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ORIGINAL RESEARCH

Still Quiet After All These Years

Revisiting "The Silence of the Bioethicists"

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Abstract Some 14 years ago, I published an article in which I identified a prime site for bioethicists to ply their trade: medical responses to requests for hormonal and surgical interventions aimed at facilitating transgendered people's transition to their desired genders. Deep issues about the impact of biotechnologies and health care practices on central aspects of our conceptual system, I argued, were raised by how doctors understood and responded to people seeking medical assistance in changing their gender, and there were obviously significant issues of regulation involved as well. Yet mainstream bioethics was conspicuous by its relative absence from the discussion. Here, I return to the matter and find that, while the conceptual issues are just as profound and their connection to health care practice and policy just as intimate, even as transgender issues have become much more socially visible, bioethical engagement with gender reassignment has increased only slightly. I set the little movement that has occurred against the backdrop of the situation as I saw it in 1998 and conclude, once again, by trying to make the bait for bioethicists inviting.

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In 1998, Susan Stryker guest edited "The Transgender Issue" of the journal *GLQ*. The issue's seven articles included a discussion of the emergence of intersex political activism by Cheryl Chase (1998).[1] The other half-dozen dealt with various social, historical, political, and philosophical dimensions of transgendered subjectivities, practices, and receptions. One of those articles—mine—focused squarely on how bioethicists viewed medical responses to transgendered people requesting hormonal and surgical interventions (Nelson 1998).

The piece was prompted by the relative absence of bioethical contributions to a discussion that was picking up steam among academic humanists and social scientists. Noting that a person could make

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[1] As was. Ms. Chase's name for all purposes is now Bo Laurent.

herself master of the mainstream bioethical literature on the subject in a long afternoon, I tried to make this silence seem odd. Here, after all, were just the kind of issues that bioethicists ought to delight in: deep matters concerning the impact of medical practice and biotechnical power on such central elements of our conceptual system as sex, gender, and identity, tied to practical matters of regulating significant exercises of medical power in an area where purely technical competence seemed insufficient or at least highly contestable.

I argued further that the kinds of extra-bioethical scholarly discussion that did touch on issues of transgender and transsexual desires, actions, and policies tended to focus rather monotonically on matters of power, inclining to regard appeal to moral norms (except, perhaps, "subjugation is bad") as just another move in the struggle for power. I suggested that a more normatively sophisticated discussion was needed to supplement power-based analyses if we were to learn what such striking forms of dissent from what seemed the "natural facts" of gender had to teach us, and if we were to determine which ways of responding to that dissent were morally defensible.

To drive the bioethical relevance home, I discussed a fascinating contest between two standards of care for responding to problems stemming from people's identification with a gender other than that assigned to them at birth: the "Benjamin Standards" promulgated by the medical specialty society involved with gender reassignment procedures, the Harry Benjamin International Gender Dysphoria Association (HBIGDA); and a very different set of guidelines developed by the International Conference on Transgender Law and Employment Policy (ICTLEP), the "Health Law Standards."

The Benjamin Standards were very largely written for health professionals by health professionals and heavily stressed the role of mental health professionals as diagnostic gatekeepers to hormonal and surgical interventions. In sharp distinction, ICTLEP, which issued the Health Law Standards, was a professionally mixed group containing a heavy concentration of people who identified as transgendered, many of them lawyers. As the framers of the Health Law Standards included consumers of the professional services regulated by the Benjamin Standards, the guidelines they recommended represented a patient-based challenge to the normative authority claimed by professional health care providers. The emphasis in the Health Law Standards was almost entirely on the adequacy of informed consent.

Things have changed: HBIGDA is now WPATH (World Professional Association for Transgender Health), and the most recent revision to the erstwhile Benjamin Standards—the seventh—was approved in September 2011 (WPATH 2011). Not a great deal seems to have been written about ICTLEP or the Health Law Standards as such in recent years. However, the stress on putting informed consent at the heart of standards of care concerning transgendered people, rather than insisting on vetting by mental health experts prior to treatment, lives on in protocols governing hormonal (not surgical) interventions at the University of California at San Francisco's Center for Excellence in Transgender Health and at other community health centers as well, including the Callen Lorde Community Health Center in New York City and the Fenway Community Health Transgender Health Program (WPATH 2011, 35). Non-bioethical reflections have also become more searching, tracing out the rapid evolution of the very notions used to denote and describe different ways in which people experience and live out gender and revealing how provisional and problematic terms such as "transgender" and "transsexual" are (Valentine 2007). More strikingly, the last decade has seen much greater social recognition of various forms of gender nonconformity, with *The New York Times* suggesting that 2010 might well have been "The Year of the Transsexual" (Van Meter 2010).

Bioethics, however, remains hushed, if not altogether silent, particularly if one focuses on mainstream outlets for authors recognized as primarily working in the field. It would now take longer than an afternoon, or even a couple, to work one's way through the bioethical material that has been published since 1998: There are, for example, some recent papers that focus on global questions about the ethics of using surgery as a response to gender identity problems (Hume 2011; Draper and Evans 2006) and on more specific questions about the use of hormone blockers to delay puberty in children with strong cross-gender identification (e.g., Giordano 2008; Spriggs 2004). Analogies and disanalogies with gender reassignment surgeries have been marshaled in an effort to justify different recommended responses to those who request that healthy limbs be amputated (e.g., Bayne and Levy 2005; Johnson and Elliott 2002).[2] There has been a spate of literature on medical responses to various intersex/disorders of sex development conditions, where issues touching on transgender are sometimes mentioned, if only in a glancing way (e.g., Preves 2003). There was also a lengthy examination of the research ethics-related controversy touched off by Michael Bailey's monograph on the etiology of transsexualism, *The Man Who Would Be Queen* (2003), by historian of science and bioethicist Alice Dreger. Published in the *Archives of Sexual Behavior* (2008), it attracted 23 commentaries, but none, as it happened, by scholars readily identifiable as bioethicists.

Much of this work is valuable in its own terms, and the discussions sometimes involve issues that not only use but also question the general resources on which bioethics often draws—patient autonomy and welfare, justice in the allocation of resources, personal identity. Yet it is clear that transgender issues still do not attract much bioethical attention, and the deeply reflective kind of consideration that I had hoped more of the field would take up remains, by and large, conspicuous by its absence. Indeed, as I will discuss below, some recent work has failed to advance the discussion or has even moved in a retrograde direction by standards of the increasingly sophisticated wider scholarly discussion, effectively, though no doubt inadvertently, disparaging people who identify themselves as transsexual (as I attempt to show in my discussion of Draper and Evans 2006 below).

In what follows, I renew the case for an important niche for bioethics, recapitulating a strategy in the earlier paper: I begin with a discussion of medical understandings of and responses to transgender that comes from outside the generally recognized boundaries of bioethics, indicating both what bioethicists have to learn from such discussion and what they might bring to it. I then connect that more theoretical treatment to the practical controversies sparked by the current WPATH Standards of Care.

Doing and Undoing Gender

In the 1998 paper, rather too simplistically as I now think, I characterized a good bit of the existing non-bioethical work on transgender as so caught up with tracing who was getting to do what to whom and so suspicious about the good faith of professionals as to be, in particular, dismissive of any claim transgendered people might have to autonomous agency, and, in general, devoid of anything that could be recognized as reflective normative engagement. I illustrated this position with reference to an article by sociologists Dwight Billings and Thomas Urban (1982), on whom I was rather hard, if perhaps only slightly more than they deserved. The aim was to show how yawning was the gap bioethics might fill. Here, I will focus on recent work by another non-bioethicist scholar, but this time on one who, while certainly not naïve about the role of power in the sex-gender system, shows a kind of normative sophistication about these matters that bioethicists would do well to learn from.

Judith Butler's (2004) lucid essay "Undoing Gender" begins from the dispute about whether "gender identity disorder" (more recently, "gender dysphoria") ought to remain a nosological category in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). The implication of dropping it would be that mental health professionals would no longer function as gatekeepers to medical techniques for facilitating gender reassignment, at least as a general matter.

Butler's essay is especially sensitive to the impact of this debate on access to the medical means of helping to enable successful transitions, noting that undermining even the irregular existing forms of insurance support for surgical or endocrinal interventions would do particular damage to people who lack the considerable private resources needed for out-of-pocket payment. At the same time, she is keenly alert to the risks to transgendered self-understanding, and intelligibility to others, that the current regimen poses. As matters stand, a person seeking medical means to support her transition

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[2] Bayle and Levy suggest that, insofar as the desire for amputation stems from a psychiatric condition they characterize as "body integrity identity disorder" (BIID), analogies with gender identity disorder might authorize surgical responses. Johnson and Elliott, who are more dubious about the propriety of surgical responses to psychiatric problems, suggest that medical validation of BIID as a central characteristic of some people might function as what Ian Hacking (1995) has called a "looping kind," with the implication that people who would otherwise never have understood their identities as requiring amputation will come to see themselves in such terms; in support of this concern, they point to the growth in the number of people putting themselves forth for sex reassignment surgery since Christine Jorgenson's story became well-known in 1953. Butler (2004) might well be seen as agreeing with the possibility that "transsexual" might name a looping kind, but to celebrate, rather than decry, that possibility.

must, simply as such, present herself as mentally ill. To garner the approval of the mental health gatekeepers to hormones and surgery, she will need to correspond to professional expectations about what it is to experience a sense of gendered discordance with oneself. Doing so may significantly falsify how she fundamentally makes sense of herself. Butler writes:

> The only way to secure the means by which to start this transformation is by learning how to present yourself in a discourse that is not yours, a discourse that effaces you in the act of representing you, a discourse that denies the language you might want to use to describe who you are, how you got here, and what you want from this life (Butler 2004, 91).

Acknowledging that a person might purely instrumentally produce the kind of language required to gain access to needed interventions, Butler notes as well that strategically distancing oneself from one's testimony may be a practice whose availability is again correlated with class, education, and social power. Further, bracketing the truth about oneself—particularly in the effort to win through to a way of living whose enormous pull may stem precisely from the value of authenticity—exacts a cost for even savvy navigators of the system.

A bioethically striking feature of Butler's analysis is its sensitivity to the impact of medical practice not merely on individual lives, but on the generally available ways that people can make sense of themselves. On her view, the mental health hurdles the supplicant needs to overcome are regressive, not simply with respect to their impact on that individual but because they reduce the chance that transgender desires—and the medical practices that respond to them—might prompt people more generally to appreciate alternative and possibly more adequate understandings of themselves as gendered beings.

Treating such desires as evidence of pathology tends to lock in a conservative (antediluvian, in the view of some theorists) view of gender that has roughly the following shape: Everyone, or virtually everyone, successfully develops a phenomenally distinctive, deeply significant, and enduring sense of themselves as female or male. In almost all cases, that sense is concordant with an individuals' possession of physical traits that are taken to be determining criteria of female or male sex. In those few cases where there is discordance, such individuals will have been aware of the problem from their earliest development of a sense of self and are deeply and persistently disturbed by it. It is reasonable to see this kind of experience—call it gender dysphoria—as a disease: It is inconsistent with our species-typical functioning and causes systematic and painful disruptions in people's lives, interfering with their ability successfully to pursue many of the aspects of their own conception of the good. As, for all we can tell, their bodies function normally, it seems the disease must be psychological. However, there is no reliable psychotherapeutic or psycho-pharmaceutical way of dealing with this problem; *faute de mieux*, we are landed with surgical, endocrinological, and social interventions, which offer reasonable hope of ameliorating these people's sufferings. People who experience gender dysphoria are the prime candidates for endocrinological and surgical gender reassignment procedures; people who want the procedures have excellent reason for presenting themselves in a way that squares with this general view.

What they should probably *not* do is suggest that their life experiences and reflections provide them with reason for dissenting from reigning conceptions of gender. As Butler puts it:

> It won't do, for instance, to walk into a clinic and say that it was only after you read a book by Kate Bornstein that you realized what you wanted to do, but that it wasn't really conscious for you until that time.[3] 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 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 changeable, 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, 80–81).

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[3] Butler does not mention just which of Kate Bornstein's books she had in mind, but likely contenders would be those from 1995 or 1997.

Part of Butler's point here, plainly, is that norms of gendered sensibility and behavior are in principle fluid and in practice expandable, and that precisely seeing that "transgendered lives are lived and therefore livable," to use an expression of Naomi Scheman's (1996, 132), both draws on and helps direct that expansion.

This perspective, in my view, expresses what might be described as an alternative to the medical model of responding to people whose gender identity is incongruent with somatic sex, in ways analogous, perhaps, to how some scholars and activists have challenged the medical model of disabilities or surgical and medical responses to intersex conditions/disorders of sexual development. There is, of course, a crucial disanalogy: While only some disabilities and intersex conditions uncontroversially require medical interventions as well as changes in social understandings and practices, a "social model of transsexualism" would have to retain links to the use of medical modalities. A drive to move transsexualism out of a medical model threatens to move it into something like a cosmetic surgery model. Butler's concerns about insurability make up only some of the worries about forging that link.

Still, it seems strongly pertinent to how medicine responds to transgendered people's desires for more congruent embodiment that a basic concept in play—gender—is understood by relevant experts differently from the Standard of Care's construal. As a critical conduit of such alternative understandings into the discourses and deliberations of the relevant clinical fields, bioethics would seem a natural.

Bioethics and Gender Theory: Translation and Testing

Yet the "critical conduit" agenda for bioethics actually understates the sophistication of current clinical discussions, and I mean that in two senses. One is that the current version of the Standard of Care—one iteration later than that available to me in 1998 or to Butler in 2004—is now very explicit that transsexual, transgender, or gender-nonconforming people are *not* to be understood as ill. Quoting from a WPATH Board of Directors statement released in May 2010, the most recent standards endorse the view that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative" (WPATH 2011, 4).

The other sort of sophistication is that the standards distinguish between what is termed *gender nonconformity* and *gender dysphoria*, or significant distress about one's assigned gender. Not everyone who is gender nonconforming will experience gender dysphoria; not all those who do will do so permanently; and those whose gender dysphoria is deeply troubling and persistent can sometimes find "comfort with self and identity" via medical treatment options (WPATH 2011, 5). Gender dysphoria is what licenses gender reassignment therapies. But gender dysphoria is (or might be—the standards are a bit coy here) a "disorder."

WPATH's "nonconformity/dysphoria" distinction is in keeping with the state of play in the revision of the relevant portions of the American Psychological Association's *DSM* in preparation for the issuing of its fifth edition. There, the diagnosis that licenses such medical interventions as administering hormones or genital and gonadal surgery is no longer referred to as "gender identity disorder" but as "gender dysphoria" (APA DSM-5 Development Website 2011). So, while there is nothing pathological about challenging conventional norms of gender, if one is suffering profoundly enough by how he or she has been interpolated into those norms, one meets the "criteria for a formal diagnosis that might be classified as a medical disorder" (WPATH 2011, 5).

The Standards of Care stress that such a diagnosis is not to be thought of as grounds for deprivation of rights or for stigmatization: "A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity" (WPATH 2011, 5). Yet it is also clear that the Standards of Care endorse the use of medical interventions in those cases where a mental health professional has been convinced to provide a letter attesting to a level of gender dysphoria that has tripped the threshold into mental disorder.

The Standards of Care also underscore via repetition that decisions concerning medical interventions are always "first and foremost the client's decisions," with mental health professionals at hand to "encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared" (WPATH 2011, 25 and 27). However, access to endocrinological interventions require either the endorsement of a mental health professional or of a health professional with behavioral health training and competence in the assessment of gender dysphoria. Surgical treatment requires one referral for breast or chest surgery and two for genital surgery. The mental health screening and assessment needed for these treatments no longer requires psychotherapy (though psychotherapy is highly recommended), although they do insist on what has been called the "Real Life Test" or "Real Life Experience" as a condition for genital surgery: "12 continuous months of living in a gender role that is congruent with their gender identity" (WPATH 2011, 28 and 60).

The new standards then, make some careful distinctions in an effort to distinguish nonconformity from pathology *and* having a mental disorder from one's status as a person. But in the end, getting access to what for many will be the most significant gender reassignment procedures has significant overlap with earlier standards: A candidate still needs to run the mental health gamut and still must accept the classification of being mentally disordered to get access to the intervention she seeks. She would probably still be ill-advised to walk into her gender clinic and cite her encounter with Kate Bornstein as the moment that the scales fell from her eyes.

The question we are left with here, then, is whether the accommodations built into the new standards constitute effective responses to the criticisms of the sort Butler has advanced. Will these distinctions and exhortations reduce the odds that those who are diagnosed will undergo a sense of being tainted by mental disorder or that others will see them so? Will any philosophical and moral progress involved in seeing gender norms as contestable and fluid be undermined by the message that nonconformity is just fine, so long as you do not want to enlist medicine in a serious effort to bring your body into better conformity with your gender identity?

This seems to me to set a more interesting agenda for bioethicists than translating gender theory for clinicians, since it requires hard thinking about the connections between health care practices and their impacts on individual and social psychologies. We are also confronted with other intriguing problems. Suppose reflection indicates that the effort to extract a pathological variant from gender nonconformity is not defensible as a requirement for medical interventions. How should transgender medical options be dispensed then? On the same basis as cosmetic surgery? As we do vasectomy or tubal ligation? Would live organ provision offer any useful analogues?

Nor, of course, should bioethicists slight Butler's deep concern about access. She tries to rough out a way of conceptualizing the kind of problem that a transgendered person might be facing that could, at least in principle, differentiate it from other desires for elective interventions for which insurance or social support might not be appropriate.

> Examples of the kinds of justifications that ideally would make sense and should have a claim on insurance companies include: this transition will allow someone to realize certain human possibilities that will help this life to flourish, or this will allow someone to emerge from fear and shame and paralysis into a situation of enhanced self-esteem and the ability to form close ties with others, or that this transition will help to alleviate a source of enormous suffering, or give reality to a fundamental human desire to assume a bodily form that expresses a fundamental sense of selfhood (Butler 2004, 92).

Butler is not naïve about the practical politics of moving insurance companies or other third-party payers to support transgender interventions, absent their having a place in the nosology. What she is in effect challenging them to do is to allocate support, not according to an "objective" schema produced by experts in a scientific field but by exercising a kind of wise judgment that might allow, say, augmentation mammaplasty for a transgendered woman but not for a non-transgendered woman, on the grounds of deliberations about differential contributions the intervention might make to one's "fundamental sense of selfhood."

Perhaps bioethicists might try to develop this effort to guide clinical judgment concerning, and justify third-party support for, medical interventions that do not proceed under cover of a diagnosis of pathology. In doing so, they might be expected to display more alertness to concerns supporting judicious gatekeeping to medical responses than Butler displays, or that one might expect from non-bioethical analyses in general. The possibility of patient regret in the wake of surgery is mentioned in her article, but it is largely relegated to footnote status. Yet surely surgeons (and physicians prescribing hormones) ought to be concerned about whether removing or substantially altering physiologically healthy tissue and severely hampering standard reproductive capacities would achieve a result that would, in a persistent and significant fashion, reliably make their patients' lives go better for them overall.

Medicine and Gender Nonconformity: Liberating or Regressive?

Some of what bioethical literature there is on this point seems to be overdramatic, as witness this from Draper and Evans' contribution to David Benetar's collection on the ethics of controversial forms of surgery:

> Clearly such radical—some might say mutilating—surgery would be difficult to justify, even with the consent of the patient, without certainty about the following: that the patient's assertion is real rather than delusional; … that the therapy is effective; that the therapy is the only means of resolving the patient's problems; and, finally, that the correct diagnosis has been reached (Draper and Evans 2006, 97).

This, as it stands, is, of course, just silly. "Certainty" is an absurdly high epistemic standard for any intervention, even radical ones, and the insistence on the "only means of resolving the patient's problems" is unmotivated. (Why might not "the best means" be sufficient, for example?) But it does place squarely on the table a range of serious considerations that favor scrupulous care in determining who receives powerful and possibly physically damaging hormones or goes under the knife—considerations that bioethicists would not be expected to underplay, as arguably Butler does.

Further, although it is not the focus on their discussion, Draper and Evans' essay does remind us that bioethicists tend to come at the issue of access differently from Butler. Expansion of access is presumptively regarded as a Good Thing by bioethicists as a general matter, but bioethicists also by and large appreciate the problems with medicine's expansion in an era when every intervention is fiscally scarce, if not scarce in absolute terms. In the absence of high-quality data showing that in gender reassignment interventions we have effective responses to a bona fide condition, bioethicists will reasonably ask whether the cost of these interventions is justified.

How such high-quality data could be developed is itself an interesting bioethical issue, at least if the threshold is something like a randomized clinical trial. If the relevant patient population consists of those who deeply desire precisely the kind of bodily refashioning that medical interventions offer, it seems unlikely that researchers would be able to attract a large enough cohort of subjects who would consent to randomized assignment to interventional and non-interventional arms, at least without certain forms of controversial incentives.

What is perhaps less likely to strike bioethicists is the social impact of medical response to gender nonconformity. To what extent do transgender-focused medical interventions promote a more expansive and humane understanding of the impact of gender norms on all of us? Some, of course, have worried about just the opposite possibility—that gender reassignment as a medical procedure calcifies and thus reinforces gender's regimen ("Real women have vaginas, not penises!"). Yet to the extent that one saw the broadening of gender norms as a desirable thing, it would surely be worth inquiring just what features of the enterprise of medicalized gender transitions might be exerting a narrowing force: the interventions as such, the subjectivities of those who desire them, or the understandings of what constitutes their legitimate use that wends its way through the *DSM* and the WPATH guidelines.

The position at which Draper and Evans arrive is that, while gender reassignment is not the sort of intervention about whose effectiveness we can be certain, clinical experience suggest that, when candidates for the interventions are carefully vetted by exacting standards—for example, those provided by WPATH, conformity to which they see as a moral requirement—gender reassignment procedures can lay claim to a sort of pragmatic authorization, as there does seem reason to believe that they substantially improve at least some lives otherwise greatly hampered.[4] Like Butler, Draper and Evans are also aware that gender nonconformity and the medical response to it may have an assessable impact beyond the lives of individual patients, although their concerns about what that impact may be are very different from hers.

Butler's theoretical sympathies are pretty plain: She is inclined to see the crossing of gender distinctions in a positive light, as helping to reveal the social, historical, performative, and hence fluid character of gender and to contribute to making people's engagement with gender more expansive, more humane, and less oppressive. She sees gender nonconforming people as among those who are oppressed by the sex-gender system and, therefore, as warranting the kind of careful respect due to those who are the targets of abusive power systems.

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[4] Draper and Evans cite the Harry Benjamin International Gender Dysphoria Association, WPATH's predecessor body (Draper and Evans 2006, 109).

Draper and Evans, on the other hand, use locutions and feature citations that reveal that they have quite different sympathies. While making a number of insightful points, particularly about such matters as the role of subsequent sexual attractiveness in judging the outcome of gender reassignment procedures and of the proper role of families and family responsibilities in assessing the morality of transgender interventions into specific lives, their repeated reference to veterans of gender reassignment as "constructed women/men" suggests a rather essentialist picture of gender. (It is not hard to imagine Butler's response to this: which women or men *aren't* constructed?) The "constructed" phraseology in particular is reminiscent of the ferociously anti-transsexual writer, Janice Raymond (1979), and so prepares the reader for her appearance in a concluding citation that attacks the legitimacy of transsexualism. With apparent approval, Draper and Evans echo Raymond's warning to feminists about "welcoming what she terms 'she-males' within feminism," on the grounds that, even lacking penises, these constructed women (particularly those who identify as lesbian feminists) retain the ability to "penetrate women—women's identities, women's spirits, women's sexuality … [to] not only colonize female bodies but appropriate a feminist 'soul'" (Raymond 1979 quoted in Draper and Evans 2006, 109).

My view is that Raymond's perspective represents a particularly malign call for one class of victims of prevailing sex-gender systems to delegitimize another, and I confess I am disappointed to see my fellow bioethicists uncritically lending credence to it without so much as noting the quarter-century of theoretical and political reflection on gender variance that has gone on since Raymond published her book. The general point, however, is that bioethicists who do take up the opportunity to explore the fascinating issues involved in this meeting between health care powers and the intricate roles played by gender differences in individual and shared lives ought to realize that there is already a pertinent theoretical literature that has not kept still even if they have, and that they may run the risk of complicity in enforcing the stigma that harms gender-nonconforming people.

This is not a concern that makes its way to the page for Draper and Evans: If reducing the incidence of bad results requires psychologically pathologizing seekers of such interventions, that seems to them a price worth paying. Their apparent endorsement of Raymond's perspective makes it difficult to avoid the thought that the politically dubious character of transsexualism reduces the incentive to take the perspectives or agency of transsexual people with much seriousness.

Harm, Benefit, Respect

However, another commentator on the ethics of diagnosis, Jacob Hale, has offered an explicitly bioethical analysis in support of a proposal for removing mental health professionals from their gatekeeping roles. His proposal retains a role for professional judgment in the provision of surgery and hormones, but one that does not default to mental health professionals. The analogy is to the role surgeons play in assessing informed consent to surgical sterilization (Hale 2007).

Hale provides an overview of the 2001version of the WPATH Standards of Care, noting that they require those seeking surgical or hormonal interventions to undergo substantial periods of psychotherapy and to pass indicators of consolidating their new identities that are measures of growth in mental health. On his view, the gatekeeping position assigned to mental health providers by the Standards of Care violates "the dominant principles of bioethics in the contemporary United States" (Hale 2007, 493), which he takes to be the principles of nonmaleficence, beneficence, justice, and respect for autonomy, primarily as articulated in Beauchamp and Childress (2001). The autonomy of those seeking interventions to facilitate gender crossing is slighted in comparison to every other category of adult prospective patients, he claims: The very request for hormonal and surgical intervention is regarded as signaling decisional incapacity, a particularly worrisome result in a social and cultural context in which gender-variant people already risk the attenuation of their moral status.

Nonmaleficence is the chief justification for insisting on mental health screening: These interventions carry with them likely or actual irreversible losses of reproductive capacities, other medical risks, and the possibility of intensifying social stigmas; while data indicate that subsequent regret is rare, the potential is real.[5] Hale, however, claims that the Standards of Care do not prop-

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[5] Hale relies chiefly on Pfäfflin and Junge (1998), who report an incidence of post-operative regret of less than 1 percent for female-to-male procedures, and 1 percent to 1.5 percent for male-to-female procedures.

erly balance these risks against the potential benefits and that they are mistaken in seeing the risks as justifying the suspension of respect for autonomy.

Consider vasectomy: a procedure that is so unreliably reversible that it needs to be considered as a permanent elimination of reproductive abilities and which cannot typically be counted as a way of warding off illness, injury, physical pain, or the threat of death. The American Urological Association's standards of care quite understandably emphasize informed consent; if the doctor is convinced that the patient understands the consequences and his other contraceptive options, that's the end of the matter.

Consider, now, the disanalogies: The level of medical risk connected to surgeries aimed at facilitating gender crossing is considerably higher than those attending vasectomy. Then there are "social risks" connected with the controversial character of the acceptability of such medical interventions and the resultant vulnerability of recipients to prejudice, bigotry, or violence.

For Hale, assessment of such risks has not been judicious: It has persistently misconstrued the "net balance of harms and benefits that might be caused by the intervention sought, by alternative interventions, and by refusals to intervene" (2007, 498) and has scanted the principle of respect for patient autonomy as well. In part as a result, a "black market" in medically unsupervised interventions has sprung up, resorted to by gender-variant people who either cannot find affordable, culturally appropriate care or who resent the mental health screening requirement. Furthermore, offsetting respect for autonomy on these ill-considered grounds is offensive to gender-variant people, diluting a basis of their self-respect and undermining their agency. As Hale observes, in routinely figuring people requesting transsexual medical procedures as lacking full autonomy, the Standards of Care actually contribute to the "social risks" whose mitigation is part of the rationale for mental health gatekeeping in the first place.

Hale's conclusion is that access to hormones and operations is a matter for patients and their physicians to decide upon jointly, on the basis of careful consultation and rigorous informed consent processes. In other words, the general standards governing the appropriate use of physicians' professional skills ought to apply in this area of medicine just as it does in others. Thus, Hale rejects the idea that gender-variant people have the right to receive any desired interventions they can pay for; the agency of health care professionals is also respected. Hale thus aims for parity for gender-variant people with individuals who seek professional assistance through other medical procedures that are not responses to pathologies—and, here, it might be well to bear in mind that pregnancy and parturition would be included in this category as well as surgical sterilization, breast reduction surgery, or Botox injections.

Are Hale's criticisms of the mental health screening stipulation of the sixth version of the Standards of Care met by the 2011 version? I think the verdict must be, "not substantially." While the new standards relax the requirement of psychotherapy—not a negligible change—they still insist on mental health screening, and do so with particular vehemence for genital surgery. Gender dysphoria of a degree sufficient to justify provision of hormones or genital surgery is seen as crossing the line between "mere distress" and mental disorder.

Yet this seems to violate the default assumption that people's self-regarding agency is worthy of respect. Lacking systematic evidence of impairment in transgendered people's ability to make sense of reality and the options it presents, or in their own grasp of their values and preferences, it is disrespectful to treat as incipiently pathological the desire for a kind of embodiment a person sees as more coherently expressive of her identity. Doing so invidiously singles out that sort of desire from other human yearnings that can lead people to make large and enduring changes in their lives.

Gender Variance and the Work of Bioethics

In 1998, I argued that bioethicists could bring their skills at normative and conceptual analysis to an area where such skills were conspicuously lacking, and do so in a way that engaged with interesting and distinctive controversies about how medicine should be practiced. As we enter the second decade of the 21st century, it seems to me as though bioethicists may have to ramp up their analytic game to make useful contributions to this area. Theorists, practitioners, and patients have not been idle in the intervening years.

Yet it also strikes me that bioethical contributions could be just as crucial to understanding medicine's engagement with gender, even if the requirements for getting into the discourse are a bit tougher. If Hale's analysis is on track, as I have here suggested that it is, it would seem that, despite the best efforts of well-meaning, thoughtful clinicians to learn from their own experience and from the articulate and politically aware people who seek their services, there is a persistent disparagement of patients going on. One does not have to regard autonomy as the most valuable feature of human lives to look askance at practices that systematically erode our regard for agency, and particularly for the agency of people suffering from social stigma, no matter how benevolently intended. As contemporary bioethicists have persistently entered the lists in this cause, it would seem curious, to say no more, if analyses like Hale's and Butler's should excite no detectable response.

Nor is this to suggest that a fundamentally regulatory function is the chief role for bioethics in this area: There are many questions about gender, medicine and culture, and bioethical theory operating here, and more searching assessments of nosological manuals, standards of care, and professional practice will require that bioethicists think them through, in what I expect would be distinctive and enlightening ways.

However, the concerns that Hale, Butler, and, in their own way, Draper and Evans bring to the fore about clinical engagement with gender variance contain an important lesson for bioethicists who wish to engage in such theorizing with an eye to influencing practical recommendations: Gender variance makes itself manifest in the lives of people whose claim to respect perhaps needs more than a perfunctory acknowledgment. While we do not customarily admit it, bioethicists resemble their clinical colleagues in that bioethical professional practice can, contrary to intent, also wrong others. Thinking about the nature of gender variance and the ethics of how health care responds to it may be a fruitful context for thinking about the nature of bioethics and the ethics of how we do it.

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