that they will be capable of determining when procedures that produce good medical outcomes conflict with other goals that they may have, (Young, 2009). In liberal democracies competent patients are generally taken to be the best judges about how medical treatments and their associated costs fit into their overall life goals. For this reason, and in order to preserve patient autonomy generally, it is usually best for patients to control the course of their own medical treatments. Strong paternalism occurs when a choice is made for patients even when those patients are competent enough to make medical choices on their own, (Collier & Haliburton, 2011, p. 91). Strong paternalism can be appropriate if the medical decisions made on behalf of patients are likely to provide such a great benefit that other considerations outside of what is medically best are unlikely to produce greater utility than that which is provided through medical care. This line of argumentation must use a classical interpretation of utility (i.e. maximizing pleasure and minimizing pain as manifested through beneficence and non malfeasance) since strongly paternalistic requirements likely fail to meet the demands of alternative
interpretations of utility.\textsuperscript{10} Given the importance placed upon patient autonomy it is very
difficult to justify strongly paternalistic positions.

The GRE is strongly paternalistic since it is forced upon typically competent
patients who wish to undergo SRS (a sometimes vital part of treatment for gender
dysphoria). Since the GRE is a strongly paternalistic measure in that it interferes with
patient autonomy (when it is not sought out voluntarily), it requires ethical justification.
One way to justify the GRE is to suggest that patients who seek out SRS are not
competent and thus require a forced medical intervention. This could be the case with
adolescents who are gender nonconforming and have not yet had the experience that is
required to fully understand the consequences of SRS and a corresponding change in
gender role.

It may also be the case that adult patients are considered incompetent in terms of
understanding the consequences of SRS and a corresponding change in gender role
because the change in gender role presents patients with obstacles that cannot possibly be
understood in advance. While information can be presented to patients about SRS and the
challenges that could arise during changes in gender role, how these challenges will
manifest in a patient’s life will not be known until they occur. It is often assumed that
SRS will be accompanied by a significant change in gender role and thus, SRS is distinct
as a form of surgery in that it will have extensive and unpredictable psychosocial
consequences. However, this distinction is overblown—both because SRS need not

\textsuperscript{10}The strong paternalism of the GRE is unlikely to be supported if preference satisfaction is used as a
measure of utility since we are dealing with competent patients who presumably have all of the relevant
facts available to them and who have adequate time for rational reflection concerning their preferences.
Thus, if such patients (having undergone such reflection) still prefer to avoid the GRE in their pursuit of
SRS then their utility is maximized only through having this choice supported unless this choice conflicts
with the preference satisfaction of others in some comparatively meaningful way.
always be associated with a change in gender role and because the consequences of any surgery cannot be fully understood by the patient until they have actually occurred. Lacking this knowledge does not make patients incompetent in terms of making choices about medical treatments.

If we assume that patients who seek out SRS are competent in that they are capable of understanding the consequences of SRS and any associated gender role transition to a reasonable degree, then the GRE is a strongly paternalistic requirement since it forces competent patients to take a course of action against their will (provided that the requirement is not pursued voluntarily). Since there is little reason to believe that patients with gender dysphoria in particular are incompetent when it come to making medical decisions (unless, of course, the nature of a gender role transition is so complicated that no one would normally be considered competent to make medical choices regarding SRS) the GRE must be considered strongly paternalistic and would thus require significant ethical as well as legal justification. The GRE must be justified by providing patients with a great deal of utility, such that it outweighs non-medical considerations that may be sought out by autonomous patients who wish to avoid the GRE. The GRE is said to accomplish this by providing better surgical outcomes, by reducing post-surgical regret, and by providing patients with the preparation required for a change in social gender role that is thought to accompany SRS, (Cascio, 2003; Cohen-Kettenis, 1998; Levine, 2009). A large portion of this chapter is dedicated to examining this claim.
Non malfeasance

The GRE is supported on the basis of non malfeasance. Before surgeons can damage and reconstruct otherwise healthy anatomical structures (which would be considered a harm done to the patient) they must be sure that doing so is justified on the basis that surgery is likely to improve the quality of life for patients with gender dysphoria. Surgeons must also ensure that patients are prepared to handle the consequences of surgery, and that patients are fully aware of what they are seeking out when they request SRS. Michael Brownstein (2009) states in an article contributing to the SOC that “the guiding principle of medical practice, and surgical practice, is ‘first do no harm,’ *primum non nocere*,” (p.220). The GRE is intended to minimize the harm done to patients through sex reassignment surgery by ensuring that patients: are well informed about the difficulties of a gender role transition, have developed resilience to negative social stigmata and the unique challenges that are presented to those who change their gender presentation, and are given ample time to reconsider SRS—thus reducing the incidence of post-surgical regret, (Levine, 2009, p. 188; WPATH, 2012, p. 60). The GRE gives patients an opportunity to “come out” to family, friends, community members, and coworkers, which allows patients to develop support networks and to come to terms with the social difficulties of transitioning gender role. The GRE can allow those with gender dysphoria to experience what life would be like while living full-time in a new gender role, which might contrast sharply with expectations, (Levine, 2009, p. 188). For example, it is better to find out prior to SRS that family members refuse to accept or support a gender transition so that patients have the opportunity to find alternative social supports or to decide that they do not wish to proceed with SRS after all. Finally, the
GRE is said to be correlated with better surgical outcomes—a claim that shall be challenged due to the lack of empirical evidence in support of it, (Levine, 2009).

The benefits of the GRE as a preparatory requirement for SRS depend on connecting SRS to a change in gender role. If no change in gender role is required then the GRE will offer little benefit other than time to reflect on the decision to undergo surgery. Although, Brownstein (2009) claims that “the real-life experience [the GRE] is important as an indicator of the patient’s motivation, resolve, and adjustment, factors that suggest that reassignment surgery, if desired, will have a favorable outcome when performed competently,” (p. 220). This suggests that the GRE also functions as a test of character and level of desire, which supposedly indicates better surgical outcomes, according to Brownstein, (ibid.). While the GRE may be a good indicator of these traits in a patient, it is not necessary to purposely erect barriers in order to force patients to prove it.

The potential benefits of the GRE could make it a useful experience for some patients. However, it is not clear that these benefits provide a strong enough justification for autonomy overriding strong paternalism. Additionally, I shall demonstrate that the GRE can cause more harm than benefit. Thus, non malfeasance, which is thought to be the ethical justification in favour of the GRE (Levine, 2009 p. 187), actually requires that the GRE is avoided in many cases. First, the GRE causes harm if it delays SRS and prolongs gender dysphoria in patients as a result. Second, the GRE can cause harm if a patient’s gender identity does not require a significant shift in gender role but still requires SRS, (Lawrence, 2001). Other concerns about harm that are caused by the GRE include: breach of privacy, having to overcome obstacles to access healthcare, and forced
exposure to dangerous situations due to social stigma. If any of these concerns about the potential harms caused by the GRE are true then the justification of the GRE as a measure to reduce harm becomes even weaker. This will undermine support for the GRE as a strongly paternalistic requirement that is said to be required due to concerns of non malfeasance.

**Delay in Surgery**

Requiring patients to undergo a gender role experience can delay desperately required surgery. Often it is in the patient’s best interest to undergo one year of hormone replacement therapy prior to SRS because it can improve surgical outcomes by introducing the body to the suppression of sex hormones, (WPATH, 2012, p. 60, 106). If the year-long GRE occurs during this time, or if the GRE occurs while patients are on a waitlist for surgery, then it may be likely that no additional delay prior to surgery will occur as a result of the GRE. However, the GRE will cause additional delay if patients have failed to undergo the GRE during hormone replacement therapy or if patients cannot take hormones due to contraindications. It is also unlikely that patients will be allowed to undergo the GRE while on a surgical waitlist since approval would be required beforehand. Delaying surgery can cause psychological, social, or even physical harm to patients if it prolongs gender dysphoria (the Trans Pulse survey described above lists some specific harms that can come about as a result of gender dysphoria). Therefore, delaying surgery requires justification, whether it is practical or otherwise. Some reasons why surgery can be delayed are: wait times for initial assessments, lack of funding, surgical waitlists due to lack of available surgeons, or the requirement for hormone
replacement therapy prior to surgery. While these reasons might not be ideal, they often cannot be helped. However, removing the requirement for the GRE is one way to reduce wait times for SRS, thus reducing the time that patients must endure gender dysphoria. Inasmuch as the GRE prolongs gender dysphoria by delaying surgery it constitutes harm done to the patient—whether or not this harm is offset by the benefits of the GRE.

The GRE without a Change in Gender Role

There are various treatment pathways available for those who are gender nonconforming and experience gender dysphoria, (Ehrbar & Gorton, 2010). However, “...the single combination that is precluded by the SOC is genital surgery without social transition,” (Ehrbar & Gorton, 2010, p. 204). It is possible that patients have gender dysphoria that can be resolved through SRS but not through a shift in gender role, (Lawrence, 2001). Again, if we are to adopt a fluid gender model and do not assume that a change in genitalia must be accompanied by a related change in social gender role then this possibility should not be excluded. For such patients a GRE would not be helpful. It would cause unnecessary delay in surgery, which would prolong gender dysphoria. It might also encourage patients to undergo changes in gender role that are not congruent with their gender identity—a practice that is now largely considered to be ineffective and unethical, (WPATH, 2012, p. 16). In cases such as these the GRE cannot be justified and should be avoided. If it is not avoided then it exposes patients to all of the risks of the GRE while providing none of the benefits (aside from time for reflection about surgery). This undermines the purpose of the GRE as a measure to avoid causing harm.
Privacy

Assessment of the GRE also includes documenting that the change in gender role has been successfully enacted on a full-time basis, (Blanchard & Fedoroff, 2000). Some clinics, such as CAMH, require that the patient provide documented proof that they have engaged in the GRE prior to being approved for SRS. 11 This means that the patient must provide a letter from some member of the community that has witnessed the patient engage in a full-time gender role transition for one year. The letter provider cannot be a healthcare professional treating the patient since they are unlikely to have continuous contact with the patient. Family and friends are also not considered to be eligible due to possible bias and to ensure that patients have expressed their gender identity within the greater community. This leaves patients looking for letters from places of employment or education, which requires that patients explain their gender transition process to others who might be in a position of power over them. While such letters can be acquired without much hassle by some patients this requirement may leave other patients vulnerable to a breach in privacy especially if there is not a noticeable change in gender presentation. While someone who is transitioning from a traditional female gender role to that of a traditional male role (or vice versa) might present obvious cues to coworkers and members of the community due to changes in clothing, mannerisms, etc., more subtle changes in gender role such as the case outlined in the previous paragraph might not be visible to employers or members of the public. Patients in these cases will need to expose their desire for SRS to members of the public, such as an employer, in order to obtain

11 The SOC also indicates that documentation may be required, stating that clinics “may communicate with individuals who have related to the patient in an identity-congruent gender role,” as part of the documentation process, (WPATH, 2012, p. 60-61).
documented proof of a GRE even when they have no intention of making changes in gender role. As a result, requiring documentation for the GRE can reveal the private health information of patients to members of the public unnecessarily—and since there is a strong social stigma attached to those who are gender nonconforming, releasing this information presents a number of risks to patients.

The GRE as an Obstacle to Medical Treatment

The GRE can also be considered harmful since it acts as an obstacle that patients must overcome to gain access to healthcare. This depends on how one views the GRE—either primarily as a requirement that needs to be met prior to surgery or as a healthcare service in of itself—although, it can be difficult to see the GRE as the latter since it is often left to the patient to accomplish without much oversight.\(^1\)\(^2\) Even if we consider the GRE to be an obstacle to healthcare it might be a justified obstacle in some cases—such as the case with adolescents who wish to access SRS in addition to pursuing a significant change in gender role.\(^1\)\(^3\) Purposely erecting an obstacle to accessing medical treatment can be justified if doing so will increase overall utility. For example, forcing adolescents to gain experience in a new gender role when they could not have had the time to do so otherwise may increase utility by ensuring that they have the information necessary to make competent choices concerning their healthcare. However, there is something important to say about the GRE as an obstacle to care within the context of transgender

\(^{12}\) The SOC highly recommends psychotherapy to go alongside hormone therapy and surgery but does not require it outside of initial assessments and diagnosis, (WPATH, 2012, p. 28). As a result, it is not required during the GRE period. It is also unlikely that psychotherapy specifically geared towards gender transitions will be available in smaller cities—although support groups are likely available.

\(^{13}\) Even in cases such as these it might be better to avoid the GRE if it is likely to cause harm. See chapter 5 for more detail concerning cases in which the GRE should be avoided.
health. People who are gender nonconforming routinely encounter barriers in accessing healthcare. First, it can be very difficult for those with gender dysphoria to receive adequate treatment for gender dysphoria in particular. Local physicians can be (and often are) untrained in providing treatment for gender dysphoria, (Tom Waddell Health Center, 2013). As a result of this lack of experience physicians in Ontario usually refer patients to the CAMH to seek treatment, which has a two-year long waiting list for a first appointment, (CAMH, 2016). This is prior to the beginning of hormone replacement therapy, let alone SRS.

In addition to accessing care for gender dysphoria people who are gender nonconforming often face generalized discrimination in the healthcare system, (Bauer, 2013). Physicians have shown disgust towards transgender patients, have refused them treatment, and have refused to address patients using pronouns that are congruent with their gender identities—an experience that can be exposing and humiliating, (Bauer, 2013; Films Media Group, 2009). It has also been found that it is very common for transgender people in Ontario to avoid accessing healthcare services—especially emergency services, (Bauer, 2013). This problem is made worse given the power differential in the patient-physician relationship. Gender dysphoria can be very distressing and most of the treatments available are under the control of physicians. This leaves physicians with an enormous amount of power over their patient’s lives, (Bockting, 2008, p.215; Ehrbar & Gorton, 2010, p. 204-5). Bockting (2008) argues that the ‘gatekeeper’ function of the healthcare provider may be beneficial because “it can be used to encourage clients to confront fears or other issues that one would rather avoid (e.g., coming out to certain family members),” (p. 215). It could certainly be the case that
withholding treatment will force patients to confront challenges that they would rather avoid but it is another question whether or not it is the physician’s place to force this confrontation. Patients who fail to meet these challenges could be denied access to SRS. This creates a situation where the patients who have the worst social supports, who are least capable of adapting to social stigma and gender dysphoria, and who are the most downtrodden in general, are the ones who are denied care. It is unreasonable to expect patients to engage honestly and openly with physicians when physicians yield this kind of power and when there is a history of discrimination and neglect when accessing healthcare for people who are gender nonconforming.

Ehrbar & Gorton (2010) argue that patient values and expectations can differ from those of care providers and that providers should discuss their treatment models with patients up front so that patients can choose a different physician if there is a conflict, (Ehrbar & Gorton, 2010, p.198). They also state that “no one provider or treatment model is a perfect fit for every client, and it is beneficial to have a range of different treatment models available within a health care system,” (Ehrbar & Gorton, 2010, p.199). However, since there are still very few physicians who will treat gender dysphoria patients do not often have the choice to switch physicians if they receive inadequate care or if their values do not mesh well with the treatment models proposed by physicians. A patient’s only chance for treatment and relief from gender dysphoria may lie with a single physician, which places a great deal of control with that physician. This can have important implications for the patient-physician relationship. Patients whose treatments are completely under the control of a single physician might be willing to undergo requirements such as the GRE simply because they are desperate for treatment. This can
make it difficult to negotiate a fair treatment plan or it could encourage inaccurate 
reporting of information from patients since they might be dishonest in an attempt to 
continue treatments.

This is the context in which patients attempting to gain treatment for gender 
dysphoria encounter the GRE, which places yet another obstacle before their care. While 
something like the GRE can be a justifiable barrier to treatment in other contexts, within 
this context, where patients have routinely encountered barriers, it might not be 
appropriate. At the least, when putting up the additional barrier of the GRE—which can 
be an intense, year-long process that is intended to build resilience by purposely exposing 
patients to psychologically and socially difficult situations—careful consideration should 
be made whether or not the GRE will benefit patients enough to overcome the harm it 
produces.

Effects of the GRE on Family

Friends and family members are also strongly affected when someone undergoes 
202). It can be very difficult for friends and family to adjust to a person’s new gender 
role. There could be feelings of loss or family members may feel like they did not really 
know the gender nonconforming person because they were not aware that they had a 
hidden gender identity, (Bockting, 2008, p. 216). Friends and family can also share in the 
stress of a transition if it occurs—for example, they might need to console the gender 
nonconforming person as they deal with gender dysphoria or they might need to advocate 
on behalf of the gender nonconforming person in the face of social stigma. Gender
transitions can be difficult for friends and family members either way but the GRE may increase this difficulty unnecessarily. The GRE can cause harm by encouraging or forcing patients to disclose their gender transition to friends and family members who might not be well prepared to receive this information. For example, in more conservative cultures the idea that a family member is transitioning gender can be very distressing. Since the GRE requires a full-time expression of a new gender role it does not allow patients to be selective about whom they disclose their gender transition to. This is likely to cause unnecessary distress for patients or their family members. While being forced to disclose gender identity could help patients develop resilience and recognize social supports, it is likely that being selective about whom to disclose gender identity will still enable patients to develop some measure of resilience while recruiting more effective social support by withholding information from parties who are unlikely to be supportive.

The Inflexibility of the GRE as a Process of Gender Transition

If we do not view SRS as the final step in a gender role transition then there is no need to ensure that patients live full-time in a gender role that conforms to their gender identity prior to surgery. Viewing SRS as an end-point (and thus requiring the GRE before allowing access to surgery) can force patients to complete a gender role transition before they are ready in an attempt to reduce the delay before surgery. It is not clear why

---

14 It may be argued that gender transitions can decrease aggregate utility within a family—i.e., reduce overall happiness by exposing family members to painful situations. However, given the severity of distress that gender dysphoria can provide for a gender nonconforming person, it is unlikely that the additional pain suffered by family members will compare to the pain of gender dysphoria. As a result, it is almost always better in terms of generating aggregate utility for a person with severe gender dysphoria to proceed with a gender transition.
SRS needs to be considered a finishing point in a gender transition just because it is perhaps the end of medical intervention. Gender transitions may run more smoothly if patients can adapt to their new gender role gradually throughout their lifetimes rather than directly before surgery. For example, Bocking (2008) states: “for adult clients, coming out in the workplace is usually the last step in transitioning to living full-time in the desired gender—role. This step needs to be timed appropriately in the pacing of the entire coming-out and transition process. Social support must be in place before confronting this step, which may be particularly risky as it involves the client’s livelihood,” (p. 217). Harm might be minimized if the patient can choose the appropriate time and place to express their new gender role without being forced into a full-time transition. This is consistent with a gender transition without the GRE. While a careful coming out can be planned within the GRE, the requirement that the GRE is a full-time experience lasting one year suggests that the timing of this experience begins after changes are made to gender expression in the work place, which would serve to cause further delay in treatment.

The GRE is Superfluous for Prepared Patients

The GRE might not be justified in cases in which the patient can demonstrate a clear understanding of the challenges of SRS and any associated change in gender role and has developed an adequate plan to deal with potential challenges that can arise. Such an understanding may be acquired through educational sessions or experience. Often, patients who approach their physicians have already thought carefully about whether or not they wish to transition gender long before beginning even the first steps of the
treatment process, (Tom Waddell Health Center, p.6). This could be due to the difficulty of coming out to a healthcare provider, which can be compounded by both external and internalized transphobia. Given that many transgender people are hesitant to access healthcare services due to a general lack of knowledge among healthcare providers about the needs of gender nonconforming patients (Bauer, 2013; Films Media Group, 2009) it would not be surprising if patients develop a strong knowledge base before approaching healthcare providers. It is not unusual for patients with gender dysphoria to understand dysphoria and its treatments better than their physicians or therapists, (Bauer, 2013; Hage, Karim, 2000 p. 1224). Patients who have adequate knowledge or experience, and/or who have explored matching their gender role with their gender identity prior to any official GRE may be harmed by the imposition of this requirement since it would provide little to no further benefit and possibly prolong gender dysphoria without appropriate justification. In cases such as these utility is maximized when the GRE is avoided since the purpose of the GRE has already been met through other means.

**Lack of Empirical Evidence Supporting the GRE**

Considering that the GRE can be harmful to patients in a number of ways it is not clear that it is justified as a measure to ensure non malfeasance. Perhaps the most significant way in which the GRE is said to reduce harm done to patients is by improving surgical outcomes. Prior to the SOC surgical outcomes for SRS indicated that surgery was unsuccessful at improving the quality of life of patients, (WPATH, 2012, p. 107). However, since the SOC has been introduced, surgical outcomes have improved significantly, (ibid.). Because the GRE is a part of the SOC it is assumed that the GRE is
partly responsible for the improved surgical outcomes. However, it is often stated that the GRE currently has no empirical evidence to support its benefits, (Lawrence, 2001; Levine, 2009). Very few (if any) clinical studies have found a strong correlation between the GRE and improved surgical outcomes, (Levine, 2009). Rather, the GRE is supported by the opinions of clinical experts, (ibid.), which is the best evidence available in support of the GRE so far.

While there is no empirical evidence to suggest that the GRE improves surgical outcomes there is limited data to suggest that the year-long GRE is unnecessary or even harmful. One small study by Lawrence (2001) surveyed 13 transgender patients who underwent a GRE that was shorter than the standard one year length. None of the patients regretted undergoing SRS and only one of the patients regretted having a shorter GRE, stating that while a year-long GRE would be excessive, it still would have been beneficial to have additional time for reflection, (Lawrence, 2001). Another patient (who did not regret having a shorter GRE) stated that a disadvantage of avoiding a year-long GRE was having too many treatments in too short of a time, (ibid.). Some of these patients felt that the GRE was a harmful experience. For example, one patient required SRS but no change in gender role—which made the GRE superfluous, (ibid.). Others were concerned about the effect of the GRE on their employment prospects—they felt that transitioning in their local areas would likely result in being fired from their places of employment. Some benefits of avoiding a year-long GRE were “reducing fear of physical harm; pursuing significant relationships; and perhaps most important of all, achieving personal comfort,” (ibid.). An earlier study by Lawrence (1997, as cited in Lawrence, 2001) found that 18 patients who underwent a GRE of less than one year (including no GRE at all) had no
post-surgical regrets. The sample sizes of these studies are too low for generalization but it does indicate the possibility that the year-long GRE does not reduce the incidence of post-surgical regret any more than GREs of shorter duration or when patients fail to undergo the GRE at all. This draws into question the claim that the GRE is justified because it reduces post-surgical regret, (Levine, 2009).

While it might not be directly related to the ethical problem in question (i.e., whether or not the strong paternalism of the GRE requirement is justified), the lack of empirical evidence supporting the GRE raises other important ethical problems. In an article concerning ethical questions surrounding SRS, Brownstein (2009) states that: “The Code of Ethics of the American Society of Plastic Surgeons (2007) includes the statements that ‘physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion,’ and ‘physicians should practice a method of healing founded on a scientific basis, and should not voluntarily associate professionally with anyone who violates this principle’ (pp. 310–313),” (p. 221). It seems that the SOC could require that surgeons break this code of ethics. If surgeons require that patients undergo the GRE and there is no empirical evidence to suggest that the GRE is correlated with better surgical outcomes, then using the GRE could be scientifically unsound. Using the GRE may still be valid based upon clinical experience—that is, “expert opinion that is not based on research”—but this kind of knowledge tends to vary considerably based on locale and is very uncertain according to Levine, (2009, p. 187). Levine (2009) claims that “since our field has not been supported by consistent significant funding, it is quite difficult to move beyond expert opinion,” (p. 187) and that “professionals who employ the RLE [GRE] as a firm requirement should realize that their
policy belongs to the tradition of clinical art rather than clinical science,” (p. 187).\textsuperscript{15} However, if surgeons claim to “practice a method of healing founded on a scientific basis” and yet enforce the year-long GRE which has little scientific basis, then it is not clear that they are maintaining the standards of the Code of Ethics, (Brownstein, 2009). Of course, when new treatments are proposed it might not yet be possible for them to have a strong scientific backing. However, the GRE has been in use for decades with no significant study. Practicing evidence based medicine could require that we “discard this requirement until there is persuasive evidence that it is important,” (Lawrence, 2001). SRS in general has had a less than ideal number of studies devoted to it. In fact, Levine (2009) claims that no part of treatment for gender dysphoria has evidentiary support beyond that of expert opinion, (p. 187). However, several reviews covering nearly 100 studies have found reduced gender dysphoria and favourable outcomes after SRS, (Gijs & Brewaeys, 2012, p. 184). It is not clear what role the GRE plays in these outcomes, if any.

Levine (2009) claims that the lack of scientific evidence supporting the GRE creates two ethical problems:

\begin{itemize}
  \item First, the principle of [non malfeasance] reminds us to “above all, do no harm.”
  \item The employment of the scientifically unsubstantiated requirement of a RLE [GRE] can be a needless, cruel, and harmful obstacle for patients who are eager to use hormones or undergo genital surgery. Second, the principle of Respect for Patient Autonomy reminds us that the imposition of a scientifically unfounded RLE may
\end{itemize}

\textsuperscript{15} Levine makes this claim on the basis that there are no peer-reviewed articles published concerning the GRE. While expert opinion does contribute to evidence based medicine, Levine considers this type of evidence to be of the lowest admissible quality, (Levine, 2009. P. 187).
be a disrespectful abrogation of allowing for patient self determination

(Roberts & Dyer, 2004), ” (p. 186).

Levine finds neither of these arguments convincing, (ibid., p. 187). He claims that while the GRE has no scientific backing, no other components of the treatment for gender dysphoria do either. However, several studies supporting the effectiveness of SRS existed at the time, and many more have been published since Levine’s article, (Gijs & Brewaeys, 2012, p. 184). As a result, the GRE stands alone as part of the treatment process that lacks at least some publicly available scientific backing. He also argues that non malfeasance is actually the reason for the GRE to begin with, (Levine, 2009, p. 187). He states: “such arguments reflect the long-standing ethical tensions inherent in clinical encounters in which the patient wants immediate access to hormones or SRS and the professional wants to follow a colleague-honored step-by-step procedure,” (ibid.). It is not clear how Levine’s argument (that both those for and against the GRE appeal to non malfeasance) should convince us that these ethical problems are not relevant. It is true that SRS requires that we should consider what harms may come to the patient as a result of such surgery and do our best to guard against it. However, as has been demonstrated in this chapter, the GRE is not be the most effective route to do so since it can cause more harm than it prevents.

The GRE is intended to minimize the harm caused by SRS by ensuring that patients are well prepared for surgery and for associated changes in gender role. It is also intended to reduce the incidence of post-surgical regret and improve surgical outcomes for patients undergoing SRS. However, given that a change in gender role is not necessarily connected to desire for SRS, the GRE might not help prepare patients for
surgery. There is also no published empirical evidence connecting the GRE to improved surgical outcomes and a lack of evidence regarding whether or not the GRE reduces post-surgical regret. Other benefits such as helping patients develop resilience to social stigma, shore up social support, and adapt to the unique challenges of a gender transition are benefits that patients can be reasonably expected to develop in their own time. Additionally, the GRE, which is intended as a measure to ensure non malfeasance can actually cause harm to patients by delaying surgery, prolonging gender dysphoria, purposely exposing patients to challenging social and psychological situations (including risk of violence, job loss, harassment, and discrimination), providing a requirement that is not applicable for those who do not desire a significant change in gender role, invading patient privacy, causing unnecessary pain for friends and family members who may not be well prepared to receive the news of a gender transition (but will be exposed to it anyway given the full-time nature of the GRE), and erecting yet one more barrier to accessing healthcare services for transgender people, (Trans Pulse 2010, 2011, 2013, & 2014)\(^{16}\). As a result, it is questionable whether or not the GRE can be justified as a measure of non malfeasance.

Since competent patients are able to choose among treatment options within the context of their own lives they may reasonably choose a course of action that results in poorer medical outcomes in favour of achieving other objectives of value, (Mohr, 1987). As a result, sometimes we ought to respect patient autonomy even if paternalistic measures would result in better medical outcomes. Given that patient autonomy is a

\(^{16}\) The Trans Pulse survey indicates that this is a problem in Ontario but earlier versions of the SOC also state: “change of gender role and presentation can be a factor in employment discrimination, divorce, marital problems, and the restriction or loss of visitation rights with children,” (Meyer, 2001 as cited in Ehrbar & Gorton, 206).
primary consideration in medical decisions a strongly paternalistic measure such as the GRE requires extraordinary evidence in order to justify overriding competent patient choice. Because there is a lack of empirical evidence to support the GRE in terms of surgical outcomes and since the GRE is doubtful in its capacity as a measure of non-malfeasance, there is insufficient evidence to support it. Consequently, the GRE should only be pursued voluntarily with competent patients and should not be held as a mandatory requirement for access to SRS in most cases. Patients ought to be allowed to take the risk of surgery without the GRE if they are competent enough to make that choice. In the case of patients who are not yet competent for the purposes of medical decision-making, such as adolescents, evidence supporting the GRE at the level of expert opinion can be sufficient justification for paternalism when SRS is to be accompanied by a significant change in gender role. If there is no significant change in gender role planned then the GRE will not be justified as a requirement even for adolescents due to the lack of connection between the GRE and SRS without a change in gender role.
Chapter 5

Recommendations for the SOC and Healthcare Providers

In this paper it has been argued that the year-long GRE requirement for SRS is strongly paternalistic in most cases and thus requires significant justification. The GRE is said to be justified by ensuring that the harm done to patients who seek out SRS is minimized. The GRE aims to do this by preparing patients for a change in gender role, by minimizing post-surgical regret, and by improving surgical outcomes. However, the ability of the GRE to perform these functions has been challenged. Additionally, the GRE can present its own form of harm to patients, which undermines its purpose as a measure intended to reduce harm. Consequently, I have argued that the reasons for supporting the GRE are insufficient to justify strong paternalism, in which case patient autonomy should take priority. Patients should be able to choose the course of their medical treatment and should be allowed to take medical risks that are likely to result in improved quality of life. In any case, it is not certain that avoiding the GRE constitutes a risk taken on the part of the patient since it is unknown whether or not the GRE contributes to surgical outcomes.

The 7th version of the SOC requires that patients with gender dysphoria undergo a year-long GRE if they wish to pursue SRS as part of their transition process. Considering that overriding patient autonomy by enforcing the GRE is not justified given the evidence currently available to support it, the SOC should remove the GRE as a mandatory requirement for competent patients who wish to undergo SRS. The GRE might still play a useful role as a voluntary requirement or as a requirement that is mandatory for adolescents who wish to pursue SRS in combination with a significant change in gender
role and whose social and cultural situation is likely to be supportive of a full-time gender role experience. Whether the GRE is pursued on a voluntary or mandatory basis the duration of the GRE should be negotiated with the patient since there is no evidence currently available to support the efficacy of a year-long GRE and there is at least some evidence to suggest that the current one-year length of the GRE does not produce any further benefit than a GRE of shorter duration, (Lawrence, 2001).

The GRE might be recommended for any patients who desire a significant change in gender role along with SRS and who do not appear to have a full understanding of the implications of a change in social gender role. However, a patient in this position might be better served through educational seminars geared to prepare people for the challenges of a change in social gender role—if such seminars were to become available. This would give patients the opportunity to gain further insight into gender role transitions without immediately putting them at risk. For some patients the GRE should be discouraged. This last option is for those who appear to run the risk of reduced utility and may include those whose social life is structured in such a way as to make a full-time coming out dangerous or potentially harmful in a way that negates the possible benefits of the GRE.

Considering that the GRE can be harmful in many situations it is important to distinguish between which patients the GRE is likely to benefit and which patients it is likely to harm. The SOC could recommend that patients be interviewed to determine the likelihood that the GRE will be beneficial. This interview should be conducted regardless of whether or not the GRE is pursued voluntarily or if it is enforced upon adolescents. An interview should determine the following: Is the GRE superfluous for this patient? (Do they already have the necessary experience or understanding of a change in gender role or
do they not require a change in gender role at all?) Will the GRE delay surgery and prolong gender dysphoria? Will documentation of the GRE result in an unacceptable (according to the patient) breach in privacy? Has the patient been previously frustrated by barriers in accessing care? Will a full-time GRE cause unnecessary suffering for family members or be likely to expose the patient to violence or discrimination? If the answer to any of these questions is ‘yes’, then there is reasonable cause to consider avoiding the GRE on the basis that it may not reduce harm. This must be weighed against the potential benefits of the GRE for a patient. Will a GRE be likely to provide the experience that is necessary to make informed decisions concerning SRS? Will the GRE provide considerably more benefit in understanding than an educational seminar (if one is available)? Will the GRE help to establish social supports that will be difficult for the patient to establish otherwise? Will the GRE provide opportunities for reflection concerning either surgery or change in gender role that will not otherwise be available to the patient? If it is not clear that the GRE will provide benefit for a patient given their situation then it is better to err on the side of caution and avoid the GRE in order to prevent the harm that it may cause.

The Flexibility of the SOC

The SOC clearly indicates that the standards it outlines are flexible, (WPATH, 2012, p. 2) and attention has been drawn to the flexibility of the SOC by some authors, (Ehrbar & Gorton, 2010). Given the wide variety of patient needs, cultural differences, and possible treatment models, it is ultimately up to healthcare provider to use the SOC as a guideline to inform their practice. This caveat might seem to provide the flexibility that
would be required to meet the suggestions that I have outlined above. If providers take issue with a portion of the SOC, then they can adapt their treatment models accordingly. However, this notice of flexibility does not allow the SOC to escape criticism for a number of reasons. First, the SOC uses language that seems to contradict this notice of flexibility. Second, inexperienced physicians will be unlikely to depart from the recommendations of the SOC if their training offers no alternatives, (Ehrbar & Gorton, p. 204). Third, whatever its flexibility, the SOC firmly supports the GRE as a requirement for surgery and it offers no alternatives to this requirement. Fourth, the amendment to the Health Insurance Act in Ontario states: “the proposed changes align the Ontario requirements for access to insured SRS with the World Professional Association for Transgender Health (WPATH) Standards,” (Service Ontario, 2015). This implies that treatment models that deviate from the SOC will be unlikely to be insured. For these reasons future versions of the SOC should explicitly state its flexibility in regards to surgical requirements (and these requirements should, indeed, be flexible). It should also offer viable alternatives to the usual suggestions in the guidelines. If the GRE in its current form is shown to be ethically problematic it should not be recommended as part of treatment procedure in the SOC without qualification.

Ehrbar and Gorton (2010) suggest that the SOC is already very flexible and that patients and physicians regularly fail to recognize this. The 7th version of the SOC (following Ehrbar and Gorton’s article) makes a more explicit statement concerning the flexibility of its guidelines. The SOC states:

Clinical departures from the SOC may come about because of a patient’s unique anatomic, social, or psychological situation; an experienced health professional’s
evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection, (WPATH, 2012, p. 2).

The 7th version also states: “It is impossible for the SOC to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the SOC according to local realities,” (WPATH, 2012, p. 2). These statements very clearly indicate that the SOC is flexible and that physicians should depart from it whenever it makes sense to do so. However, concerning SRS the SOC states:

While the SOC allow for an individualized approach to best meet a patient’s health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one’s gender identity [GRE], (WPATH, 2012, p. 58).

This seems to contradict the opening statements that tout the flexibility of the SOC since it excludes many of the requirements for several forms of SRS from the earlier statement that the SOC can be individualized based upon patient needs (among other considerations).
If this statement is not intended to exclude the requirements for SRSs from the SOC’s stance of flexibility then it is at least ambiguous and requires further clarification. It is important that the SOC is explicit about the flexibility of specific requirements because so many physicians will be referring to it for training and as an authority to aid in conflict resolution. Brownstein (2009) claims that:

*The patient may feel that the requirement for a real-life test [GRE] is unrealistic and paternalistic in that he or she has suffered long enough with the psychological pain associated with his or her transgenderism and that denying him or her early surgery would be detrimental to his or her health and well-being. This may lead to conflict and affirms that the Standards of Care (SOC) should be the proper venue for guidance in all cases, (p. 221).*

If the SOC is ambiguous then it will not be able to provide guidance for conflict resolution. The same problem might occur if the SOC is flexible but explicit flexibility at least opens the requirements up for negotiation.

The SOC should adopt and explicitly state its flexibility for requirements such as the GRE. However, it should also take the time to include common alternatives. Changes in the Health Insurance Act in Ontario will allow many physicians to provide a full treatment plan for patients with gender dysphoria. This will encourage physicians to undergo the prerequisite training in the SOC. While this presents an excellent opportunity for patients who require better access to care, the arrival of many newly trained physicians can raise some problems. Ehrbar and Gorton (2010) suggest that physician experience is a major factor in shaping treatment models. Ehrbar and Gorton (2010) state that “specific ‘usual’ interpretations [of the SOC] give inexperienced providers a
framework with the expectation that with experience their treatment models will evolve,” (Ehrbar & Gorton, p. 204). Inexperienced physicians will be unlikely to deviate from their initial training in the SOC until they gain more experience so even if the SOC states that it is flexible newly trained physicians could be too inexperienced to know what alternatives are available. Thus, to ensure that broad treatment models are available, the SOC should include possible alternatives in its guidelines, (Ehrbar & Gorton, 2010). There are clinics that depart from the SOC but these are outside of Ontario and employ healthcare providers who are very experienced in treating gender dysphoria (the Tom Waddell Health Center, for example). Additionally, alternative treatment methods can be referred to during conflicts between patients and physicians if they exist in the SOC. Otherwise, it is not clear exactly how flexible physicians can be with their treatment models, especially if they are inexperienced, (Bockting, 2008, p. 208).

Conflict resolution may also be important between healthcare providers. Since the treatment of gender dysphoria requires a multi-disciplinary approach—with help from mental health professionals, physicians, nurse practitioners, endocrinologists, and surgeons—the SOC must be direct about its flexibility and offer alternatives without any guesswork that needs to be done on the part of physicians, (Brownstein, 2009, p. 220). Otherwise, coordination of healthcare providers outside of the setting of a gender clinic could be difficult. This is another reason why the GRE requirement needs to be clarified in the SOC. Of course, inflexibility within the SOC could also serve to limit conflict but this would come at the cost of less effective healthcare for patients since treatment will not be able to respond to the wide variety of patients needs. Also, inflexibility in the availability of treatment models is something that the SOC specifically attempts to avoid.
for the reasons stated in the quoted passages above, so inflexibility would be an inappropriate method for conflict resolution. Rather, offering several viable alternatives to choose from will better perform this function since it will offer flexibility while still ensuring that inexperienced physicians have a range of good options to choose from.

The Health Insurance Act of Ontario has been changed such that access to funding for SRS is no longer limited to approval from CAMH but is still limited by the requirements set out in the SOC. As a result, ambiguities concerning the flexibility of the SOC have a direct impact on the wellbeing of patients in Ontario. In some passages the SOC welcomes departures from its guidelines but the funding for SRS in Ontario specifically requires that physicians follow the guidelines without deviation—at least in regards to the year-long GRE, which physicians must indicate has taken place on the funding application form, (Ontario Ministry of Health and Long-Term Care, 2016, p. 5-7). If the GRE is intended to be a flexible requirement then its forced inclusion for funding applications is a clear indication that the flexibility is ambiguous. However, the listed criterion in the SOC seems unlikely to be intended as flexible.

Finally, the previous chapter should have demonstrated that there are ethical problems in the blanket use of the GRE for all patients wishing to undergo SRS. As a result, physicians and other healthcare providers who are involved in treating gender dysphoria should carefully consider whether or not the GRE will be beneficial for their patients and what shape the GRE should take if it is pursued. It seems likely that the GRE requirement could be shortened without much harm in some cases and may even be beneficial for some patients if it were avoided all together.
Given the recent changes in the Health Insurance Act considerations such as these must be balanced with ensuring that eligible patients meet the requirements for funding applications in Ontario. Otherwise, patients could fail to receive the funding necessary to proceed with SRS. Perhaps further changes in the SOC or the Health Insurance Act will open more opportunities for flexibility in treatment models in the future.
References


