

Reply to 'Hormone replacement therapy: informed consent without assessment?'

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ABSTRACT

In a previous article, I argued that assessment requirements for transgender hormone replacement therapy (HRT) are unethical and dehumanising. A recent response published by the *Journal of Medical Ethics* criticises this proposal. In this reply, I advance that their response misunderstood core parts of my argument and fails to provide independent support for assessment requirements. Though transition-related care may have similarities with cosmetic surgeries, this does not suffice to establish a need for assessments, and nor do the high rates of depression and anxiety justify assessments, especially given the protective role HRT plays towards mental well-being.

INTRODUCTION

I have read Saad, Blackshaw, and Rodger's response to my article 'Gatekeeping hormone replacement therapy for transgender patients is dehumanising'.^{1,2} In their response, they first argue that the informed consent model I defended is unlike the standard medical model. Second, they suggest that cosmetic surgeries are a better analogy to hormone replacement therapy (HRT) than abortion and that in any case abortion is frequently restricted. Third, they argue that assessments are needed to manage coexisting mental health issues prior to initiating HRT. Fourth, they advance that I misuse a source I reference. I will reply to these critiques in turn.

THE INFORMED CONSENT MODEL

Saad, Blackshaw, and Rodger correctly point out that my view is inconsistent with the standard medical model of care, in which assessment precedes informed consent and is used to identify the cause of symptoms.

This view of informed consent contrasts with the informed consent model I propose. The reason for this, is

that the informed consent *model* in trans healthcare centres informed consent and decentres assessment.³ The belief that informed consent is an ethically sufficient condition for obtaining HRT underpins the informed consent model and distinguishes it from the standard medical model which requires informed consent but also requires prior assessment. In making their criticism, Saad, Blackshaw, and Rodger appear to misunderstand what the informed consent model refers to, in transgender health.

Given that my article was articulated as a critique of the standard medical model, it is peculiar for Saad, Blackshaw, and Rodger to criticise me for adopting a model that is not compatible with the standard medical model. It is no rebuttal to my argument for abandoning the standard medical model that it requires us to abandon the standard medical model, so long as the argument for its abandonment is sound. My critics have failed to make such a case. They do suggest that people may mistakenly believe themselves to be trans due to psychosis, sexual motivations or wanting to run away from a painful reality into a more comfortable fantasy. People undergoing a psychotic episode are not typically incapable of providing informed consent, placing them outside of my discussion. As for the suggestion that sexual motivations and comfortable fantasies may underpin desires to transition, there is little evidence that they are common, that assessments accurately identify them or that they lead to worse outcomes.⁴⁻⁷

On a similar note, Saad, Blackshaw, and Rodger accuse me of conflating the self-report of symptoms and self-diagnosis. According to them, my epistemic arguments only bear on self-reporting of gender dysphoric symptoms but do not guarantee a right to self-diagnose. This critique is puzzling considering that I dedicated a paragraph of my original article to the observation that we do not lend credence to mental self-diagnosis, but that gender dysphoria under the WPATH Standards of Care refers to a subjective experience rather than a diagnosis pursuant to the Diagnostic and Statistical Manual of

Mental Disorders, Fifth Edition (DSM-5). Given that my argument was purposefully not centred on self-diagnosis, it is difficult to see how I could have conflated self-report of symptoms and self-diagnosis.

COSMETIC SURGERIES AND ABORTION

Saad, Blackshaw, and Rodger argue that cosmetic surgeries are substantially similar to transition-related interventions and therefore warrant similar informed consent protocols. Since psychological assessment is an accepted, important element of accessing cosmetic surgeries, psychological assessments are warranted for HRT.

I have argued elsewhere that some forms of transition-related care are partially similar to cosmetic surgeries.⁸ However, treating all cosmetic surgeries in the same manner is unhelpful. There are many relevant differences between different types of cosmetic surgeries. Different levels of risk and benefits, the psychological impact of delays, the presence or absence of significant social pressure to conform to bodily ideals, the ability of the intervention to meet expectations and the phenomenological difference between gender dysphoria and bodily dissatisfaction may all amount to morally relevant differences. One significant moral difference is that psychological assessments for cosmetic surgeries are not comparably dehumanising, since those seeking cosmetic surgeries are not stigmatised and pathologised in the way trans people are. Unnecessary but harmless assessments do not have the same moral standing as unnecessary and harmful assessments.

Saad, Blackshaw, and Rodger suggest that the analogy between transition-related interventions and abortion is strained. They do not elaborate on why this is the case. They follow-up by saying that, in any case, the analogy with abortion has undesirable consequences since abortion is a contentious topic. If restrictions on abortion and especially mandatory psychological assessments are ethical, then so must be those on HRT. It is true: I do not expect those holding conservative positions on abortion to be progressive when it comes to HRT. That the fates of abortion and HRT are tied is a bug, not a feature. An implicit premise of my analogy with abortion is the feminist stance that restrictions on abortion are unethical, a position I stand by, now, more firmly than ever. It is worth noting that restrictions on abortion have many times been struck down as unconstitutional in both the USA and Canada, strengthening my

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argument despite the contentiousness of abortion. If Saad, Blackshaw, and Rodger wish to critique my argument by adopting a conservative stance towards abortion, I welcome them to do so explicitly.

COEXISTING MENTAL HEALTH PROBLEMS

My critics defend the provision of psychological assessment by pointing out that trans communities suffer from high rates of depression, anxiety, suicidality and self-harm. They bolster their argument by claiming that the WPATH Standards of Care recommends addressing mental health concerns prior to initiating HRT.

It is true that trans communities suffer from high rates of mental health problems. It is, however, unclear why this fact supports requiring assessments. Saad, Blackshaw, and Rodger do not claim that these mental health issues have an impact on whether HRT is beneficial or provide literature to that effect. Access to medical transition is known to have a positive impact on suicidality and related aspects of mental well-being⁹; delaying HRT in order to get depression and anxiety under control is counterintuitive given the protective effect on HRT on depression and anxiety.

As for the Standards of Care, it is true that they state that significant mental health concerns must be reasonably well-controlled prior to initiating HRT. However, the significance of mental health concerns must be understood in relationship to their potential interference with prognostic and capacity to provide informed consent. Depression, anxiety, suicidality and self-harm are largely alleviated rather than worsened by HRT, and do not in general preclude or undermine capacity to provide informed consent. If providers have serious doubts as to whether the patient has capacity to provide informed consent, it would be appropriate to refer them to a mental health professional—this would not be inconsistent with the informed consent model I proposed, quite the contrary.

Assessment and treatment are not one and the same. The Standards of Care do not require treatment as a precondition to HRT, except where coexisting mental health concerns meet the high threshold of being significant and not reasonable well-controlled. Depression and anxiety

do not meet this threshold. It would be unethical to require psychotherapy prior to HRT given that it is well-established that HRT improves them. I nevertheless share my critics' enthusiasm towards psychotherapy and wish that cheap, accessible mental healthcare was more widely available to trans communities.

USE OF SOURCES

Saad, Blackshaw, and Rodger advance that I misused the paper by Cavanaugh *et al* when I quoted them saying that '[t] here is no scientific evidence of the benefit of (referral letter) requirements'.¹⁰ It is indeed true that the quote appears in the context of letter requirements for genital surgeries rather than HRT. I did not note this in my original paper because it did not seem to be a relevant distinction and mentioning it would have broken the flow of the writing. If assessments for genital surgery are not supported by evidence, even though genital surgery is more immediate, irreversible, risky and disruptive than HRT, than it is reasonable to infer that assessments for HRT are not supported by evidence either. The core assessment requirements for HRT and genital surgery are the same: establishing gender dysphoria and ensuring the absence of countervailing mental health concerns. Any plausible benefit of assessments would lie in its ability to distinguish between those meeting these requirements and those who do not, a benefit that applies equally to HRT and genital surgery.

The choice to focus on this single quote is perplexing, given that the immediately following sentence cites two studies evidencing good outcomes without letter requirements for HRT. The informed consent model has a long history in the USA and Canada. There is also evidence that lying in assessments does not lead to worse outcomes, shedding further doubt as to the usefulness of assessments.¹¹ Given the foregoing, Saad, Blackshaw, and Rodger's decision to focus on the Cavanaugh *et al* quote feels an odd lot like cherry picking in the hopes of producing a 'gotcha' moment.

CONCLUSION

My original article is taking a stance that departs from the orthodoxy in transgender health and proposes a radical break with the standard medical model. I expected and welcomed significant push-back against my proposal. I am thankful for the attention my critics' have given my article, although their critique ultimately falls short.

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