

Prioritizing Trans Autonomy over Medical Authority in Gender-Affirming Care: The Role of Risk and Uncertainty

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Historically, gender-affirming medical care has been provided through an assessment-based model of care that prioritizes the clinician's expertise and authority over the trans individual's desires or lived experience, which has been widely critiqued by trans communities. More recently, informed consent approaches that de-emphasize formal mental health assessments are becoming increasingly common in gender-affirming care. However, previous research has found that many gender-affirming care providers continue to practice gatekeeping despite using the language of informed consent. In this article, I analyze the tensions between medical authority and patient autonomy in the recently updated 8th edition of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC-8). I find that while the SOC-8 generally supports informed consent models, when faced with heightened risk or uncertainty, the SOC-8 reverts to an assessment-based model of care that reinforces medical authority and compromises trans people's autonomy. I argue that without deconstructing the assumed authority and expertise of healthcare providers, we cannot achieve fully equitable and accessible gender-affirming care. Specifically, gender-affirming care providers must practice epistemic humility and value trans peoples' lived experience as legitimate sources of knowledge. I suggest strategies for teaching clinicians to value trans people's autonomy and embodied knowledge.

KEYWORDS gender-affirming care; transgender; informed consent; medical authority; decision-making; autonomy

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Gender-affirming care—used here to refer to medical interventions such as hormones and surgery for transgender people seeking to change their body to better affirm their gender identity—is essential to many trans people's health and wellbeing (Coleman et al. 2022). However, experiences of gatekeeping, paternalism, pathologization, and

transphobic stigma and discrimination have led many trans people to mistrust health care providers (Fraser, Brady, and Wilson 2021; MacKinnon et al. 2020; Riggs et al. 2019; Shook et al. 2022; shuster 2021). A recurring tension in gender-affirming care is balancing health care providers' medical authority and expertise with patients' autonomy and self-knowledge. In this article, I investigate how the recently updated global clinical guidelines for gender-affirming care—the 8th edition of the World Professional Association for Transgender Health's (WPATH) Standards of Care (SOC-8)—deal with this tension. I find that while the guidelines generally emphasize the importance of patient autonomy, the SOC-8 reverts to prioritizing medical authority over patient autonomy when faced with heightened uncertainty or risk. I argue that to provide truly equitable gender-affirming care that centers trans people's self-determination, clinicians must practice epistemic humility and recognize trans peoples' embodied knowledge as legitimate, valid, and important.

Anyone accessing health care services is subjected to medical authority, but trans people's lives are especially controlled by medical authority. Gender-affirming medical care is necessary for many trans people's ability to live as their authentic self with integrity (Rowland, 2023). While many individuals rely on medical interventions to live, gender-affirming care is unique in that it impacts an individual's embodied gender expression in a culture where gender is seen as an essential and inextricable part of an individual's personhood and humanity (Martin and Mason 2022). Further, the legacy of psychopathologizing transness casts undue suspicion on trans people's self-knowledge and grants clinicians the epistemic power to (dis)believe trans people's asserted gender identity. As such, I argue that medical authority exerts disproportionate power over trans lives.

I begin by briefly outlining the history of gender-affirming care and the shift from older gatekeeping models of care to newer informed consent models. I highlight how uncertainty leads to conflict between medical authority and patient autonomy in gender-affirming care. I then carefully analyze of the SOC-8 and find that despite the contemporary shift towards informed consent models of care, the SOC-8 continues to prioritize clinicians' authority over trans people's self-determination when faced with heightened uncertainty or risk. I argue that equitable access to gender-affirming care is not possible until we deconstruct medical authority used to control trans lives. Finally, I consider the implications of my argument for future clinical practice and research.

HISTORY OF GENDER-AFFIRMING CARE

Gender-affirming hormones and surgeries have existed since at least the early 20th century (Gill-Peterson 2018). However, the foundation of the contemporary model of access to gender-affirming medical care in North America did not emerge until the 1950s and 60s. Endocrinologist Dr. Harry Benjamin is widely credited with pioneering gender-affirming care in North America (Gill-Peterson 2018; shuster 2021). His 1966 book *The Transsexual Phenomenon* presented a typology of trans people along with treatment recommendations. According to Benjamin (1966), only individuals with extreme distress related to their assigned gender and strong cross-gender identification should be allowed to access gender-affirming care. To differentiate these “true transsexuals”

from “fetishistic transvestites,” (Benjamin 1966, 23), Benjamin began referring patients to psychiatrists for assessment (Marrow 2023a; 2023b; shuster 2021; Velocci 2021). In part, these psychiatric evaluations were used to determine the patient’s likelihood of successfully assimilating into cisnormative society after transitioning (Marrow 2023a; 2023b; shuster 2021; Velocci 2021). Beans Velocci (2021) and Elliot Marrow (2023a; 2023b) have argued that Benjamin and his colleagues also used psychiatric evaluations to ensure patients were unlikely to regret their decisions and therefore to avoid future lawsuits. As such, while Benjamin’s ‘true transsexual’ diagnostic criteria were in theory about authenticating gender identity, in practice the criteria bolstered doctors’ professional credibility and protected them from legal liability (Marrow 2023a; 2023b; shuster 2021; Velocci 2021).

Also in the 1960s, several university-based gender-affirming care clinics opened in the US (Magrath 2022; Marrow 2023b). These clinics conducted extensive and invasive assessments for patients seeking gender-affirming care and often required participation in unethical and demeaning research (Marrow 2023b). Before accessing hormones or surgeries, patients had to pass the ‘real life test’ of living in their chosen gender role for months or years—a requirement that persisted for decades (Amengual et al. 2022; Marrow 2023b). Consistent with Benjamin’s protocol, patients were expected to fully assimilate into cisnormative society by adopting a gender-normative job, being in a heterosexual relationship, and concealing their transgender status (Marrow 2023b; shuster 2023; Velocci 2021). These criteria permitted very few trans people to access gender-affirming care and excluded many trans people because of their race, class, mental illness, substance use, or sexuality (Marrow 2023b; shuster 2023; Velocci 2021). Further, the criteria emphasized binary gender roles and normative femininity and masculinity (shuster 2021; 2023).

By the 1980s, many university-based gender clinics closed as transphobia and negative publicity grew (Magrath 2022; Marrow 2023b). In 1979, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) was founded and published the first Standards of Care (SOC) (Amengual et al. 2022; Marrow 2023b). The SOC codified and standardized the assessments used by clinics, which made gender-affirming care more widely accessible through private practice providers while retaining strict gatekeeping protocols (Marrow 2023b). Periodic revisions to the SOC gradually relaxed requirements while maintaining the real-life test, mental health evaluation, and diagnostic criteria (Amengual et al. 2022). Now in their 8th edition, the SOC are published by WPATH—the renamed HBIGDA—and are widely used across the globe. While the real-life test is no longer used, trans people must still complete a mental health or readiness assessment before accessing gender-affirming care (Coleman et al. 2022).

While adult access to gender-affirming medical care has increased in recent decades, youth access has been inconsistent and rare. For much of the 20th century, psychotherapeutic approaches focused on ‘treating’ childhood gender deviance to prevent adult transsexuality (Gill-Peterson 2018). By the 1970s, some clinicians began to offer gender-affirming care to post-pubescent adolescents, but access was limited and often structured along racialized and classed lines (Gill-Peterson 2018). In the late 1990s, a group of Dutch clinicians began prescribing puberty-suppressing medications to trans youth after extensive longitudinal assessment (de Vries and Cohen-Kettenis 2012). Pausing puberty gave the youth time to solidify their gender identity before begin-

ning hormones at age 16 and surgery at age 18 (de Vries and Cohen-Kettenis 2012). The Dutch approach emphasized “watchful waiting” and assumed that most gender-expansive young people would grow into cisgender adults (de Vries and Cohen-Kettenis 2012). The model was adopted internationally by a growing number of youth gender clinics, some of whom later adapted the Dutch protocol and developed the gender affirmative model (Hidalgo et al. 2013; Keo-Meier and Ehrensaft 2018). This model offers medical interventions as one part of holistic supports for affirming the child’s gender expression in developmentally appropriate ways (Hidalgo et al. 2013; Keo-Meier and Ehrensaft 2018). Unlike the Dutch protocol, the gender affirmative supports social transition at all ages and does not model prescribe minimum ages for hormones or surgery (Hidalgo et al. 2013; Keo-Meier and Ehrensaft 2018). The gender affirmative model informs the SOC-8 clinical guidance for youth and has been endorsed by many professional organizations (Coleman et al. 2022; Ehrensaft 2021).

CONTEMPORARY APPROACHES TO GENDER-AFFIRMING CARE

The SOC has become a guiding text for clinicians who provide gender-affirming care. While the SOC allows for flexible interpretation across clinics and jurisdictions, it has still cemented a transnormative narrative that has been recirculated for decades as trans people learn from their peers what clinicians expect to hear. (Bradford and Syed 2019; Riggs et al. 2019; shuster 2021). To conform to this narrative, many trans people emphasize childhood gender nonconformity and feelings of dysphoria and distress during mental health and readiness assessments and hide any doubt or uncertainty (Bradford and Syed 2019; Fraser, Brady, and Wilson 2021; Johnson 2019; Spade 2003). Nonbinary people face added pressure to prove they are ‘trans enough’ to access care, given the history of requiring normative binary gender expression to access care (Fraser, Brady, and Wilson 2021; Kinney and Cosgrove 2022; Lampe 2023; Occhino and Skewes 2020). Many trans people do not view mental health and readiness assessments as a safe therapeutic space and describe feeling defensive and powerless against clinicians who can grant or deny them access to life-changing care (Dewey 2015; Fraser, Brady, and Wilson 2021; Horton 2022; Lane 2018; Shook et al. 2022). While recent editions of the SOC emphasize that mental health providers should focus on supporting patient readiness rather than evaluating gender identity (Coleman et al. 2022), many trans people remain distrustful of health care providers (Dewey 2015; Fraser, Brady, and Wilson 2021).

Though phrases like “true transsexual” are no longer used, stef shuster (2021, 99) has argued that clinicians conducting readiness and mental health assessments for gender-affirming care still focus on identifying worthy patients:

No longer within the discourse of “sane” or “insane,” the distinction is now more covertly asserted through the language of “risk,” which continues to be established based on whether or not a patient has physical or mental health issues or is perceived to develop them when initiating trans-related medical interventions.

Indeed, research has found that readiness and mental health assessments are particularly fraught for trans people with psychiatric diagnoses, as some clinicians doubt these individuals’ self-identification and instead attribute their gender dysphoria to

their diagnosis (MacKinnon et al. 2021; 2020; Lane 2018). In these assessments, “risk” becomes a key tool to enact medical authority, gatekeeping, and injustice.

Clinicians’ concerns about risk are often tied to legal liability. Several researchers have found that some gender-affirming care providers structure their clinical practices to prevent medical malpractice lawsuits from patients who regret their medical decisions (Blasdel et al. 2022; Dewey 2015; Lane 2018; MacKinnon et al. 2021; Shuster 2021). These clinicians tend to closely follow the SOC guidelines and may require additional psychiatric evaluations for patients who they perceive as being at risk of regretting gender-affirming care (Dewey 2015; Lane 2018; MacKinnon et al. 2021). As media attention on individuals who detransition or regret their gender-affirming care choices surges, legal liability and fear of regret may increasingly impact clinical practice (MacKinnon et al. 2021).

Clinicians’ fear of regret reflects a broader tendency to value medical authority over trans people’s embodied knowledge. Devaluing trans people’s self-knowledge is an example of epistemic injustice—unjustly discrediting the knowledge of a person or community (Enxuga 2022; Fricker 2007). Since gender-affirming care is rarely covered in medical education, trans people often know much more about their own healthcare than their typically-cisgender clinicians. However, health care providers’ position as medical experts means that their knowledge is assumed to be authoritative and accurate, even when it is based on transphobic stereotypes and ignorance. Consequently, trans people’s knowledge is frequently treated as suspicious, subjective, biased, and unreliable, while clinician’s knowledge is treated as trustworthy, objective, expert, and reliable. As such, a trans person expressing a desire and readiness for gender-affirming care is seen as insufficient evidence to provide that care; instead, an external assessment must validate the trans person’s identity and desires.

As I have shown, the logic of requiring mental health assessments for gender-affirming care is inextricable from the historical pathologization of transness. Cisgender patients regularly receive many of the same hormonal and surgical interventions as trans people without any mental health assessment (Latham 2017; Schall and Moses 2023). However, a few other surgeries require preoperative psychological assessment, such as bariatric weight-loss surgery and organ transplants (Bailey et al. 2021; Sogg, Lauretti, and West-Smith 2016). However, the justifications for these assessments differ from their use in gender-affirming care. In bariatric surgery, preoperative assessments are used to identify and manage psychosocial risk factors which are known to significantly impact postoperative outcomes (Sogg et al. 2016). Similarly, organ transplants rely on a very limited supply of organs, and as such, psychosocial assessments are used to identify candidates with the strongest likelihood of postoperative success (Bailey et al. 2021). Nonetheless, assessments for organ transplants and bariatric surgery also raise similar ethical challenges related to epistemic injustice and medical authority (Parker and Chin 2020; Rouleau, Rash, and Mothersill 2016). Unique to gender-affirming care, though, is the use of psychological assessment to prevent patient regret (MacKinnon et al. 2021). However, there is no evidence that these assessments predict or prevent regret (Ashley, Parsa, et al. 2023). Further, only about 1% of patients regret gender-affirming surgery (Bustos et al. 2021), compared to 14% of patients who had any other type of surgery (Wilson, Ronnekleiv-Kelly, and Pawlik 2017). The preoccupation with preventing gender-affirming

firming care regret reflects a deeper lack of trust in trans people to define their identity and make decisions for themselves.

To avoid the problems with assessments, some gender-affirming care providers have implemented an informed consent model of care (ICM) (Cavanaugh, Hopwood, and Lambert 2016; Gerritse et al. 2021). Informed consent is a crucial part of all medicine and involves communication between a clinician and a patient about the risks, benefits, and alternatives of a medical intervention (Shah et al. 2022). ICMs for gender-affirming care differ from this more general definition in that they prioritize informed consent over other considerations in clinical decision-making (Cavanaugh, Hopwood, and Lambert 2016; Gerritse et al. 2021). Specific protocols vary between clinics, with some ICMs still involving mental health professionals in patient assessment but not requiring a formal readiness letter, and others not requiring any mental health assessment at all (Ashley, St. Amand, and Rider 2021). ICMs task healthcare providers with educating and supporting the patient's decision-making, rather than acting as gatekeepers (Gerritse et al. 2021). In doing so, ICMs are thought to value patient self-knowledge and reduce barriers to care. However, not all ICMs prioritize patient autonomy equally, and balancing patient autonomy with medical authority remains an ongoing debate in gender-affirming care.

EVIDENCE, EXPERTISE, AND UNCERTAINTY IN GENDER-AFFIRMING CARE

As ICMs gain popularity, Shuster (2021) has argued that many gender-affirming care providers perform the language of informed consent while still acting in ways that prioritize their own authority and expertise over their patients' autonomy. Shuster (2021) has argued that one key reason for this is that clinicians feel they are operating with limited evidence and great uncertainty regarding the risks and benefits of gender-affirming care. While gender-affirming care is an established field of science and medicine and is endorsed by many major medical organizations (Coleman et al. 2022), randomized-controlled trials of gender-affirming care are ethically and methodologically difficult and existing evidence is largely comprised of observational research designs (Ashley et al. 2023). In particular, research on the long-term outcomes of various hormonal and surgical interventions is lacking (Coleman et al. 2022). The SOC have historically relied on expert consensus and clinicians' professional experience, with later editions increasingly drawing on published scientific research (Coleman et al. 2022). The SOC-8, released in September 2022, employs the most evidence-based and scientifically rigorous methodology to date, with recommendations based on systematic reviews and approved through a Delphi consensus method (Coleman et al. 2022). Still, the guidelines identify numerous topics where more research is needed to develop an evidence-based guideline.

In addition to the limitations of the research evidence, medical education rarely prepares clinicians to serve trans clients. Medical school curriculums typically devote little or no time to gender-affirming care (Obedin-Maliver et al. 2011; Tollemache, Shrewsbury, and Llewellyn 2021). Consequently, physicians may not be comfortable prescribing hormones or referring patients to gender-affirming surgeons, unless they seek out additional education on their own (Christopherson et al. 2022; Kent et al. 2022; Shires et al. 2018b; 2018a). Given this lack of education, gender-affirming care

providers often turn to their intuition to resolve their discomfort with risk and uncertainty (shuster 2021). However, clinicians' assessment of risks and benefits may not align with their patients' priorities. Pervasive anti-trans stigma may lead clinicians to emphasize the potential risks of gender-affirming care over potential benefits (Cavanaugh, Hopwood, and Lambert 2016; Poteat, German, and Kerrigan 2013). Conversely, many trans people do not trust health care providers and feel pressure to demonstrate unhesitating certainty with no doubts or worries about their treatment (Dewey 2015). However, clinicians may interpret a patient's reluctance to discuss treatment risks as a sign of unrealistic expectations or as a threat to the clinician's expertise. These differing interpretations of a patient's behavior may spawn mutual mistrust and disrupt the therapeutic relationship. Unarticulated differences between clinicians' and patients' perceptions of risk and uncertainty are an ongoing source of tension in gender-affirming care.

Previous qualitative interviews with gender-affirming care providers have found that clinicians interpret the SOC in a variety of ways (Dewey 2015; Dewey, Oppenheim, and Watson 2023; Gerritse et al. 2021; Lane 2018; Poteat, German, and Kerrigan 2013; shuster 2021). Some providers treat the SOC guidelines as a strict rulebook and cite the guidelines as justification for delaying or denying gender-affirming care (Dewey, Oppenheim, and Watson 2023; Lane 2018; shuster 2021). Others emphasize the SOC's flexibility and view the guidelines as a general roadmap to guide decision-making and individualized care (Dewey, Oppenheim, and Watson 2023; shuster 2021). Given the wide variation in interpretations of the SOC guidelines, clinicians appear to cite the SOC to legitimate their work as aligned with best practices, regardless of what the SOC actually says (Dewey, Oppenheim, and Watson 2023; shuster 2021). However, even the most flexible and patient-centered clinicians who view themselves more as supporters than gatekeepers still wield significant power over trans people's ability to access life-saving medical care (Dewey, Oppenheim, and Watson 2023; shuster 2021).

Existing research has primarily focused on how clinicians interpret the DSM-5 and the SOC-7, and the revised SOC-8 has yet to be examined. As the field of gender-affirming care evolves and the political and scientific climate shifts rapidly, clinicians' strategies for dealing with uncertainty may change. As such, the role of risk and uncertainty in gender-affirming care requires further scholarly attention.

ANALYSIS OF WPATH SOC-8

The SOC-8 represents a significant step forward in gender-affirming care. Broadly, the new guidelines shift away from the assessment-based gatekeeping model of care. The SOC-8 mentions informed consent models as an emerging area of research and "supports the role of informed decision-making and the value of harm reduction approaches" (Coleman et al. 2022, 6). The guidelines repeatedly emphasize individualized, patient-centered care and recommends a "collaborative decision-making" approach that "recognizes the lived experience and self-knowledge of the TGD [transgender and/or gender-diverse] person and the clinical knowledge of the assessing health care professional" (Coleman et al. 2022, 31). On the surface, these quotes suggest that the SOC-8 has left paternalism and gatekeeping behind. However, a careful read of the SOC-8 highlights several areas where the guidelines return to emphasizing assessment.

Adolescent Chapter

The first of these areas is Chapter 6 on Adolescents, where the guidelines recommend additional assessment for some youth seeking gender-affirming care based on perceived heightened risk. The chapter recommends that all youth seeking gender-affirming medical care should undergo a “comprehensive biopsychosocial assessment,” ideally conducted by a multidisciplinary team (Coleman et al. 2022, 48). In contrast, assessments for adults do not have to be multidisciplinary and may be relatively brief depending on the patient’s needs and complexity (Coleman et al. 2022). The SOC-8 suggests that for youth who have complex mental health histories, autistic traits, or did not experience gender incongruence as a child, “a more extended assessment process may be useful” (Coleman et al. 2022, 51). This extended process “may include additional time and structured opportunities for the young person to practice the skills necessary for medical decision-making” (Coleman et al. 2022, 62). While the guidelines recommend that assessments should be “collaborative and supportive” (Coleman et al. 2022, 50), previous research suggests that trans youth do not experience assessments as safe or supportive environments (Fraser, Brady, and Wilson 2021; Horton 2022; Shook et al. 2022; Strauss et al. 2022). Many trans youth describe feeling defensive and powerless and needing to prove that they are ‘trans enough’ to pass the clinician’s tests (Fraser, Brady, and Wilson 2021; Shook et al. 2022; Horton 2022). If adolescents feel they must prove their gender and desire for gender-affirming care to clinicians, it may be difficult for them to practice and develop skills in medical decision-making in the context of a high-stakes assessment.

The SOC-8 recommends that adolescents should only receive gender-affirming care when their “experience of gender diversity/incongruence is marked and sustained over time.” (Coleman et al. 2022, 60). This requirement has been previously articulated as youth being “insistent, persistent, and consistent” about their gender identity (Hidalgo et al. 2013, 286). Yet the guidelines also note that adolescents must demonstrate the “emotional and cognitive maturity” necessary to understand the long-term consequences of medical interventions (Coleman et al. 2022, 61). In particular, the guidelines suggest that clinicians should consider whether the adolescent has “thought through the implications of what they might do if their priorities around gender do change in the future” (Coleman et al. 2022, 62). Simultaneously then, young people seeking gender-affirming care must demonstrate consistent and persistent desires, yet also have a plan for the possibility that their desires will not be consistent and persistent in the future. This places adolescents in an impossible double bind, where their unhesitating certainty could be used as evidence of being both ready and not ready for a gender-affirming medical intervention.

Trans historian Jules Gill-Peterson (2018) has argued that the contemporary moral panic surrounding trans youth is driven by larger societal discourses that frame youth as precious, pristine resources that must be carefully shaped and guided towards successful normative futures and away from ‘deviant’ trans futures. As such, a logic of protectionism and risk aversion guides the SOC-8 to recommend extensive assessment of all youth seeking gender-affirming care, but especially those whose identities, diagnoses, or life experiences do not neatly align with existing clinical research on trans youth. The Adolescent chapter conceptualizes risk and uncertainty as significant threats to good medical practice that should be managed through patient assessment.

An alternative approach to managing risk and uncertainty is providing additional supports rather than additional assessments. Rather than asking whether a youth can do a particular skill, clinicians could ask what supports a youth needs to be able to do that skill. Such supports could be provided concurrent with gender-affirming medical interventions rather than as a prerequisite. For example, if a youth struggles with future-oriented thinking and hopelessness, clinicians might support the youth to reflect on their desires for the future as their body begins to change with hormone therapy. As trans people often experience reduced suicidality and increased hope for the future after beginning hormones (Allen et al. 2019; Baker et al. 2021; Chen et al. 2023; Green et al. 2022), this approach would capitalize on the mental health benefits of gender-affirming care to develop the youth's skills. Further, providing supports outside of the high-pressure assessment setting and without tying them to access to gender-affirming care may enable youth to engage with the supports more fully. This strategy would fulfill the SOC-8 guidelines' goal of providing additional supports to neurodivergent youth without burdening them with additional assessments.

Nonbinary Chapter

Another area where the SOC-8 recommends a comprehensive, multidisciplinary assessment is in the Nonbinary chapter. The SOC-8 recommends that surgeons should “consult a comprehensive, multidisciplinary team of professionals in the field of transgender health” when patients request an “individually customized” surgery (Coleman et al. 2022, 133). The text defines these surgeries as “1) a procedure that alters an individual's gender expression without necessarily aiming to express an alternative, binary gender; 2) the ‘non-standard’ combination of well-established procedures; or 3) both” (Coleman et al. 2022, 133). The SOC-8 does not provide examples of individually customized surgeries, and the vague wording suggests that some surgeons may require additional assessment for *all* patients seeking to express a nonbinary gender, not just those seeking less common surgical procedures. The SOC-8 goes on to explain that since individually customized surgeries are backed by less research evidence than more common standardized surgeries, patients must understand the risks and uncertainties of such a procedure (Coleman et al. 2022). This approach appears to promote transparency and collaborative decision-making with the patient when there is no clear research evidence to guide the decision.

However, not all individually customized surgeries lack evidence or carry higher risks to the patient. For example, phalloplasty without urethral lengthening is associated with fewer complications than the more conventional phalloplasty without urethral lengthening (de Rooij et al. 2022). Similarly, vulvoplasty—also known as shallow-depth vaginoplasty, which creates an external vulva without an internal vaginal canal—has fewer risks than the more common full-depth vaginoplasty, yet surgeons often deny requests for this procedure because the resulting genitals do not enable penetrative sex (Milrod, Monto, and Karasic 2019; Stelmar et al. 2023). Finally, a double incision mastectomy without nipple grafts is thought to be at least as safe, if not safer than one with nipple grafts, but may be deemed unusual because it does not create a normative masculine chest (Cuccolo et al. 2019; Esmonde et al. 2019). Of course, some individually customized surgeries do come with increased risks. For example, phalloplasty with urethral lengthening without vaginectomy carries an increased risk of

urethral fistula (Al-Tamimi et al. 2018). However, I argue that a well-informed patient who understands the risks and benefits of their surgical choice should not be subjected to additional psychosocial assessments simply because their surgical preference has greater risks than a more common procedure.

Individual clinicians must decide when a multidisciplinary assessment is required. In doing so, clinicians should consider the patient's knowledge of the risks and benefits of the procedure as well as the research and clinical evidence for the specific procedure requested, rather than automatically requiring additional assessment for all nonbinary people seeking surgery or all requests for individually customized surgeries. Dewey and colleagues (2023) has found that some clinicians already use the language of multidisciplinary to justify denying gender-affirming care to clients until they are treated by a mental health professional. As such, it is reasonable to be concerned that the SOC-8 guidelines may be used to enforce transnormativity and gender binarism by subjecting nonbinary people to additional psychopathologizing assessments, even if this is not the intention of the SOC-8.

It is important to note that multidisciplinary *care* is not synonymous with multidisciplinary *assessment*. While multidisciplinary care offers different types of care from a variety of professionals, multidisciplinary assessments require multiple evaluations for a single type of care. Many trans people benefit from multidisciplinary care that does not involve additional assessments. For example, some gender-affirming care clinics in the US have developed innovative multidisciplinary surgical preparedness programs that have high patient satisfaction and fewer barriers to care compared to traditional assessment-based models (Lichtenstein et al. 2020; Poceta et al. 2019). At its best, multidisciplinary gender-affirming care should provide holistic, patient-centered supports without creating additional barriers to care.

The above analysis of the Nonbinary and Adolescent chapters of the SOC-8 demonstrates that behind the language of patient-centered and individualized care, the SOC-8 continues to conceptualize risk and uncertainty as threats to good medical practice. While all gender-affirming care providers face ethical and epistemic challenges, different strategies can have very different consequences for trans people. Determining how clinicians can best navigate these challenges and improve trans people's healthcare experiences is therefore a critical task.

FUTURE DIRECTIONS AND PROMISING PRACTICES

Efforts to improve trans experiences of health care often focus on educating clinicians about trans people and their healthcare needs through cultural competency training (Dubin et al. 2018; van Heesewijk et al. 2022). However, merely increasing providers' knowledge about trans people may be insufficient to improve medical care for trans people, given the unresolved questions of uncertainty, evidence, and authority (shuster 2021). Further, research by Stroumsa and colleagues (2019) found that higher levels of transphobia was associated with clinician's knowledge of transgender health care, but number of hours of relevant education was not, suggesting that addressing transphobic attitudes may be more important than providing education. shuster has argued that clinicians "need to become more flexible in navigating professional norms and questioning the utility of evidence-based medicine, and to begin placing more

trust in clients as the experts over their bodies and identities” (2021, 166). However, encouraging clinicians to confront the limits of their own expertise and recognize their patients’ self-knowledge is challenging in a cultural context that positions doctors as the ultimate experts.

Informed consent models of gender-affirming care, as described above, represent one strategy for resolving these epistemic challenges. However, recent research by Gabriel Enxuga (2022) found that patients who accessed gender-affirming hormone therapy through ICMs and traditional assessment models both experienced epistemic injustice through invalidation and dismissal. This suggests that even when operating in an informed consent model of care, clinicians are still influenced by transnormative ‘born in the wrong body’ narratives. Shuster’s (2021) work indicates that dominant ideas of clinical authority and expertise also guide clinicians working in informed consent models and contribute to epistemic injustice. As such, implementing informed consent models of care is one important step toward improving gender-affirming care, but must be considered alongside other strategies.

One such strategy is explicitly teaching healthcare students and practitioners about epistemic issues in medicine. Weingartner and colleagues (2022) have proposed *epistemic peerhood* as a model for doing so in gender-affirming care. They argue that healthcare providers should view their patients as epistemic peers—that is, as holding knowledge that is equally as valuable as their knowledge as clinicians (Weingartner et al. 2022). Importantly, epistemic peerhood does not imply that clinicians and patients possess the *same* knowledge, but rather, recognizes that both forms of knowledge are needed to create the best care plan for the patient (Weingartner et al. 2022). Weingartner et al. have suggested that one way to teach epistemic peerhood in medical education settings is by bringing trans people in as guest speakers and explicitly “naming what [they] are doing: treating patients as epistemic peers and placing value on their embodied knowledge” (2022, 6). In the realm of chronic pain, Buchman and colleagues (2017) have proposed *epistemic humility* as a framework. Epistemic humility as a clinical skill encourages health care providers to critically evaluate their beliefs about authority and expertise and to identify the limits of their knowledge (Buchman, Ho, and Goldberg 2017). Buchman and colleagues (2017) argue that developing epistemic humility requires explicit training in socio-emotional and communication skills that are often absent from medical education. Including trans people as patient partners and developing curriculum to teach empathy, communication, and collaboration to clinicians are already widely recognized as important aspects of medical education about trans health care (Dubin et al. 2018; van Heesewijk et al. 2022). However, explicitly introducing the frameworks of epistemic peerhood and humility may help clinicians to deal with uncertainty in their work without perpetuating the harms of epistemic injustice and gatekeeping.

While I have argued here that pathologizing transness embeds epistemic injustice in gender-affirming care readiness assessments, epistemic injustice occurs in many other health care settings. Research has identified epistemic injustice in clinical decision-making related to organ transplantation (Parker and Chin 2020), childbirth (Villarme and Kelly 2020), chronic pain (Buchman, Ho, and Goldberg 2017), chronic fatigue syndrome (Blease, Carel, and Geraghty 2017), and mental health care (Grim et al. 2019), among others. Future scholarship should explore the parallels between gen-

Table 1. Summary of problems identified with soc-8 and suggested approaches

Problem	Suggested Approach
Extended assessments for neurodivergent youth can be distressing and harmful	Provide additional supports concurrent to gender-affirming medical interventions rather than extending assessments
Requiring multidisciplinary assessments for “individually customized surgical requests” may increase barriers to care	Evaluate the risks and benefits of the procedure and the patient’s knowledge before referring for additional assessment
Multidisciplinary assessments may increase barriers to care	Provide multidisciplinary, holistic supports that do not require additional assessments
When faced with risk or uncertainty, clinicians typically prioritize their own expertise over patient’s self-knowledge, resulting in epistemic injustice for trans people	Use epistemic humility or epistemic peerhood as a framework for medical education
Increasing providers’ knowledge about trans people does not address underlying issues of uncertainty, risk, and liability	Incorporate strategies for prioritizing patient autonomy and informed consent into gender-affirming care medical education
Extended assessments for neurodivergent youth can be distressing and harmful	Provide additional supports concurrent to gender-affirming medical interventions rather than extending assessments

der-affirming care and other sites of epistemic injustice in health care, and potential shared strategies for promoting epistemic humility and justice for all patients across a variety of health care settings.

Future research should investigate the effectiveness of different supports for gender-affirming care providers to deal with uncertainty. Researchers and practitioners developing educational resources for clinicians about gender-affirming care should consider evaluating epistemic humility as a learning outcome and clinical skill. MacKinnon and Ross’ (2019) website *Path to Patient-Centered Care* is one example of an educational resource for clinicians on gender-affirming care that discusses strategies for prioritizing patient autonomy. Future research could investigate the learning outcomes and practice implications for clinicians who access the website.

Since the influence of the SOC-8 depends on how clinicians interpret it, the impact of the additional assessments proposed in the Nonbinary and Adolescent chapters remains to be seen. The SOC-8 may have little influence on care if providers simply continue with their usual practices. Alternatively, clinicians may turn to the SOC-8 to justify requiring extended or additional assessments for neurodivergent youth and nonbinary people. Future research should explore these possibilities.

CONCLUSION

While informed consent models are one important strategy for promoting patient autonomy and self-knowledge in gender-affirming care, additional strategies are needed to achieve fully equitable and accessible gender-affirming care. Table 1 summarizes the problems of uncertainty, risk, and assessment in the SOC-8 and the alternative approaches suggested in this article. Considering epistemic humility as a key clinical skill offers one potential path forward, but more research is needed to develop ad-

ditional strategies. To avoid repeating the historical harms of gatekeeping models of gender-affirming care, we must remain attentive and reflexive to issues of uncertainty, risk, authority, expertise, and liability seriously, and develop strategies to confront these challenges.

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