

MEDICINE AND SOCIETY

Understanding Transgender and Medically Assisted Gender Transition: Feminism as a Critical Resource

Jamie Lindemann Nelson, PhD

Abstract

Feminism has fought the trivialization of women's experiences, championed women's security, and insisted on respect for women's choices. In so doing, feminism has developed important perspectives on the complicated connections between what gender means as it plays itself in people's lives, and the inequalities of power and authority that structure much of human experience. Here, I put a few of these perspectives into contact with an issue where the interactions of gender and power are squarely in play: medicine's role in assisting gender transitioning generally and, specifically, the enduring controversy between medicine and many transgender people about the pathologization of transgender and the role of clinicians as gatekeepers to gender-transition interventions.

Introduction

It's an interesting time to be alive if your sense of yourself is out of alignment with parts of your body that traditionally have been taken to determine your gender. "Transgender" has in recent years become a (generally) viable, commodious, diverse social identity, one that has achieved some semblance of legal parity with other fundamental parts of people's identities. We can see people like ourselves in positions of responsibility in government, industry, academia, health care, in the police and military, and the arts. We see more realistic depictions of transgender lives in the media, conveyed without scorn.

Yet if scorn is no longer routine in the media, it is still painfully, and for some of us, fatally present in day-to-day interactions; if laws at the national level and in some states and localities are moving us toward recognition as full and equal citizens, there are many people who still fear and disdain us. We've become targets for politicians seeking to ban access to public accommodations in an effort to curry favor with the fearful by blocking further social uptake of how we make sense of ourselves and of gender [1].

This is not to say that transgender people are the only group who has sought to revise what gender means—or who have experienced backlashes for these efforts. Reimagining what gender is, and what it means in our own and other's lives, has been an

increasingly important feature of social life throughout the last century. Women in particular have challenged limitations on their lives that traditionally had been seen as part and parcel of the ["natural facts" of gender](#). Feminist thinkers and activists have done substantial work in responding to these challenges and in articulating the values and concepts—for example, that the agency of women must be fully respected, that their physical integrity must be honored, that the importance of their needs and desires are not lessened by their biology—that they embody. The upshot for both women and men has been slow but steady movement toward the possibility of living in ways that are more equitable, less hemmed in by rigid gender roles, and more reflective of these values.

Medicine and What Gender Means

Medicine has played both progressive and regressive roles in this general process and has had a distinctive involvement in the lives of transgender people that extends at least back into the early decades of the twentieth century. Medical engagement gained momentum as the century wore on and academic centers and specialty societies dedicated to transgender-specific care began to appear. Authoritative standards of care governing access to endocrinological and surgical responses to ["gender identity disorder"](#) were first promulgated in 1979, and have been in continual evolution since [2]. However, while medicine was trying to help some people liberate themselves from the alienating experiences and expectations attached to their birth-assigned gender, it also tried to isolate the challenge such efforts posed to ordinary understandings of gender. That is, if your gender identity did not match your anatomy, you were understood to have a mental illness resistant to psychiatric intervention, but amenable to physical intervention. Surgery, for example, was often depicted in a *faute de mieux* fashion—as facilitating not a real "change of sex" but merely a harm-reducing simulacrum that preserved a familiar and safe gender binary. That is, society could rest easy with medicine pathologizing gender "deviance" and proposing a clinical strategy for explaining and containing it: nobody's genitals were going under the knife unless they had the right kind of illness, and besides, nothing that happened in an operating room on any single patient could really challenge gender's "fundamental truths"—e.g., that there are two and only two, that everyone has one or the other, and which one you are is determined by some deep and immutable fact.

Very little of this has any direct connection to medical knowledge or practice: a person could be, for instance, a highly skilled surgeon, endocrinologist, or psychiatrist without believing that transpeople suffer from a disease or a disorder, or that gender is fundamentally bivalent and unalterable. The "fundamental truths" are much more matters of ideology than science, and feminists and transgender people themselves have been busy replacing them with conceptions better equipped to consider adequately the complexities of gender.

Medicine no longer needs to make transgender unthreatening by portraying it as a disease whose therapies must preserve the gender binary. Yet giving up a disease model may seem to leave medicine in a quandary. The kinds of [psychiatrically mediated gatekeeping](#) to medical help required by various iterations of the World Professional Association for Transgender Health standards of care—for example, a mental health assessment and a referral from a mental health practitioner for gender-affirming interventions—make most sense if transgender is a sort of illness. If transgender is not an illness, it might be wondered, what business has medicine with it at all? Perhaps surgical and hormonal interventions should be seen as merely a sort of extreme cosmetic intervention—involving the destruction of healthy organs and the removal of reproductive abilities—legitimated solely by consumers’ (informed) choice. Yet seeing transgender interventions in this way seems hardly more likely to reflect most transgender people’s experience of themselves than would the mental illness story. Achieving a recognizable gender identity that reflects one’s sense of self is not merely one choice among others aiming at more social or professional success. A habitable gender identity is not important because it is chosen; it is chosen because it is important. Understanding transgender interventions as elective cosmetic surgery could also threaten the insurance coverage that does exist for transgender-directed medical interventions and make any expansion of that coverage less likely, as it would not be seen as medically necessary.

Yet if neither “medically indicated” pathology nor elective cosmetic surgery are good ways of understanding what is going on in medically assisted gender transitioning, how can it be best understood? Here, some prominent strands in feminist thinking about gender can be helpful.

The relationship between transgender and important currents of thought within feminism is complex; over the years, feminists and feminisms have served as allies as well as critics of transgender people. Feminists agree, however, on the enormous social importance of how people are gendered and, in particular, about how damaging practices associated with gender typically are for women and girls. Disagreements among feminists concerning transgender often pivot on whether transgender and, particularly, medically assisted forms of gender crossing, reinforce or erode damaging features of gender [3].

In my view, transgender can do either, and it has done both; it has both challenged and reinforced norms and practices associated with gender that have hampered people’s lives. Part of the way forward is to tap the potential of *transgender* to make of *gender* a more humane set of social relations, as well as subjective experiences. A big question for medicine is how to understand and respond to transgender in ways that will promote these conceptual, social, and cultural goals.

Gender, Authority, and Analogies

Gender differences are not simply natural "givens." There is a lingering temptation to think that gender differences are straightforwardly natural facts and that social organizations have to accommodate those facts in one way or another. Some have even thought that transgender must abet this temptation: something presocial *must* be happening to explain why transpeople so strongly resist assimilation to the gender socialization to which most so readily succumb.

Yet, as many feminists and other theorists have argued, this temptation too readily accepts the idea that "natural facts" can be clearly and distinctly separated from the social contexts in which they occur [4]. What those facts mean to us, how they are taken up into our lives, reflect and reinforce the ways in which respect, authority, and access to goods are distributed in human societies; they cannot by themselves justify those distributions.

What might accepting a broadly feminist—which is at least to say a highly social and critically inclined—account of the nature of gender mean for clinicians involved with transgender patients? Feminism would provide reason to resist the notion that there is something artificial, not natural, and therefore second-best in the ways transgender people live out their gender identities. This realization might help clinicians recall that how we [express our genders](#) is important to many of us, not just to transgender people. Most people engage in practices—how they walk, talk, or wear clothing, for example—designed to make their gender identities plain to others; virtually all of us are addressed by gender-distinctive standards of behavior and of aspiration, not all of which seem unwelcome. In this sense, gender's subjective and social dimensions are not so different for trans- and nontranspeople. What the existence of transpeople can do is to testify that gender-related expectations can be assessed, resisted, and reworked, as well as affirmed.

Transpeople, then, face a certain set of problems as they live out their lives in ways that simultaneously challenge and converge with what tends to be important for most people. Medicine has resources to help some of them better resolve those problems and achieve goals—personal peace, social acceptance—that are in many respects quite commonplace. Understanding transgender also might relieve some of the social anxieties that may have prompted clinicians to continue to insist on psychiatric endorsement of transpeople's self-understanding [5]. Furthermore, it might well improve the experience of transgender people in all their dealings with [health care](#)—dealings that go far beyond what occurs in a gender identity clinic. Perhaps most importantly of all, it might speed the spread through social life of supportive and welcoming attitudes to transgender people. There is reason to believe that such attitudes can go a long way toward causing the rate of trans suicide, particularly among trans youth, to plummet [6].

The authority of women over their bodies and their lives must be honored. This is a key tenet of feminism, but why should we think it has special relevance for transgender people? There are, after all, transmen as well as transwomen, and transpeople who seek to live insofar as possible beyond the gender binary, resisting identification as either women or men. But in general, medicine's engagement with gender crossing involves people who have either been socially configured as women, or who understand themselves to be women, despite their anatomy. Like everyone else, these people have a presumptive authority over the fundamental terms of how they are understood by others. Yet, as is the case with many forms of authority, women face particular resistance to its recognition. This resistance can hamper gender identity expression for transmen and transwomen both. If medicine is to align itself with defensible values as it aids gender crossing, it needs to do so in a way that fully endorses both the worthiness of women's choices and the choiceworthiness of women's lives. Psychiatric assessment as a required hurdle to gender-affirming hormone therapy or surgery tends to undermine that endorsement. Counseling—including peer counseling—should be readily available and can be an important part of achieving fully informed consent, but [psychotherapy should not be mandatory](#) for access to hormone treatment or surgical procedures.

Being a woman, or a man, or a nonbinary person are worthy ways of living, not pathological impulses; those who seek medical assistance to help them live so are not on that basis alone ill or confused, and there is every reason to avoid giving the impression that they are. It then might seem that the feminist perspectives discussed here support an elective cosmetic surgery model.

But feminism, in its insistence that women's experiences need to be acknowledged as central features of human experience, might remind us that we are not limited to merely two options in thinking about the relationship between medicine and transgender.

Birth giving as a model. Motherhood is a social role that many people deeply want to occupy. Moreover, many of them want to achieve that role in a way that crucially involves their bodies. Medical assistance in the project is often welcome and sometimes needed to avert poor, or even tragic, outcomes. Yet it is not strictly necessary for becoming a mother. There are analogies here with transgender: while many transgender people see medical interventions as essential for social acceptance and personal integrity, others do not. Many different transition strategies are used by transpeople. Consider further how giving birth to a child can transform one's life. The process is arduous and not without dangers; the outcomes may well bring as much heartbreak as joy. Yet women aren't required to undergo any form of screening or therapy as a condition of getting medical help with pregnancy and delivery.

Pregnancy is not a disease. Nor is the decision to begin or add to a family likely to be of only instrumental significance; often, it emerges from a person's sense of what matters

deeply to her. Here too, analogies with gender crossing seem clear. As medical assistance with pregnancy and with birth giving are altogether appropriate, and insurable, it would seem that policies withholding insurance coverage for medical assistance with transgender would need to be able to cite significant disanalogies between the two to escape the charge that refusal of coverage is arbitrary.

There have always been ideologies of gender expressed in medicine's dealings with transgender people—messages sent and received in ways that do not require them to be explicitly endorsed by any particular caregiver. It seems to me, however, that now medicine should openly ally itself with ways of making sense of gender that affirm the value of transgender people's experiences and choices, in preference to conveying a hodgepodge of confused attitudes that may disrespect transgender people and slow the bend of history's arc toward justice [7].

References

1. Human Rights Campaign. Anti-transgender legislation spreads nationwide. <http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/HRC-Anti-Trans-Issue-Brief-FINAL-REV2.pdf>. Published February 2016. Accessed March 20, 2016.
2. Meyerowitz JJ. *How Sex Changed: A History of Transsexuality in the United States*. Cambridge, MA: Harvard University Press; 2002.
3. Stryker S. Transgender feminism: queering the woman question. In: S Gillis, G Howie, R Munford, eds. *Third Wave Feminism: A Critical Exploration*. 2nd ed. New York, NY: Palgrave Macmillan; 2007.
4. Kessler SJ, McKenna W. *Gender: An Ethnomethodological Approach*. Chicago, IL: University of Chicago Press; 1978.
5. Nelson J. Medicine and making sense of queer lives. *Hastings Cent Rep*. 2014;44(suppl 4):S12-S16.
6. Bauer GR, Scheim AI, Pyne J, Travers R, Hammond R. Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC Public Health*. 2015;15:525. <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1867-2>. Accessed September 29, 2016.
7. The phrase "the arc [of the moral universe] ... bends toward justice" is from Parker T. *Ten Sermons of Religion*. Boston, MA: Crosby, Nichols; 1853:84-85.

Jamie Lindemann Nelson, PhD, is a professor of philosophy at Michigan State University in East Lansing, Michigan. She is also a fellow of the Hastings Center and co-editor of *IJFAB: International Journal of Feminist Approaches to Bioethics*. Her work on philosophical and bioethical issues sparked by gender and transgender has appeared in the *Hastings Center Report*, *Journal of Bioethical Inquiry*, and *GLQ: A Journal of Lesbian and Gay Studies* among other places.

Related in the *AMA Journal of Ethics*

[How Should Physicians Refer When Referral Options Are Limited for Transgender Patients?](#), November 2016

[Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients](#), November 2016

[Proposed DSM-5 Revisions to Sexual and Gender Identity Disorder Criteria](#), August 2010

[Sexual Sunday School: The *DSM* and the Gatekeeping of Morality](#), November 2014

[Should Mental Health Screening and Psychotherapy Be Required Prior to Body Modification for Gender Expression?](#), November 2016

[Transgender Rights as Human Rights](#), November 2016

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

**Copyright 2016 American Medical Association. All rights reserved.
ISSN 2376-6980**