

ETHICS CASE

Should Psychiatrists Prescribe Gender-Affirming Hormone Therapy to Transgender Adolescents?

Commentary by Cary S. Crall, MD, and Rachel K. Jackson

Abstract

Gender-affirming hormone therapy is a safe and effective way to improve quality of life and mental health outcomes for transgender adolescents. Access to this treatment is limited, with the most vulnerable transgender people experiencing the greatest gaps in care. Because some psychiatrists help transgender patients receive needed medical interventions, we analyze the ethical values they must balance when deciding whether to provide hormone therapy to patients who seek it.

Case

In the medium-sized city where he practices psychiatry, Dr. Lao has developed expertise in treating and counseling transgender adolescents. This afternoon, Dr. Lao is scheduled to meet with Jessie, a 15-year-old high school student with autism spectrum disorder. Jessie has been Dr. Lao's patient since elementary school. Within the last two years, Jessie, who was birth-assigned male, began opening up to her family and Dr. Lao about her identity as a transgender female.

In the waiting room, Jessie's parents pulled Dr. Lao aside. "Is it true that you will soon start administering hormone therapy yourself?" Jessie's father asked Dr. Lao. "Because it would be great if we didn't have to find another physician when Jessie starts hormone treatment. Jessie said she would much rather have you perform the treatments."

It was true that Dr. Lao was considering becoming trained to administer hormone therapy. Many of Dr. Lao's transgender patients and families have complained about the lack of physicians in their rural community who are trained in hormone therapy administration. Dr. Lao thought he might play a role in reducing this resource disparity for his patients by becoming trained himself.

Their previous session ended just as Jessie began to describe some of her anxieties to Dr. Lao about transitioning from male to female. Jessie worried about what her classmates might think about her transition, and, while her immediate family was very supportive, Jessie worried about the opinions of members of her extended family, who tended to be less progressive on issues of gender and sexuality.

In their session today, Dr. Lao wanted to follow up with Jessie about these concerns. “Jessie, when we last met, you mentioned concerns regarding how your classmates and family members might react to your transition—would you like to keep discussing that?” With that question, Dr. Lao noticed that Jessie seemed somewhat withdrawn and uncharacteristically uncomfortable in front of him. “No,” she replied, “I thought it over, and I’m not as worried anymore about what they’ll think.” Dr. Lao tried a couple more times in their discussion—with little success—to veer the conversation back to Jessie’s formerly expressed worries about her transition. At the end of their session, Jessie said to Dr. Lao before leaving his office, “I’m feeling very ready to begin hormones—and it would make me so happy if you were the one managing my treatments, Dr. Lao.”

As Dr. Lao waved goodbye to Jessie and her family, he couldn’t help but wonder if Jessie’s refusal to discuss her anxieties about her transition were related to her wish to pursue hormone therapy under his care. Could it be that Jessie feared Dr. Lao would be hesitant to treat her or might delay the process if Jessie disclosed her anxieties about transitioning with him? Dr. Lao wondered: If he developed expertise in hormone therapy, would his patients then perceive him as a kind of gatekeeper in the process of their transition? Will his role in offering hormone therapy sacrifice important elements in his therapeutic relationships with his patients like Jessie?

Commentary

Initiating and managing care for transgender patients can often be daunting, even for a caring, motivated physician like Dr. Lao. Transgender people who seek gender-affirming medical care are a small, geographically diffuse community with specialized medical needs requiring coordinated communication among multiple medical specialists. They experience rampant social discrimination, often leading to unemployment and unequal access to health insurance [1] as well as high rates of mental illness [2], further complicating their ability to obtain adequate care. Additionally, many transgender people are hesitant to engage with clinicians and medical office staff due to a personal history of mistreatment by the medical community. In a 2009 survey, 70 percent of transgender or gender-nonconforming respondents reported experiencing at least one type of discrimination in health care settings, with 26.7 percent of the total reporting that they were refused care due to their gender identity and 7.8 percent of the total reporting that clinicians were physically rough while providing care [3]. Given this precedent, their hesitance is understandable.

These challenges have led to a system in which transgender care is centralized in specialized, cross-disciplinary health clinics located in major cities, leaving the most vulnerable transgender patients—those from racial or ethnic minority communities, of low socioeconomic status, or young or elderly people living in rural communities—largely without quality care. What is the nature and scope of an individual psychiatrist’s obligation to provide gender-affirming medical treatment to patients seeking hormone

therapy, especially when providing such care can extend beyond his or her normal scope of practice?

As is the case with many medical interventions, Dr. Lao's decision to provide hormone therapy is clinically and ethically complex. Careful analysis guided by the principles of patient autonomy, beneficence, nonmaleficence, and justice provides an overall framework to guide psychiatrists, particularly those in rural communities, on how they should proceed.

Ethical Principles Favoring Hormone Therapy Administration

The principles of patient autonomy and beneficence support the need for psychiatrists to prescribe hormone therapy for [gender-transitioning adolescents](#).

Patient autonomy. The patient autonomy argument for providing HRT is straightforward—physicians should honor transgender patients' right to express their gender identity by providing desired medical interventions in line with the established [standard of care](#) [4, 5]. Historically, clinicians serving as gatekeepers to hormones led to an outcry from members of the transgender community that such a practice violates their basic human right to gender expression [6]. In turn, physician gatekeeping policies and practices limiting access to hormone therapy for those who desire it has led to a robust, unregulated black market for hormones outside the purview of pharmacist or FDA regulatory monitoring of hormone product safety and quality. Gatekeeping can exacerbate disparities in access to safe and reliable hormone treatment, particularly among transgender youth [7]. Thus, honoring patient autonomy by providing access to hormone therapy serves the dual purpose of acknowledging transgender persons' right to self-determination regarding gender expression and expressing regard for the principle of nonmaleficence by limiting potential negative health consequences of unsafe products from unregulated sources. While ethical issues of consent and autonomy specific to initiating hormone therapy in minors are complex, they have been effectively analyzed elsewhere [8, 9].

Beneficence. The principle of beneficence—the obligation to do good for the patient—additionally supports Dr. Lao's providing hormone therapy. The best available evidence, along with decades of clinical experience, indicates that effective hormone therapy has a positive effect on psychological and quality of life outcomes in transgender people [10]. Jessie's anxiety and depression plants her firmly within the mainstream for young transgender people who live with varying degrees of social, legal, and medical affirmation of their gender identity. In a recent study featuring a diverse, multicity cohort of 298 young transgender women, Reisner et al. found that 41.5 percent had at least one mental health or substance dependence diagnosis and 35.4 percent reached criteria for a lifetime major depressive episode [2]. Although only 7.4 percent of participants reported current suicidality in Jessie's age group (i.e., ages 16-19), that number was 23.7 percent for those just ten years older [2]. This finding suggests that the patient sitting in front of

Dr. Lao is at a critical period of development, at high risk of developing mental health problems and suicidal ideation if effective interventions are not put in place.

The causal pathway to higher rates of mental illness in transgender youth is illuminated by a recent study, which found that socially transitioned transgender children who are supported in their gender identity have developmentally normal levels of depression and only minimal elevations in anxiety compared to other children their age [11]. This finding suggests that psychopathology within this group is a product of poor social acceptance rather than an intrinsic part of transgender identity. [Pubertal suppression](#) and hormone therapy are the chief tools physicians have at their disposal for minimizing a transgender patient's risk of suffering adverse mental health outcomes.

Opportunities to provide benefit to the patient extend well beyond psychological care as Jessie, at age 16, is undergoing physical development that requires timely medical intervention to maximize medical affirmation of her gender identity. Depending on Jessie's current height, timely estrogen administration might aid in closure of the growth plates, possibly allowing for her to remain closer to the median height for girls her age. Additionally, each passing day of androgen-predominant puberty leads to further facial masculinization, deepening vocal range, and male pattern hair growth that will require costly—and variably effective—medical and behavioral interventions if Jessie chooses to pursue them in order to pass as her affirmed gender.

Tragically, passing can be a matter of safety and survival for young transgender women. In one large survey of transgender people, 53 percent reported being victims of harassment in public accommodations [12], and, in 2015, 67 percent of victims of hate crime homicides reported by the National Coalition of Anti-Violence Programs were perpetrated against transgender and gender-nonconforming people [13]. Passing can also affect transgender people's ability to find romantic partners, housing, and employment, with 63 percent of transgender survey respondents reporting acts of serious discrimination in one or more of these domains [12]. Although these are largely social and legislative problems, timely hormone therapy is crucial for transgender patients' quality of life and physical safety, given the current risks of violence and [discrimination](#) they face. In the absence of other physicians willing to provide hormone treatment, Dr. Lao's obligation to intervene based on the principle of beneficence is imperative to Jessie's well-being.

Ethical Principles that Do Not Support Psychiatric Administration of Hormone Therapy

Ethical analysis based on the principles of nonmaleficence and justice suggests that Dr. Lao should think twice before providing hormone therapy for gender-transitioning adolescents.

Nonmaleficence. Although there are strong arguments in favor of Dr. Lao being trained to provide gender-affirming medical care, specifically hormone therapy, the ethical principles of nonmaleficence and justice weigh on the other side of the balance. Nonmaleficence—to do no harm—is a complicated standard to uphold in this case. Much has been made of potential iatrogenic harms of estrogen-based hormone therapy in late adolescence—including increased risk of deep vein thrombosis, prolactinomas (brain tumors that cause excess prolactin release by the pituitary gland), and loss of fertility for those who do not undergo cryopreservation prior to hormone initiation [14, 15]. While these medical complications can be severe, recent studies have found the incidence of adverse effects of hormone therapy to be low overall [16], and the potential harms of any treatment must be weighed with the potential gains in mind.

Dr. Lao must be prepared to monitor and treat all side effects of the medications he prescribes, whether through his own efforts or expert consultation. Unfortunately, he is unlikely to have been taught basic hormone therapy administration or pubertal suppression while completing his psychiatry residency training. Although current Accreditation Council for Graduate Medical Education (ACGME) core competencies require psychiatric residency programs to teach “fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual” [17], management of gender dysphoria—the conflict between birth-assigned and self-identified gender—including hormone therapy, is seldom taught [18]. While psychiatrists have long prescribed estrogen for indications ranging from postnatal unipolar depression to premenstrual dysphoric disorder, there is little precedent for psychiatric practitioners providing hormones for gender dysphoria [19]. Because Dr. Lao is practicing in a rural setting without access to transgender-affirming medical specialists for consultation, he must consider the potential harm to Jessie of initiating hormone therapy and then being required to stop if complications arise that he does not have the expertise to manage.

Additionally, because Dr. Lao is Jessie’s psychiatrist, he must consider the potential harm to his therapeutic alliance with her if he chooses to prescribe hormone therapy. On the one hand, the standard of care for prescribing hormone therapy, especially in adolescents, calls for invasive physical exams, including of breast and genital tissue—a practice that could generate negative [transference reactions](#) from Dr. Lao or Jessie and be detrimental to the therapeutic relationship. On the other hand, as Jessie’s mental health clinician, Dr. Lao has an obligation to help Jessie process her gender dysphoria, regardless of whether she chooses to continue medical assistance with her transition. If Dr. Lao is invested in managing Jessie’s hormone therapy, will he be able to integrate the physical dimensions of her care into their therapeutic relationship without causing harm?

Justice. Finally, the principle of distributive justice—the fair distribution of scarce resources and the balancing of competing needs—calls into question the ethical and

clinical wisdom of Dr. Lao taking on the responsibility of prescribing hormone therapy. While providing hormone therapy would serve to bring this resource to a population in which there is a relative scarcity of access, Dr. Lao's position as a psychiatrist who sees adolescents in a rural area makes his time another scarce resource to consider. A 2010 study in the *Journal of Pediatrics* reported that primary care pediatricians rated child and adolescent psychiatrists as the least accessible subspecialists for [patients requiring a referral](#), with the worst access reported in rural communities [20]. Long wait times for patients with high-acuity chief complaints, ranging from first-episode psychosis to posttraumatic stress disorder (PTSD) from chronic abuse, would potentially increase if a clinician unfamiliar with a relatively rare condition took time to learn its management. Is there truly a clinical and ethical imperative for Dr. Lao to take on learning to serve outside his current scope of practice when the need for him to serve within its limits is already so great?

Conclusion

Physicians who choose to provide quality care for a stigmatized patient population within a system that generally ignores its unique medical needs do so at the fringes of their clinical comfort zone. In the absence of a functional system of consistent and equitable care delivery for all patients, the onus of competent care often falls on conscientious individual clinicians who are passionate about [caring for the underserved](#). As the sole clinician offering Jessie crucial gender affirmation, we argue that it is Dr. Lao's responsibility to ensure Jessie receives all medically indicated interventions she desires, including hormone therapy. To do this, it is his clinical and ethical responsibility to perform due diligence by helping Jessie receive gender-affirming medical treatment, including hormone therapy, from an experienced clinician. If geographic and cultural factors, such as transphobia, limit the availability of adequate transgender care, it becomes Dr. Lao's responsibility to become trained in and to initiate hormone therapy with the patient as long as the benefits of providing hormone therapy outweigh the potential risks. Although each psychiatrist must make his or her own decision about whether to help patients receive desired hormone therapy, a few basic principles should serve as a guide:

1. When transgender patients present seeking gender-affirming medical interventions, psychiatrists are responsible for ensuring these patients receive access to all medically indicated care. Due to the clinical complexities of gender-affirming medical treatment for adolescents, due diligence in locating an experienced and skilled clinician must be exercised.
2. ACGME-accredited psychiatry residency training programs should teach management of pubertal suppression and gender-affirming hormone therapy as part of their standard curricula. Some of this training might take the form of grand rounds, case discussions, and simulated patients if residents do not come into contact with transgender people with regularity at their available training sites.

3. When assessing the urgency of hormone therapy initiation for adolescents, special attention should be paid to developmental window periods in physiologic puberty.
4. Psychiatrists should give special consideration to the therapeutic alliance when considering initiating hormone therapy. Co-management with other professionals is the preferred method of treatment. In most cases, due to the possibility of negative transference reactions, psychiatrists should not perform sensitive physical exams on patients with whom they have an established therapeutic alliance.

With these principles in mind, it is our hope that psychiatrists will work to reverse a legacy of exclusionary gatekeeping policies towards transgender patients seeking gender-affirming medical treatment by becoming champions in the effort to expand access to care.

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