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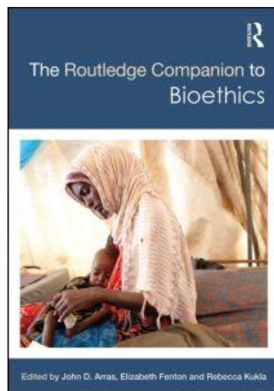

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Transgender

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TRANSGENDER

Jamie Lindemann Nelson

A recently coined term that has already developed a somewhat complicated and controversial history of meanings, "transgender" will be used in this chapter to characterize people who are uncomfortable—sometimes deeply so—with the gender to which they've been assigned at birth, as well as a loose collection of ways in which some of those people express that discomfort.

For some transgender people, medicine plays a significant role in how they deal with their unwelcome identities as women or as men—as it has in Karl's life. On the basis of the standard indications that are so carefully noted at birth, Karl was identified as female, and raised in one of the many ways that are more or less distinctive for girls. As life went on, however, Karl found that he could not find a rewarding or even coherent way of living as a woman, and that it made much more sense to see himself, and be seen by others, as male. Eventually, he obtained some rather invasive medical interventions—in his case, his ovaries and uterus were removed, his chest re-contoured and he was started on a regular regimen of testosterone—that helped him to do so.

Carrie has lived out an analogous story. Identified and reared as a boy from the start, growing up into what almost everyone thought of as just one guy among others, Carrie had a private but powerful conviction that life as a man simply could not be made to fit with her own grasp of who she was and wanted to be. As part of finding a way of living that seemed more in keeping with her feelings and hopes, she also turned to medicine: Carrie started taking estrogen and a medication that reduced the effects of testosterone. She later underwent a number of surgical procedures that reshaped her genitals and otherwise provided her with physical traits associated with women, and rid her of those associated with men.

For present purposes, then, "transgender" will be taken to include people like Karl and Carrie, who are also often referred to as "transsexuals," and in whose experience medicine plays a special role. Yet there are also people who, while rejecting (or at least revising) the gender identities thought to be determined by their bodies, don't look to medicine to provide physical changes, perhaps because they have no access to the kind of intensive interventions required, or possibly because they don't like the balance of risks and benefits involved, or maybe because they don't accept that a person's genitals, hormones or other "sex characteristics" necessarily determine gender. They use medicine largely for more ordinary kinds of health care, although they can face some extraordinary barriers to getting it.

Some transgender people take themselves to have permanently "migrated" from one gender to another, using clothing and accessories, verbal and non-verbal forms of expression, and

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self-ascription, rather than hormones and surgery, to help provide passage. Others cross back and forth between gendered presentations, perhaps because the ways in which they most value their lives overall won't accommodate permanent moves, or perhaps because they don't see gender as a deep identity-determining fact about who they are, but as something that should be treated less seriously, as a set of tools for access to different experiences, for personal growth, for amusement, even for profit. Still others are resistant to the seemingly relentless drive, at least in contemporary Western societies, to fix everyone as female or male. Rather than "migrating" from femaleness to maleness, or "visiting" femaleness from maleness, they tend to be suspicious about whether those very categories are good places for them—or perhaps for anyone—to inhabit. Some such people might selectively use surgery or hormones; many do not.

These people often identify themselves as transgender, too—in fact, in some uses of the term, they occupy the center of the concept, while people who are transsexual are admitted to the term by courtesy, if at all. So, while all transgender people will have health care needs like anyone else—and perhaps more so on average than people who confront less stigma (Institute of Medicine (IOM) 2011)—there is not a necessary connection between transgender and scalpels or syringes.

Yet, while some transgender or otherwise gender-variant people have tried to dismantle or at least substantially reconfigure gender, and some theorists have recommended people adopt skeptical or ironic attitudes towards it, gender remains a gravely important status socially as well as subjectively. Transgender people often strenuously try to understand themselves and be understood by others as women or as men as these notions are typically used. Success can be vital to transgender people, in part because being seen as gender ambiguous or non-conforming can make a person vulnerable to various harms: Harassment, vocational insecurity, and violence, including deadly violence (Beemyn and Rankin 2011). Further, the disharmony between how some transgender people feel, how their bodies are shaped, and how others see them can threaten their ability to live lives they see as authentic. For some of those people, medicine does play a centrally important role.

Yet if medicine is not a necessary means for expressing transgender objections to some of the standard ways gender is understood and enacted, neither are all objections to gender's operations necessarily examples of transgender. Feminism, for example, might also be a name for some people's deep discomfort with how the gender to which they have been assigned plays itself out in their lives. It may be tempting to say that many feminists' objections to gender are inherently political, whereas transgender people's dissent tends to be fundamentally personal. Yet feminist theories and practices themselves have made the "personal/political" distinction difficult to see as very helpful. It might be more accurate to suggest that feminism's range of complaints against how gender is practiced is broader than those typically pressed by people insofar as they are transgender.

Further, some feminists see these forms of objection to standard gender practices as operating at cross purposes. They have complained that transgender practices and understandings don't really grasp how deeply gender structures lives—one's identity as a woman or a man, so the complaint goes, is not something that decisions, or desires, or dress, or even surgery and hormones, can change. This line of thought has led to general critiques of medicine's involvement in gender reassignment procedures as exploitive of those who seek them out, and as disrespectful to women generally (most notably, Raymond 1979). Some feminists have worried that forms of transgender expression reinforce what's objectionable about gender categories: A transgender woman's concern

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about high heels, for example, may end with the fact that she can be punished for wearing them, while a feminist's objection may start with the fact that they can be punishing to wear. The tendency to construe genital surgery as the heart of gender reassignment strikes some feminists as reducing gender from a complex, encompassing social phenomenon to mere bits of biology that are themselves quite inoffensive; an authoritative social institution, medicine, that provides the interventions and the mental health screening that "justifies" access to the operating room, has been charged with reinforcing such naïve and politically retrogressive attitudes (see, for instance, Hausman 1995).

Yet it may not do to press too hard the notion that the scope of feminist objections to gender is wider than those of transgender people. Transgender individuals who see themselves as demonstrating with their lives that gender is as porous as it is problematic have also criticized many of the uses made of gender categories. Some transgender people are themselves explicit feminists: Transgender-based dissatisfaction with how gender is practiced may be influenced by feminist convictions (e.g., Aragon 2006; Bettcher 2009); some feminists have written sympathetically and insightfully about transgender and its possibilities for enriching feminist thought. (e.g., Scheman 1997; Salamon 2008). Despite the many ways that gender can limit and damage human lives, many transgender people's experiences testify to how vital a habitable gender identity can be to a rewarding or even merely tolerable life.

At the same time, transgender desires and actions may help undermine what some writers have identified as fundamental "natural attitudes" about gender: That being male or female is given, exclusive, and immutable. Everybody gets one and only one gender, and the one they get is unchangeable. Medicine contains a wealth of experience with various disorders of sexual development that put enormous pressure on this "natural attitude"—as do the lives of people with intersex conditions. The interest in medical and surgical interventions on the part of some transgendered people, however, in part perhaps because such interventions are often sought by people whose bodies seem perfectly "normal" physically, may make it harder to ignore just how much social stage setting and personal effort is required to maintain gender distinctions in their familiar forms. In light of what's been done by people such as Carrie and Karl (and the health care professionals helping them), any effort to insist that gender distinctions, roles, identities, or practices are as natural as breathing, rather than complicated and carefully monitored social practices, becomes much harder to defend (Kessler and McKenna 1985).

Medical Practices, Transgender Goals, and Bioethics

While some transgender people, then, do not take medicine to be a special ally in how they express their genders, others do want substantial interventions: Surgeries on genitals and reproductive organs, and procedures aimed at changing body contours or rendering faces more typically feminine or masculine; the use of hormones and hormone blockers to suppress menstrual cycles or erections, or to stimulate mammary growth or facial hair. Some physicians were providing some such services as early as the 1920s (Meyerowitz 2002; Ebersoff 2000). More recently, medicine in many parts of the world has largely regularized how it responds to such requests; there are diagnostic criteria and treatment protocols that are widely accepted as constituting good practice. There is, further, at least some ongoing research into the social and physical impact of transgender interventions, as well as into just why some people are so powerfully convinced that their given gender assignment is so profoundly wrong for them.

Bioethicists, it seems, should find these ways in which medicine so dramatically connects with such a central and problematic organizing concept of human life a rich source of fascinating moral and philosophical questions. Is "gender reassignment surgery" a paradigm of problematic "medicalization" of a social problem? Is it an effective treatment for a bona fide disease? Or, rather, might it best be seen as a way of reducing unhappiness and releasing human potential? Might medicine's response actually increase the incidence of the condition, channeling various forms of intense discomfort with gender norms that might be expressed politically into a single diagnosis–treatment pair? Or is gender reassignment itself a kind of social and political action against prevalent understandings of gender? Do people who ask for medical help with their gender crossing show themselves by that very request to be mentally ill? Or are they exhibiting a valuable form of human diversity that ought to be respected and facilitated, rather than tolerated and treated?

Oddly enough, although other scholars have raised questions of this sort, bioethicists for the most part have not (Nelson 1998, 2012). Academic efforts to come to grips with medicalized gender transitions were readily available through the 1980s—in addition to work by feminists, cultural theorists interested in gender and social scientists interested in health care made contributions (e.g., Billings and Urban's (1982) sharp skepticism about the motives of professionals involved in gender identity clinics)—but the amount of bioethical attention to the issue was meager in quantity if not quality. (Lavin's (1987) critique of the idea that "sex change" procedures were inherently mutilating or deceptive stands out for its thoughtfulness, but also for its simple presence.) In the early 1990s, an interdisciplinary field of transgender studies started to emerge (touched on by Stone's (1996) reply to Raymond), and social trends started to make transgender a less outlandish topic generally. Yet bioethicists still showed little interest. While some attention focused on a related area—"gender normalization" procedures performed on children born with disorders of sexual development (Dreger 1999; Chase 1998)—bioethics failed to keep pace with other bodies of scholarship. Until very recently, such bioethical literature that did specifically address transgender issues often relied on older theoretical understandings, rather than trying to develop or even question them (e.g., Draper and Evans (2006), drawing importantly on Raymond (1979)). Well into the first decade of the twenty-first century, it would not have taken long—certainly the inside of a non-taxing fortnight, more likely a moderately paced week—to read with due care all the literature on transgender-related themes contained in the twenty or so most prominent journals publishing bioethics.

There are, however, signs that bioethics is finally starting to take a closer, more considered look at medicine's efforts to help transgender people to achieve or consolidate their desired gender identities, and about health care's broader interactions with transgender people as well. An initiative started in 2010, "Bioethics, Sexuality, and Gender Identity," spearheaded by Autumn Fiester and Lance Wahlert from the University of Pennsylvania, aims to enrich bioethics with research from queer studies, an interdisciplinary field that includes the study of lesbian, gay, transgender, and related forms of sexual or gender expression (see http://www.queerbioethics.org). The initiative now involves a large number of bioethicists from many centers and programs, some of whose work includes an interest in transgender. In 2012, it sponsored a conference, and has organized special issues of bioethics journals around its themes. Further, at the national meeting of the American Society for Bioethics and Humanities (ASBH) held in Washington, DC in October 2012, there were for the first time several presentations explicitly addressing bioethics and transgender.

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Then, of course, there is this very entry in the *Routledge Companion to Bioethics*—apparently the first general discussion of the issue to appear in an anthology designed for a general readership in the field. Essays of this sort often provide something of a critical summary of the leading issues and contributions of a given field to a particular issue. Yet this strategy hardly fits bioethics and transgender, precisely because the record of engagement is so sparse. If there could be said to be a standard topic for bioethics and transgender, it most likely has been whether it is legitimate to use medicine to facilitate gender reassignment, either at all, or for special populations, such as children. Against this background, however, new issues are starting to emerge.

For example, Alison Reiheld's American Society for Bioethics and Humanities paper (2012) reminds the field that transgender people have "ordinary" health needs too, and that some have faced serious obstacles in the way of getting quite standard kinds of care; track records of disrespect or rejection by health care professionals, or even the anticipation that a bad experience may be in store when a person's gender non-conformity is revealed, can delay or derail needed treatment (see also Harbin et al. 2012). Reiheld argues that some of those obstacles may not be just plainly poor practice, but ethically more complex: A provider may understand her refusal to care for transgender people as a matter of "conscientious objection," the result of a considered ethical judgment that transgender is sinful or otherwise immoral and that providers ought not to be compelled to support such forms of life by providing health care.

At another session of the same meeting, Cameron Waldman in effect argued against seeing any such objection as an ethically complex issue; he maintained that it ought to get no more hearing than would a professional's claim that he or she could not in good conscience treat people of color. Waldman also was skeptical about whether bioethics had anything of substance to contribute to society's achieving the sort of moral progress that would be marked by such questions about the treatment of transgender or otherwise queer people being simply placed off the table (Waldman 2012).

This exchange hints at the rich payoff bioethics might expect to gain from taking on transgender issues more fully; consideration of what might seem a straightforward issue—abandoning patients—quickly develops into deeper questions about tensions between personal integrity and professional values, about what moral issues decent societies ought to regard as definitively settled, and about what bioethics' role might be in *constricting* the set of open moral questions.

Research that focuses on transgender people also poses ethical issues that are starting to attract notice. The IOM's recent report on the health care needs of lesbian, gay, bisexual, and transgender people called for further investigation of relevant topics—for example on the long-term health impacts of continued hormone use by transgender people (IOM 2011). To aid research on such relatively small populations, the IOM report recommended that transgender people be routinely identified in their medical records; this proposal raises questions about how to define such a fluid and contestable term, about who has the authority to use or withhold the label, and about privacy and safety for a group of people whose gender identities put them at risk for suffering from just the kinds of stigma the IOM report itself carefully notes.

Perhaps a more fundamental issue is whether the "causes" of people's understanding themselves as transgender is an appropriate target of research at all. Such investigations have gone on, often generating considerable controversy, although not typically among bioethicists. Some transgender scholars and activists for example have expressed vehement opposition to investigations supporting the view that the desire

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to change gender is a form of paraphilia—i.e., what is sometime called by lay people a "perversion," a phenomenon driven by fundamentally erotic desires, targeted at an unconventional object.

A substantial part of the criticism in that particular case surrounded issues of research methods and research ethics used by Michael Bailey in his defense of his paraphiliac analysis of transgender (Bailey 2003); apart from a 2008 article by Alice Dreger, the dispute did not generate much attention in the bioethics literature. Yet the deeper research ethics issue may lie simply in seeing transgender desires and behaviors as inherently more puzzling than why our gender identities have the shape and significance that they do to people in general. Singling out transgender as a kind of gender identity particularly in need of explanation can convey the thought that there is something problematic with transgender ways of making sense of oneself—for example, that transgender is, or may be in some of its forms, a kind of mental disorder (cf. Wahlert and Fiester 2012).

Transgender and Mental Disorder

Whether transgender identities as such, or some ways of expressing those identities, should count as an illness or a disorder (terms that are used as rough synonyms) is a question that falls properly to the philosophy of medicine. It has ethical implications, though, perhaps chiefly for what was earlier identified as the basic question that bioethicists have tended to ask when transgender has been considered: Is gender reassignment an ethically defensible use of medicine? The "illness or not" issue also has some significant personal implications for transgender people. As the passionate debate that surrounded the de-listing of homosexuality from the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual* (*DSM*) testifies, the difference between being considered mentally ill and being thought of as simply part of life's rich pageant can matter deeply to people (Bayer 1981).

Karl and Carrie, along with several tens of thousands of other people (Olyslager and Conway 2007), chose to undergo extensive surgeries on biologically healthy tissue that at least compromised their reproductive abilities, and subjected them to the standard dangers of surgery, including the possibility of death. They elected hormone treatments that may increase long-term risks of certain serious illnesses. They were well informed about the possible consequences. Were their informed choices sufficient to authorize professionals to provide the desired interventions?

Not if those professionals are guided by standard treatment protocols. The accepted standards of care pivot on a condition—"gender identity disorder," or, in more recent diagnostic manuals and clinical guidelines, "gender dysphoria" (APA 2013; Coleman et al. 2011)—as diagnosed by mental health professionals. According to the guidelines, then, a person's own reflective and informed choice is not sufficient to authorize gender reassignment interventions. What is perhaps more troubling is the hint that, if a person wants such interventions, her choice may not be a *necessary* part of the authorizing conditions either.

The problem is that the idea of being mentally disordered is often associated with the notion that your ability to make good decisions is doubtful, at least in areas affected by the illness, if not globally. Having a mental disorder does not mean that a person cannot make authoritative choices about her life. Yet a psychiatric diagnosis, and the insistence on using mental health professionals as gatekeepers to hormonal treatment and genital

surgeries, can carry powerful stigmas. The transgender desires and choices of people in Karl or Carrie's position, then, might not be regarded as authentic expressions of who they most fundamentally and rationally take themselves to be, authorizing willing providers to intervene. Rather, they might be seen as symptoms of an illness, whose appropriate therapy is to be determined by professionals.

If mental health professionals involved in gender reassignment thought their job were to help people make a complicated and consequential decision well, that would probably not prompt great controversy. If they took themselves to be determining whether people requesting transgender medical procedures were suffering from serious depression, or another mental disorder that might impair decision-making, that might seem somewhat less contestable. Yet as things stand, if a candidate completes the screening with the authorization for surgery in hand, she or he hasn't emerged with a clean bill of mental health. What the candidate gets is a potentially stigmatizing psychiatric diagnosis.

Yet incorporating the desire to "change sex" into medicine's list of pathologies also came with advantages to both providers and recipients. Physicians and other health professionals could feel that their efforts were not merely glorified plastic surgery, serving idiosyncratic desires. Rather, their aim was to ameliorate a very serious mental disorder that, untreated, was extremely painful, correlated with serious depression and even suicidal behavior. Further, practicing under a recognized diagnosis, secured via official criteria applied by mental health professionals, reduced anxiety that a person who had received surgery might change her or his mind about whether the interventions had really been beneficial.

For their part, transgender people in search of medical interventions could feel that they weren't merely in the grip of some private perversion. Rather, they could understand themselves as ill with a recognized disorder, for which medicine had reliable responses. They were not "bad," then, merely sick. In principle, at least, they could approach physicians, not as supplicants, but as sufferers, for whom appropriate treatment could be regarded as a reasonable expectation built into the social contract between physicians and the public—at least for those who could afford it. And a recognized diagnosis could help there, too. Even though some insurance plans explicitly rule out coverage for transgender interventions, some have covered hormones, and even surgery—as the American Medical Association (AMA) explicitly advocates (AMA 2012).

Yet many transgender people do not see their discomfort with their assigned genders as warranting a psychiatric diagnosis and are not particularly keen to be seen as mentally diagnosable by others. The stresses in dealing with social stigmas and expectations surrounding what is normal for women and for men to be, to do, and to appear—like many forms of stress—may make someone prone to illness; various forms of gender transition may bring medical problems in their wake—surgical complications, for instance, or the impact of long-term use of hormones. Yet, at most, these considerations suggest that being transgender can be a health risk, not that it is itself an illness. The thought that people seeking transgender interventions were simply delusional—"this person with a penis thinks that he is *really* a woman"—have become less plausible, as understandings of what constitutes "reality" in this area have become more sophisticated, and as the ways available to transgender people to understand their own experience have also developed. While transgender desires can cause intense discomfort, this may not be diagnostic of an illness, but simply reflect that people typically are hardly indifferent to their gender. It seems reasonable to imagine that many non-transgender people would find life quite difficult if they found themselves having to live out a gender role that felt thoroughly alien to them.

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Can bioethics—aided, perhaps, by the philosophy of medicine—help resolve this issue? Not conclusively, or at any rate, not so far. Consider, for example, Jerome Wakefield's "harmful dysfunction" analysis. Wakefield's account is attractive in that it incorporates biological and social elements in its understanding of disorder, rather than trying to assimilate disorder to one or the other of these categories, as earlier theories have attempted (e.g., Boorse 1977; Englehardt 1975). His thought is that for a person to count as having a mental disorder, two conditions must be fulfilled: At least one of the person's physical or mental systems must not be operating according to its naturally selected function, and the effects of that failure to operate are generally regarded as harmful, in the disordered person's social context (1992). As Wakefield sees it, then, both biological and social considerations must be met for a condition to count as a mental disorder.

Transgender desires and feelings can clearly meet the social condition. In ways of life that make so much of gender distinctions as do contemporary societies, many people who feel that the gender they were assigned at birth does not fit them experience pain and other substantial limits to their ability to form and pursue their interests. It is, however, at least unclear whether Wakefield's biological clause holds. Gender identity is such a socially shaped, varied, and—in particular—such a heavily monitored status, that it is curious to see it as a natural result of a well-functioning biological mechanism emerging from evolutionary processes. The amount of social pressure that is exerted to police gender norms, punishing those who stray too far, seems peculiar if gender identity reliably emerges from some properly functioning neural structure.

The case that transgender desires, even if they are intense enough to prompt people to seek medical interventions, constitute a mental disorder, then, is under some strain. It might seem in the interests of transgender people, simply as a pragmatic matter, to let the current situation stand, if it keeps open the possibilities for receiving desired interventions—and maybe even having their costs reduced. Yet taking such a wholly strategic approach, the diagnosis and treatment enterprise may be experienced by some transgender people as damaging to their integrity; some health care professionals might feel something of the same sort themselves.

Consider the "clinically correct story"—the kind of transgender life story that many gatekeeping mental health professionals have seen as diagnostic for bona fide gender dysphoria (Nelson 2001). According to classic versions of the story, the desire to change sex emerges early and enduringly; it concerns identity rather than sexuality, involves revulsion at discordant body parts, includes cross-dressing and cross-living, and comes complete with a set of plausible accounts of the teller's actions and decisions that might not seem to fit in to a narrative of life-long conviction that down deep, where it mattered, one was *really* a man or a woman (e.g., "Joining the Marines/Getting pregnant was part of my struggle to suppress the truth about myself").

Unsurprisingly, many transgender people came to be able to relate this narrative by heart, whether or not the story accurately captured their own experience. Equally unsurprisingly, canny professionals knew that the narrative was no secret, and had strategies to detect the overly glib (Stone 1996). Those who were focused on getting medical interventions might then anticipate and counter the detection strategies. And so on. The problem, however, was not only staying ahead of the game. The deeper problem is that there is something deeply dissonant in having to falsify the story of one's life in order to obtain medical interventions, when for many the drive to obtain those interventions is rooted in a powerful commitment to authenticity.

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Requiring strict adherence to the clinically correct story may have eased as people's notion of what behavior is acceptable in women and men, and thus transgender people, became more accommodating. Still, as Judith Butler noted:

> It won't do, for instance, to walk into a clinic and say that it was only after you read a book . . . that you realized what you wanted to do, but that it wasn't really conscious for you until that time. It can't be that cultural life changes, that words were written and exchanged, that you went to events and to clubs, and saw that certain ways of living were really possible and desirable, and that something about your own possibilities became clear to you in ways that they had not been before. You would be ill-advised to say that you believe that the norms that govern what is a recognizable and livable life are changing, and that within your lifetime, new cultural efforts were made to broaden those norms, so that people like yourself might well live in supportive communities as a transsexual, and that it was precisely this shift in public norms, and the presence of a supportive community, that allowed you to feel that transitioning had become possible and desirable.
>
> (Butler 2004: 80–1)

Yet this *may* be the kind of narrative that most adequately does capture a given transgendered person's experience and sense of self.

The most recent edition of the *Standards of Care* of the leading organization of medical professionals involved in transgender care, the World Professional Association for Transgender Health (WPATH), is sensitive to the stigmas associated with mental disorder, and reads very much as if it is trying to split the difference between the benefits and the liabilities of diagnosis (Coleman et al. 2011). That edition—the seventh—states clearly that transgender self-understandings are not, simply as such, to be regarded as symptoms of mental disorder. It is eloquent about how transgender and analogous phenomena are human variations widely distributed among cultures and throughout history, and are to be respected. However, it retains the idea that when a person's transgender feelings make surgery or hormone treatments seem like a good way to live better, that person has gone from being (merely) "gender noncomforming" to "gender dysphoric," in the terms WPATH borrows from the fifth edition of the APA's *DSM* (APA 2012, 2013). And when a person becomes gender dysphoric, then their unhappiness with their bodies and/or their lives has crossed the threshold from a human variation to be respected, to a medical problem that requires the services of mental health professionals and the confirmation of a diagnostic category before surgery or hormones would be deemed appropriate.

The WPATH standards are clear that a diagnosis of this kind should not be thought of as grounds for taking away anyone's rights or diminishing their dignity: "A disorder is a description of something with which a person might struggle, not a description of a person or a person's identity" (Coleman et al. 2011: 169). Yet there remains the danger that in continuing to assert that the desire to obtain medical interventions for gender transitions constitutes a mental disorder, the authoritative professional group will undermine transgender people's sense of acceptance of their own identities, and may delay fuller measures of social respect.

Further, there are available alternatives for how medical professionals and transgender people might see their relationship. Jacob Hale has argued that the gatekeeping position assigned to mental health providers by the WPATH standards violates "the dominant

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principles of bioethics in the contemporary United States"—in particularly, nonmaleficence, beneficence, and respect for autonomy (Hale 2007: 493).

There are, as Hale acknowledges, risks to long-term hormone use as well as to invasive surgery, including the possibility of regret (Pfäfflin and Junge, in their 1998 article relied on by Hale, report an incidence of postoperative regret of less than 1 percent for people obtaining female-to-male procedures, and of 1–1.5 percent for those undergoing male-to-female procedures). Yet he suggests that health care professionals who have developed and enforced these standards overstress the risks, while underplaying the value of the potential benefits, and that properly weighed, the risks do not justify curtailing respect for the autonomous choices of patients. Hale notes that other decisions people make carry serious risks as well, offering the example of vasectomy, to which might be added the decision to bear and rear a child. It is also worth noting that although neither unwanted fertility nor pregnancies count as diseases, physicians are involved in how people respond to them, and insurance plans, both private and social, very often cover them.

Since the publication of Hale's article, the newest WPATH *Standards of Care* have relaxed the requirement that surgical candidates undergo extensive psychotherapy, which is a significant alteration. However, the Standards still require mental health screening, particularly when genital or gonadal surgery are in prospect. Portraying the difference between gender non-conformity and gender dysphoria as a difference between healthy and disordered states remains a controversial feature of the relationship between transgender people and health care providers, and a live topic for bioethics. Arguments for understanding the difference in this fashion drawn from the philosophy of medicine appear at best to be inconclusive, and the possibility of reinforcing stigma cannot be taken lightly. At the same time, the low levels of postoperative regret cited by Hale himself might be understood as strong evidence that the current procedures, relying on mental health screening for surgical candidates, are working very well to avoid bad outcomes.

Further, there are cases where reasons separate from the very desire to transition prompt concern about some people's ability to make self-regarding decisions. In principle, this includes transgender people who uncontroversially suffer from certain forms of mental illness, or who are cognitively or emotionally handicapped. In practice—or at least in the literature—the brunt of bioethical attention has fallen on gender-variant children.

Some young people, including pre-pubertal children, report strong and persistent transgender desires; sometimes those desires persist into adulthood, and sometimes they do not (Meyer 2012). In such cases some clinicians have advocated the use of puberty-delaying drugs (e.g., Spack et al. 2012). The effects of such drugs are reversible if suspended, and they buy time for children to mature and for their sense of their gender identity to consolidate, without their having to deal with physical changes that are deeply unwelcome, and whose impact they might have to try to reverse if they did elect gender reassignment. Some bioethicists (e.g., Giordano 2008) have defended this response, and called for it to become a more widely available option for transgender children.

Both the clinical and the bioethical justifications offered in the literature concerning puberty suppression hinge on the claim that such children have a serious problem that is made worse by social forces, but is at base medical. As such, they have a substantial claim to available medical care. It seems quite possible that any successful effort to

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de-pathologize gender dysphoria could make it harder for them to get hold of that resource. The main alternative justification pressed on behalf of transgender adults, stressing their right to make informed and free choices about their lives, is less clearly applicable to children.

Bioethics and Transgender: Coming Out from Behind the Curve?

The founding of university-based gender identity clinics began during the mid to late 1960s—roughly speaking, the same historical moment that saw the founding of research centers dedicated to the development of bioethics as a distinctive, interdisciplinary approach to understanding and guiding the growing power of medicine (Meyerowitz 2002; Jonsen 1998). While there was always a regulatory strain in its practice, bioethics was from the first interested in medicine's impact on how people understood and dealt with questions posed by our embodiment: What constitutes life, and what signals death; what distinguishes health and illness. Unlike questions concerning the nature and value of natality, mortality, and morbidity, gender stayed off the bioethics map for a long time. It is interesting to speculate on how contemporary discussions in transgender health care, but perhaps more generally about gender and social life as well, might have gone on had bioethics risen to that particular occasion, and interesting too, to speculate on why it did not.

It seems plain, however, that whatever thicket surrounded the topic and kept it insulated from bioethics is down now. Bioethicists are starting to take on a number of pertinent questions—e.g., about the authorization and financing of transgender-focused medical interventions, about the stigmas that may be inherent in transgender-oriented research agendas, as well as about the relationship between disorder and health. Newer issues are starting to come to light, too. For example, there is a small but growing literature concerning the interest of people undergoing gender reassignment in preserving their fertility and becoming parents (e.g., Hembree et al. 2009; Murphy 2012). There is reason to expect theoretically significant and practically helpful results from such work.

However, bioethics may now be less likely on its own to make as big an impact on how transgender is understood by medicine and society generally as it once might have done. In the past decade or so, many people looking to medicine for help with achieving a more desirable gender identity have started to develop a political consciousness that resembles how many people with disabilities or with intersex histories think of themselves. Many transgender people now regard themselves more as agents empowered by their identification with a social group, than as individuals significantly defined by their connection with surgeons and endocrinologists.

Bioethics has much to contribute to responsible thinking about the uses of medical power in connection with gender transitions; its contributions may well grow. However, the future relationships of transgender people with health care providers may be affected more by the political clout of a LGBT movement that is successfully transforming other central features of social life than by academic or clinical reflection.

For example, whether or not future editions of the *DSM* or the WPATH *Standards of Care* include "gender dysphoria" as a psychiatric diagnosis, the advantages and disadvantages of doing so as weighed by bioethicists may be less important than how transgender people themselves respond to the question. Insofar as they and their allies refuse to see health care concepts or practices as stigmatizing, forge their self-understandings chiefly

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from their own shared experiences, and assert the legitimacy of their own place in social life, bioethical thinking about transgender will need to go on with transgender people not merely as subjects of analysis, but as partners in conversation.

Related Topics

Chapter 39, "Medicalization, 'Normal Function,' and the Definition of Health," Rebecca Kukla
Chapter 44, "Body Integrity Identity Disorder (BIID) and the Matter of Ethics," Nikki Sullivan

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