

Please cite the published version in the *Journal of Medical Ethics* found here:
<http://dx.doi.org/10.1136/medethics-2019-105611>

INTRODUCTION

In a recent viewpoint article in this journal, Florence Ashley has argued that requiring patients with gender dysphoria to undergo an assessment and referral from a mental health professional before receiving hormone replacement therapy (HRT) is unethical and may represent unconscious hostility towards transgender people and their experiences.¹ This is clearly a sensitive issue, but one which Ashley has broached in a manner which we believe needs addressing. We respond, first, by showing that Ashley has conflated the self-reporting of symptoms with self-diagnosis and that this is not consistent with the standard model of informed consent to medical treatment. Second, we note that the model of informed consent involved in cosmetic surgery appears to resemble the one Ashley proposes for the prescribing of HRT for gender dysphoria, while also recognising the importance of psychological assessment. Third, we suggest that even if gender dysphoria is not understood to be a mental disorder, the increased prevalence of psychiatric morbidity in the transgender population supports assessment and referral from a mental health professional prior to HRT, and remark that some of the literature Ashley cites against the referral requirement is not as supportive of her thesis as her use of it implies. In light of these remarks, we conclude that the claim that it is unethical to require assessment and referral from a mental health professional before prescribing HRT is dubitable.

INFORMED CONSENT WITHOUT ASSESSMENT?

In Ashley's view, gender dysphoria is a part of normal human variance, and self-reporting it should be sufficient to obtain HRT: 'the simple report of having gender dysphoria to a physician, combined with an informed consent process to ensure that expectations match the actual effects of HRT, should suffice to obtain a prescription'.¹ Ashley argues that the goal of informed consent '...is to not assess but to facilitate thoughtful decision-making'. This avoids what Ashley describes as the unethical practice of requiring those seeking HRT to undergo an assessment by a mental health professional to evaluate 'whether they are truly trans'.¹

A key premise in this argument is that we generally take someone seriously when they say something like 'my arm hurts': they have 'epistemic authority' to make such a claim. Ashley argues that those who self-report gender dysphoria similarly have epistemic authority, and there is no more reason to question this than self-reported arm pain.¹ If we consider this example in more detail, it becomes clear that this move conflates the self-reporting of symptoms with self-diagnosis. To ascertain the cause of a patient's arm pain requires a complete assessment, including history, examination and investigations. It might be due to any of a number of causes: myocardial infarction, cervical spondylosis, septic arthritis and so on. The assessor may, then, after interviewing the patient, perform a physical examination and request laboratory tests and imaging studies to aid diagnosis, after which treatment

options can be discussed and initiated. Assessment is, therefore, a necessary stepping stone to informed consent.

Similarly, when a patient self-reports symptoms of gender dysphoria, this does not imply an automatic diagnosis of gender dysphoria: the World Professional Association for Transgender Health (WPATH) guidelines are clear that not every assessment of a person reporting symptoms of gender dysphoria results in this diagnosis.² This is because there are conditions that can lead to an individual believing themselves to be have gender dysphoria, and yet prove not to following assessment and further investigation.³ ,i Importantly, requiring a psychological assessment prior to HRT in no way calls into question a patient's self-reported experience—it merely clarifies the causes of this experience which in turn indicate options for therapy, paving the way for informed consent.

The view that a psychological assessment prior to initiation of HRT should be done away with short-circuits the informed consent process by omitting its basis in a prior assessment. Although Ashley calls her proposal 'informed consent', it bears little resemblance to the standard account of informed consent illustrated above. Admittedly, and even though Ashley gave the example of arm pain to make her point, the case is a standard medical scenario, and Ashley is keen to move away from a medical model of gender dysphoria, stating clearly that it is not a mental disorder.ⁱⁱ This raises the possibility that a somewhat different model of informed consent would be germane to Ashley's proposal, rather than what might be termed the standard medical model.

INFORMED CONSENT: THE COSMETIC SURGERY MODEL?

People seeking elective cosmetic surgery, like those seeking HRT for gender dysphoria, are not trying to cure an illness. Rather, they wish to alter non-pathological aspects of their body by medical means. Since these two sorts of intervention are substantially similar, their governing models of informed consent should be similar. However, it is now widely recognised that psychological assessment and referral is an important element of the care of patients undergoing cosmetic surgery, and an aid to the process of informed consent.⁴ It needs to be shown why psychological assessment prior to HRT for gender dysphoria is ruled out when it is considered good practice in cosmetic surgery.

In this connection, Ashley proposes a different analogy: between HRT for gender dysphoria and abortion. Neither being transgender nor being pregnant is an illness, yet people seeking abortions are not subjected to prior psychological assessment, she suggests. This is a strained analogy with implications that Ashley would probably not welcome. Abortion remains a deeply contentious issue. Even where it is permitted by law, abortion is subject to diverse legal restrictions concerning time limits and/or required indications. Indeed, abortion looks like a good counter-analogy to Ashley's argument, as it frequently attracts additional preconditions to informed consent, such as statutory waiting times or, crucially for the current subject, physical and mental health assessment by a qualified physician.

The model of informed consent Ashley proposes for providing HRT to people with gender dysphoria, therefore, bears little to no resemblance to the measures of informed consent

applied in the treatment of medical conditions or elective procedures such as cosmetic surgery or abortion. Consequently, it seems that Ashley's argument invites suggestion of special pleading.

OTHER PROBLEMS

Another issue becomes apparent when Ashley argues that current referral processes fail to consider the 'lived experiences of the trans people who undergo these assessments'.¹ Caution is warranted when making general and normative claims based on a single individual's experiences, since transgender people are not a homogenous group. Indeed, the discussion around psychological assessment should consider that transgender people have been shown to experience an elevated prevalence of adverse mental health conditions including depression, anxiety, suicidality and self-harm.^{5–7} Addressing any existing mental (and physical) health concerns continues to be recommended under the WPATH Standards of Care, including before the commencement of HRT.² Far from being unethical, psychological assessment is arguably an important aspect of holistic care of people with gender dysphoria.

Finally, Ashley states that the purported benefits of psychological assessment and a referral letter from a mental health professional are not supported by evidence: 'In their work on the ethics of informed consent in transgender care, Cavanaugh et al have pointed out that '[t]here is no scientific evidence of the benefit of (referral letter) requirements'.¹ However, in context, Cavanaugh et al are referring to the process of referral for genital reconstructive surgery (GRS).⁸ Furthermore, one of the sources cited by Cavanaugh et al summarises an article which argues for a reduction to one signature for approval from a mental health professional (in the context of GRS) and not the removal of any such requirement altogether.³ In fact, though they acknowledge that the requirement for referral in the context of HRT is challenged by some experienced clinicians, Cavanaugh et al state that further research is required; therefore, removing all requirements on this basis would be premature until there is sufficient evidence to the contrary.

CONCLUSION

We have argued that claiming that it is unethical to expect people with gender dysphoria to undergo mental health assessment prior to receiving HRT is problematic. Though informed consent is proposed as the basis of an alternative model, the meaning Ashley invests into this phrase finds no parallel in wider medical discourse on the subject. Moreover, cosmetic surgery, while being analogous to HRT for gender dysphoria, entirely supports the practice of prior psychological assessment. Furthermore, the same standard should apply to non-trans and to trans people seeking elective medical interventions; in either case assessment should precede intervention. In conclusion, Ashley's argument, it would seem, is readily applicable, not only to HRT for the management of gender dysphoria but also for surgical interventions for people with gender dysphoria, though she does not explicitly make this claim. Likewise, our response is equally applicable to this plausible extension of Ashley's view.

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