

# Ethics

## Introduction

This chapter provides an overview of the ethical considerations that arise in the field of transgender health. We begin with a brief history of the evolution of the current ethical perspective as reflected in the World Professional Association for Transgender Health Standards of Care (WPATH SOC). We then acknowledge cultural differences in the practices required in transgender health, describe ethical principles and how these relate to health care for transgender people, discuss transgender health research ethics, and describe WPATH's role in dispute resolution.

## Ethics and the Standards of Care

From the outset, the field of transgender health has been fraught with what have been seen as ethical dilemmas. Exploring the then-nascent field of sexology in Western Europe, researchers and health professionals (HPs) in the late 1800s encountered people who questioned their sex and were seeking affirming care. These patients had no linguistic frame within which they could explain themselves, and HPs had only a binary, heterosexual perspective that conflated morality and perversion with almost anything that exceeded the boundaries of traditional sex and gender roles for men and women. Transgender and gender diverse (TGD) people were regarded as sinners or moral failures, and only a few curious and compassionate scientists and HPs were willing to try to help them (Ettner, 2020; Green, 2020; Whitehead and Schechter, 2020).

By the 1940s and 50s, in both Europe and the US, professional journal articles and legal documents offer a historical record of medical, mental health, surgical, and legal cases where hormonal and surgical care, as well as legal arguments, helped to make the case in courts of law that “transsexuals” (as they were coming to be called) were a kind of “intersex persons” whose psychological and sometimes physical make-up was neither precisely male nor female. Medical opinion frequently asserted that, in each specific case, either the male or the female “predominated” in order to support the patient’s gender identity. At the same time, laws were being promulgated to criminalize surgeons who committed “mayhem” (the excision of healthy tissue), and letters to the editor in both surgical journals and lay publications decried the “barbaric process of sex-change,” often casting those who sought care as mentally ill, and those who endeavored to provide care as colluding with delusion (Ettner, 2020; Gooren, 1993; Green, 2020).

Through the 1960s and 70s, university gender clinics were established in both Europe and North America to study the phenomenon and provide treatment, and although the criteria for entry to many of these clinics could be restrictive and rigid, HPs were trying to understand why individuals sought hormonal and surgical gender-affirming care, to establish clinical treatment protocols that would successfully help people live more comfortable and productive lives, and to learn the factors that would predict success when treatment protocols were followed. HPs’ definitions of success were limited at first by a binary and heteronormative view of “sex-change,” which reinforced gender and sex role stereotypes for program ‘graduates.’ The work of these clinics was hampered in the US by political forces aimed at eliminating access to care, and overwhelmingly the professional literature of the day was rooted in a view that variance from gender norms was pathological. By 1975, HPs who listened to their patients and rejected

pathologizing views (to varying degrees) had formed a loose network that included researchers and patient advocates. By 1979, a group of these providers formed the Harry Benjamin International Gender Dysphoria Association and published the first international “Standards of Care [for] the hormonal and surgical sex reassignment of gender dysphoric persons.” That initial document and all subsequent versions of the Standards of Care (SOC) have constituted an effort to establish both clinical and ethical guidelines pertaining to the treatment of TGD people, to the extent that the document’s authors understood both clinical protocols and their ethical obligations according to the standards of the day. WPATH’s public policy statements, available at [www.wpath.org](http://www.wpath.org), are further articulations of the ethical positions supported by the Association, beginning with the 2008 Statement on Medical Necessity and Health Insurance Coverage in the US and the 2010 Identity Recognition Statement (updated in 2016 and 2017, respectively), both of which had a significant impact on improved access to health care and legal rights for TGD people in the US and globally.

By 2010, clinical experience, research studies, and the courage of TGD individuals to speak out through community-based activism, had led to protective legislation and removal of exclusions for transsexual or transgender treatments in many private health insurance plans in the US and many public health plans and services in other parts of the world. Public health coverage in the US followed with the removal of exclusions from Medicare in 2014. The available coverage led to increased demand for services, the establishment of medical and mental health training programs, expansion of clinical experience, and judicial rulings affirming TGD people’s human and civil rights in Europe, Australasia, Africa, Asia, and North and South America (Green, 2020; Whitehead and Schechter, 2020).

Each profession represented within WPATH has its own ethical standards. Continuing education is required of most licensed professionals and often includes some number of required ethics course credits. WPATH’s ethical standards are never meant to substitute for any profession’s ethical tenets. WPATH operates from the fundamental principles that inform medical ethics in the Global North and works to assist HPs in reconciling challenges, discrepancies, or conflicts that may arise between providers, patients, clients, and institutions when TGD people are patients, clients, or research participants. A foundational principle is that WPATH recognizes TGD patients or clients deserve to have their gender identity and expression recognized, validated, and affirmed in the course of care, even if that gender changes over time or proves not to be the one that the provider or the individual first assumed it to be. WPATH also recognizes all people deserve quality, responsible care, as our organization’s vision statement attests, “We envision a world wherein people of all gender identities and gender expressions have access to evidence-based health care, social services, justice, and equality.”

One of the most important practical values that WPATH emphasizes, both through our recognition of the interdisciplinary nature of transgender health and in our approach to ethics, is that “ethics is a conversation.” By this, we mean that ethical considerations must always be deliberated among the participants in any decision-making process to ensure that all aspects of the matter are fully understood by all who are impacted by the question or the anticipated action.

### **Acknowledging Differences Between Cultural Contexts**

WPATH makes every effort to work within the cultural contexts of its members, and our Board and Ethics Committee members are continually working to acquire knowledge about ethical

systems that are relied upon in cultures outside of the Global North. Below we outline the ethical principles applied to TGD health in the Global North as these are the principles most frequently discussed in the English language scholarly literature. There are perhaps other ethical approaches that could be applied to practice with TGD people that may translate better across cultures, including rights-based ethics, relational ethics, and justice doing (Clark, 2017), some of which are encompassed in *The Yogyakarta Principles* and *The Yogyakarta Principles Plus 10*, which are collaborative international statements not dominated by the Global North.

## **International Human Rights: The Yogyakarta Principles**

In 2006, in response to “well-documented patterns of abuse,” a distinguished panel of twenty-nine international human rights experts met in Yogyakarta, Indonesia with the goal of identifying a set of principles that incorporated sexual orientation and gender identity (SOGI) issues into established human rights concepts. They produced *The Yogyakarta Principles* that has since become a guiding document informing the human and legal rights of TGD people globally. In 2017, another panel of thirty-three experts, five of whom were also on the original panel, published additional principles expanding on the original document and reflecting developments in international human rights law and practice since the original Principles were drafted. The second document, *The Yogyakarta Principles Plus 10*, also contains “additional state obligations” related to areas such as torture, asylum, privacy, health, and the protection of human rights defenders. The full texts of both these documents are available at [www.yogyakartaprinciples.org](http://www.yogyakartaprinciples.org). WPATH recognizes the importance of these principles and advocates for their adoption in every context in which their application can improve the health and quality of life of TGD people, which should result in similar improvements for all people.

## **Ethical Principles**

Consideration of the ethical principles that guide clinical practice and research promotes critical thinking and reflection on the beliefs and values of the professionals working to support and provide transgender health care. The insights that arise can also assist HPs in articulating to their patients and colleagues the justification for the decisions they make (Clark, 2017). The provision of transgender health care often occurs within an interdisciplinary context. As such, WPATH encourages interdisciplinary conversation and deliberation about ethical considerations when possible. The absence of an interdisciplinary team should not automatically disqualify a person from accessing medically necessary gender-affirming health care. In making decisions, HPs should consider the ethical principles in this chapter, including the risk of harm induced through not providing care. The principles WPATH relies upon to guide ethical practice are outlined by Beauchamp and Childress, *Principles of Biomedical Ethics* (8<sup>th</sup> edition, 2019). Ethical challenges emerge when there is conflict among the principles. These principles are described below.

## **Respect for Autonomy**

According to Beauchamp and Childress, competent people should be able to “(1) act intentionally, (2) with understanding, and (3) without controlling influences that determine their action” (2019, p. 102). To have respect for the autonomy of patients or clients is to acknowledge they have the right to make voluntary decisions about their own bodies, free from coercive or

controlling influences of others (Wren, 2019). Self-determination is at the core of this ethical principle (Hale, 2007; Toivonen & Dobson, 2017).

The principle of respect for autonomy refers primarily to the patient's absolute moral right not to be subjected to any form of treatment or experimentation to which they do not provide valid informed consent, which unnecessarily violates their bodily integrity or which violates their own moral values and personal preferences. This principle also encompasses the right to be enabled to make informed decisions: clinicians have a corresponding moral duty to provide accurate, truthful information about the available alternatives, with their expected risks and benefits (Coggon, 2016).

The provision of gender-affirming care relies upon a combination of the clinical expertise of the provider and a clear understanding of the risks and benefits of that care on the part of the patient/client as those risks and benefits may impact their personal life.

HPs retain a moral and legal right, and a professional obligation, to only provide treatment which they deem to be in the client/patients' best interests. Whereas individuals are usually the best judges of what is good for them, HPs might ethically refuse to provide services which they consider inappropriate, unethical, which they don't consider themselves competent to provide, or which they regard contrary to their own understanding of the legitimate goals of their profession (Huxtable, 2014; Coggon, 2016). In making such judgments, though, HPs should be aware of prevailing social norms marginalizing TGD people, which may potentially bias a HP's judgments (see Synthesis below). Debates concerning what respect for autonomy entails are nuanced and complex debate. Certainly, though, if the HP is not technically or clinically capable of providing the requested service, or if the HP understands that the patient will be harmed if they attempt to provide that service, they must decline provision of that service. Conversely, if the patient weighs the evidence and determines that the service will put them at risk of harm, they are within their rights to decline that service.

Respectful and honest discussion may on many occasions lead to an agreed course of action; we must acknowledge however that in some cases the views of patients and HPs might be irreconcilable. In these morally challenging cases, respect for each other's integrity (including professional integrity) and compassion should remain the guiding principles.

Respect for patient's autonomy is the foundation of the patient's moral and legal right to provide informed consent to treatment, and of the HP's duty to enable patients to do so. Careful consultation between the client/patient and HP to work toward informed consent can allow this care to be carried out with the greatest respect for autonomy (Cavanaugh et al., 2016.; Hale, 2007; shuster, 2019). It is the HP's responsibility to provide the information, and the patient/client's responsibility to consent to accept the potential risks as well as any benefits of the care in question. Informed consent means TGD people should be able to make decisions about their care, free from any coercion (Cavanaugh et al., 2016; Clark, 2017; Hann et al., 2017; shuster, 2019). Providing informed consent in gender-affirming care involves facilitating a comprehensive understanding between the patient/client and the care provider about what the desires and goals of this care are, what the known risks and benefits are for this type of care, and what the limits to our knowledge about these are (Kimberly et al., 2018; Bernal & Coolhart, 2012; Wren, 2019). Health care that has higher benefits and lower risks requires a lower level of capacity to consent (Lipshie-Williams, 2020). Due to their specific knowledge of the risks and benefits, those who provide gender-affirming health care (i.e., physicians, nurse practitioners, and surgeons) are most appropriate for delivering the information necessary for a patient/client to carefully weigh the risks and benefits of treatment for themselves. See Chapters X of these

Standards for more details about the informed consent process as applied to gender-affirming care.

The principle of respect for autonomy has been given relatively little weight in the provision of gender-affirming health care in the past; some bioethicists have argued that requiring mental health assessments for accessing gender-affirming hormones and surgeries has meant TGD people have been given less autonomy than people accessing most types of similar health care, thereby undermining their self-determination, a practice that may portray TGD people as lacking capacity, being mentally unwell, or lacking full moral status (Hale, 2007; Lipshie-Williams, 2020; Toivonen & Dobson, 2017). However, a biopsychosocial assessment is common in most mental health settings and is often required before treatment begins even for concerns such as depression or anxiety (Sommers-Flanagan, J., & Sommers-Flanagan, R., 2017). These patients are not characterized as lacking capacity or being mentally unwell. Nor are patients who participate in assessments prior to administration of insulin (a hormone for the treatment of diabetes) or surgical procedures such as organ transplants (as living donors or recipients) or bariatric surgery seen as unwell or lacking moral status. Because of a history of psychopathologization and marginalization, some health care systems have been known to regard TGD patients/clients as mentally disordered, which has resulted in mental health professionals being put in a role as gatekeepers of gender-affirming care, which creates barriers to care rather than serving the best interests of the TGD client/patient. The general expectation of a preparedness assessment prior to hormones or surgery is that a preparedness assessment may contribute to readiness and eventual adaptation to physical changes as well as psychological or physical healing post-treatment and should be distinguished from therapy or the assumption of mental disorder. See Chapter X of these Standards for more details about assessments.

Recognizing TGD people as capable, independent, no less moral than cisgender people, may allow TGD clients/patients to feel more in control of determining their own lives and empowered to be responsible for their own actions (Hale, 2007; Lipshie-Williams, 2020). This may also result in TGD patients/clients gaining greater self-esteem and self-respect, which enables them to become more able to engage in equitable and mutually affirming relationships with other people in their lives (Hale, 2007).

Also relevant to the principle of respect for autonomy is for TGD clients/patients' correct names, genders, and pronouns to be recorded on their records and respected when communicating with the client/patient themselves and with other HPs (Hann et al., 2017; Markman, 2011; McCarthy et al., 2016; Seigel et al., 2019; Toivonen & Dobson, 2017). TGD clients/patients also have the right to privacy and confidentiality, as well as the right not to have arbitrary age requirements imposed on them to access care (Clark, 2017; Hann et al., 2017); age requirements should be medically justified. Persons who lack the capacity to act intentionally and with understanding due to their age or intellectual capacity may have diminished autonomy. In these cases, determining the capacity of a client/patient to provide informed consent is the task of HPs (Kimberly et al., 2018), and families and guardians may play a role in the informed consent process (see the Child and Adolescent chapters of these SOC for further discussion). Information should be provided in a way that is accessible and appropriate to the patient's/client's age or level of understanding (Wren, 2019).

## **Nonmaleficence**

Most simply understood, nonmaleficence is the duty to “first, do no harm” or “above all, do no harm” and includes both intentional and unintentional acts of harm and endangerment. Nonmaleficence generally forbids actions of a certain kind. A function of this principle is the duty of providers to operate within one’s own level of competency (refer to the Education Chapter in this document for further information about competencies). A key part of nonmaleficence requires the HP to evaluate the risks and benefits of the proposed treatment. This requires understanding the perspective of the patient/client’s lived experience and expertise about their gender and as an independent moral agent; if the risks outweigh the benefits, the professional must refuse to do what might be technically possible if the risks are too high or the gains too temporary. When considering risks and benefits, HPs should be cognizant of prevailing social norms that marginalize transgender people and consider whether these norms are influencing the fairness of their decision-making (see Beneficence and Synthesis sections below).

## **Beneficence**

As a principle, beneficence requires that providers contribute to the welfare of or confer maximal benefit to the patient/client (Toivonen & Dobson, 2017). Many acts of beneficence may be supererogatory (i.e., go beyond the minimum of what is morally necessary), while some acts of beneficence are morally required. In the field of transgender health, beneficence means providing affirming, supportive, and nonjudgmental health care (Hann et al., 2017).

Health care professionals should be aware of how they can help mitigate antitransgender stigma, discrimination, and prejudice in their patients’/clients’ lives (American Psychological Association, 2015). To provide maximal benefit to patients/clients, HPs can advocate for their patients/clients to access identity documents, social services, and public accommodations, for example by providing documentation where this is needed (American Psychological Association, 2015).

Requiring that TGD patients/clients undertake objectifying or unjustified mental health treatment, especially for protracted lengths of time, in order to access gender-affirming care creates a power imbalance between mental health professionals and their patients/clients. Such requirements may create distrust and negatively impact the rapport built between mental health providers and their patients/clients and may also make the patient/client cautious about disclosing information related to their mental health for which they might have otherwise been able to receive help (Cavanaugh et al., 2016.; Hann et al., 2017). Eliminating unnecessary assessments allows MHPs more freedom to confer benefit to patients/clients by focusing on providing supportive mental health care (Cavanaugh et al., 2016), which is often needed given the serious mental health and social disparities faced by many transgender people. However, there are times when a mental health assessment may be necessary to assess capacity to make a medical decision for various types of care, not just gender-related care. In cases of questionable capacity to make a medical decision, a MHPs assistance can be helpful to physicians or surgeons. A physician’s request for a mental health consult should not uniformly be interpreted as a maleficent act toward a TGD person; it may reflect due diligence to preserve the patient/client’s autonomy, an act of beneficence, or both. A mental health assessment or consult may help a surgical patient prepare for the procedure and can contribute to better postoperative outcomes, but when considering whether this should be a requirement, HPs should consider whether they would require such assessments for other surgeries with similar risks and benefits, such as bariatric surgery and organ transplants.

WPATH also incorporates *ethics of care*, which emphasize the role of

- Compassion—emotional responses of sympathy and tenderness and regard for the welfare of others;
- Discernment—insight, clear judgment free of extraneous or undue influences;
- Trustworthiness—established confidence in one’s character and conduct, creating a good climate of trust;
- Integrity—fidelity to one’s moral convictions, and
- Conscientiousness—extending appropriate effort and due diligence in determining what is right and in acting accordingly.

This articulation of the ethics of care is largely derived from Carol Gilligan (1982) and summarized by Beauchamp & Childress (2019).

## Justice

As an ethical principle, justice requires working toward the fair and equitable provision of health care for everyone. Injustices faced by some TGD people in society include discrimination within housing and employment and barriers to accessing health care, social services, and education (American Psychological Association, 2015; Watson et al., 2019). In some regions in the world, accessing gender-affirming health care is criminalized or highly pathologized (Kimberly et al., 2018). Despite recent legal and social advances, societal injustices mean that public health providers and insurance companies in many parts of the world still require TGD people to undertake psychiatric diagnoses or obtain documentation of psychotherapy or court orders to be able to access gender-affirming care. Governments and legal systems also often require similar measures to allow changes to identity documents. HPs should acknowledge that the process of navigating medical and legal systems to access basic health care and identity documents can be resource-consuming and emotionally taxing for many TGD people (American Psychological Association, 2015).

Injustices that create barriers for transgender people to access health care services include stigma and discrimination, as well as geographic, financial, language, and cultural barriers (Kimberly et al., 2018; Seigel et al., 2019). HPs should be aware of these barriers and strive to create environments that are positive and accessible enough for all people, including TGD people, to comfortably navigate (Clark, 2017; Seigel et al., 2019). One way to make a practice more accessible is to have transgender positive resources displayed in waiting areas (American Psychological Association, 2015). HPs should be cognizant of the authority they hold over patients/clients as well as the intersecting oppressions that exist in society that might further the authority that they hold (shuster, 2019; Sue & Sue, 2008).

HPs should work as “collaborative advocates” with patients/clients to identify and work toward improving public attitudes and the systems and institutions that perpetuate these injustices (American Psychological Association, 2015, p. 841; Markman, E.R., 2011; Toivonen & Dobson, 2017; Bernal & Coolhart, 2012; Wren, 2019). This could include conducting training or consulting about policy improvements within these institutions.

Finally, HPs should acknowledge and respect differences in knowledge, culture, beliefs, and values among their clients/patients, including the diversity of lived genders that exist within these differences (Bauer et al., 2019; Hidalgo et al., 2013). This includes indigenous and non-western understandings of gender and sexuality, and HPs should be aware of the history of medicalization of TGD people, which has had an effect of erasing these understandings (Bauer et al., 2019; binaohan, 2014). An effective way to begin increasing one’s competence in

accepting diversity is to be respectfully curious about the patient/client's experience and background.

## Synthesis

The ethical principles outlined above do not exist in isolation and should be considered in dialogue with each other. HPs commonly consider beneficence and nonmaleficence together, looking to maximize benefit and minimize harm (McCarthy et al., 2016; Toivonen & Dobson, 2017). Providing gender-affirming care based on informed consent acknowledges that clients/patients are best placed to judge beneficence, giving HPs a more complete sense of the balance between beneficence and nonmaleficence (Cavanaugh et al., 2016). The principle of informed consent does not absolve the health care provider of the duty to precede any intervention with an assessment of the patient/client's capacity to give informed consent, as well as their preparedness for hormonal or surgical interventions, which might include a recommendation for addressing any health conditions, situations of daily life, or mental health care; such recommendations should not categorically restrict a patient/client's ability to access medically necessary gender-affirming care. Beneficence and nonmaleficence should be considered alongside respect for autonomy (for patient *and* provider) and justice, and clear evidence of a very high level of risk is required before beneficence and nonmaleficence override the principle of respect for autonomy (Frohard-Dourlent et al., 2020; Hale, 2007; Toivonen & Dobson, 2017). Ethical discussions that involve more than one provider warrant consideration of the provider's professional integrity as well as of the autonomy of the patient because not all providers may view the balance of these ethical principles in precisely the same way.

Examples of harmful behavior by HPs that are particular to TGD people include conversion therapy efforts and the refusal to provide treatment (American Psychological Association, 2015; Bernal & Coolhart, 2012). Surgeries performed by unskilled professionals may also be harmful. Religious objections to providing gender-affirming care can become a hindrance to the provision of health care when the act of refusing to provide care is done in a deliberate effort to inhibit any access to care. All persons are entitled to hold their own religious beliefs, but HPs should not use their religion to justify harmful or unethical behavior toward TGD people (Boskey et al., 2019). HPs have an ethical obligation to ensure that medically necessary care, such as gender-affirming care, is provided; this means referring patients/clients to another provider if they cannot provide this care themselves (McCarthy et al., 2016). TGD people who cannot access gender-affirming care through HPs may resort to potentially harmful self-medication (Kimberly et al., 2018) and self-performed surgery such as auto castration, silicone injections, or both. The ethos of harm reduction that has inspired earlier versions of these SOC should also call HPs to consider the far-reaching consequences of their omissions should they feel themselves called to withhold care without a referral to a competent provider.

Research has also identified potentially harmful attitudes and actions TGD people may encounter when accessing health care. These include the assumption that mental health problems exist because a person is transgender; the use of pathologizing, hurtful, or insulting language; asking inappropriate questions about transgender people's bodies; and focusing on patients/clients as being transgender, even when their presenting issues or symptoms have little or nothing to do with gender or gender-affirming care (American Psychological Association, 2015; Hann et al., 2017). As with any patient/client, inappropriate boundaries between providers and TGD patients/clients are a breach of professional ethics.

When considering ethical decisions such as evaluating these risks and benefits, HPs should be aware of prevailing social norms that privilege cisgender people and binary genders, and that

marginalize TGD people (Butler et al., 2019). These norms have potential to create bias and discrimination in ethical judgments; education in TGD cultural competency and humility is important to reduce these biases. See the Education chapter in these Standards.

We encourage HPs to thoughtfully consider their own language use, beliefs, and stereotypes about TGD people (Adams et al., 2017; Morris, et al., 2020; Seigel et al., 2019). HPs can develop and maintain competence in working with TGD people through continued education (such as that available through WPATH's Global Education Institute and other medical education centers), supervision, and engagement with the TGD community outside of their practice, such as attending community events or consuming media produced by TGD people (American Counseling Association, 2010; American Psychological Association, 2015; Bernal & Coolhart, 2012). Hospitals and clinical practices can also reduce harm by providing training for support staff about TGD competency, having demographic questionnaires that are inclusive of nonbinary genders and employ contemporary language, and providing restrooms that are inclusive of people of all genders (American Psychological Association, 2015; Hann et al., 2017).

Ethical challenges may occur between providers and clients/patients, between providers and institutions, and between clients/patients and institutions (where the provider may play a role in resolving the issue). When problems arise, the key principles must be weighed and balanced to determine an optimal course of action. The process of ethical decision-making should be deliberate and conscientious, taking into consideration various viewpoints and factors pertaining uniquely to each situation.

When feasible, it can be very useful to convene an ad hoc Ethics Committee within a provider's institution or professional community to discuss the specifics of an ethically challenging patient case. In such cases, it is helpful to open the discussion to providers whose professional background is both similar and different from that of the patient's primary provider(s)—and possibly include trusted lay participants—to help ensure qualified, but also neutral input. While it is certainly helpful to include a bioethicist when one is available, even if one is not available, the assembly of a diverse group of professional and lay providers to discuss ethical challenges from the different perspectives outlined herein can often provide fresh insights and brings transparency, organized discussion, and a record of deliberation to the process of managing ethical challenges.

WPATH's Global Education Institute (GEI) training program offers an advanced ethics course that provides HPs with the opportunity to engage in anonymized case discussions to learn how the SOC may be applied in clinical situations.

## **Research Ethics**

The ethical principles described above also apply to conducting transgender health research. Many issues discussed in this section are unique to transgender health in that boards and committees conducting standard ethical reviews might not be trained to notice these issues (Adams et al., 2017.; Vincent, 2018). Institutional Review Boards (IRBs) might also be called Independent Ethics Committees (IECs) or a Research Ethics Board (REB). These bodies exist to protect the rights, privacy, and welfare of research participants, including TGD participants.

Research projects may get formal IRB approval but still be experienced as stigmatizing, oppressive, unethical, or both, by TGD individuals and communities (Bauer et al., 2019). Well-

meaning researchers may inadvertently increase the likelihood of harm. If one's goal is to demonstrate cultural competence and minimize potential harm or stigmatization of TGD individuals and communities (i.e., nonmaleficence), then one should take great care in how a study is framed and discussed.

## **Engage with Transgender Communities**

It is important that health researchers meaningfully engage with TGD communities throughout the research process, including in the formulation research questions. Where possible findings should be disseminated in ways that are accessible and usable to TGD people and other stakeholders. Authorship, acknowledgment, learning opportunities, and other compensation are factors that should be considered when transgender people provide expertise about their communities as active members of research teams (Adams et al., 2017; Bauer et al., 2019; Vincent, 2018).

Researchers should be aware of the history of research in transgender health and be cognizant that suspicion of researchers and research fatigue may be a result of this history (Adams et al., 2017; American Psychological Association, 2015; Ashley, 2020; Bauer et al., 2019; Vincent, 2018). Researchers should be transparent about their research questions, and it may take significant work to establish trust with transgender communities to achieve meaningful engagement and collect data representative of transgender people (Adams, et al. 2017; Vincent, 2018). Researchers should also be aware of the heterogeneity within transgender communities and consider how those who are most marginalized may be excluded from participating in the research and how research questions, recruitment strategies, and analyses might meet the needs of these groups (Bauer et al., 2019; Vincent, 2018).

Continued engagement with transgender people with analysis, interpretation, and dissemination of results can help to ensure results are contextualized and presented in a way that maximizes the benefit for transgender people, HPs, and policy makers, and that minimizes the likelihood that these will be misinterpreted in ways that would be harmful to transgender people (e.g., reinforcing stereotypes or stigma; Adams et al., 2017; American Psychological Association, 2015; Bauer et al., 2019). Active engagement with the media may help to reinforce the correct interpretation of research findings (Adams et al., 2107).

When conducting research that might be potentially sensitive or distressing for vulnerable transgender participants, researchers should work with transgender community groups to identify support services that are inclusive of transgender people to which research participants can be referred (Adams et al., 2017).

Note that the current landscape of academic literature is such that the research is frequently inaccessible to many behind a paywall. If one grants that well-conducted research can beneficially impact HPs, policy makers, and community organizations, then, in upholding the principle of beneficence, there may be an impetus to make our research more freely available. Potential ways to accomplish this include sharing preprint copies of manuscripts and incorporating funding for open access journals in the budgets for grants.

## **Consider Positionality**

Researchers should be aware of their own authority and social location, and it is important that transgender health researchers consider how this positionality might influence their research design, analysis, and interpretation of findings (Adams et al., 2017; Bauer et al., 2019).

In situations where gender-affirming care providers are also conducting research, this dual role needs to be carefully managed to ensure transgender people do not feel coerced or obliged to participate in the research (Bauer et al., 2019). Researchers should take care to ensure research and clinical materials are clearly distinguished (Bauer et al., 2019) and should be aware that this dual role may cause those who participate to give inaccurate responses (Vincent, 2018). This dual role should be managed with special care when research is being conducted by the only provider of gender-affirming care in a local region (Adams et al., 2017). Researchers should clearly state not consenting to participate in the research will not affect a client/patient's access to or quality of the health care they seek, including gender-affirming care (Adams et al., 2017; Bauer et al., 2019). Adams and colleagues suggested that researchers who provide gender-affirming care should designate an alternative independent contact person to whom any concerns or inquiries should be addressed. It is important to separate the consent process for research from the consent process for clinical care. IRBs often require consent for research be obtained on an occasion separate from when the option to participate in the research is first introduced. In addition, consent to participate in research should be discussed before consent for care so the patient understands the two activities are clearly separate.

### **Use Appropriate Language and Measures**

As with clinical practice, it is important language used as part of the research process be inclusive, affirming of people's genders, nonpathologizing, respectful of participants' autonomy, and free of harm (Adams et al., 2017; Bouman et al., 2017). This includes not describing transgender identities as *extreme* or *comorbid* with mental health issues (Adams et al., 2017). Language must be clear and written at an appropriate language level to be understood by the average reader. Many research questionnaire items and clinical measures that use male and female reference ranges can be adapted in ways that are appropriate for transgender people and their bodies (Bauer et al., 2019).

### **Consider Privacy, Confidentiality, and Consent Issues**

It is important transgender health researchers be aware of the possibility that information that appears to be de-identified may actually be identifiable due to the small size of transgender communities (Bauer et al., 2019). This may cause transgender participants to be more cautious about what they disclose (Adams et al., 2017). In many regions of the world, disclosing sensitive research data could put transgender people at serious personal risk (Adams et al., 2017).

It is common practice in the US for IRBs to grant "Waivers of Informed Consent" for retrospective studies (e.g., chart reviews)—where all information is de-identified prior to publication—and for studies with no more than minimal risk to participants. Arguments in favor of such waivers assert that waivers of informed consent increase the feasibility of research (by reducing barriers to conducting research) and do not put participants at any meaningful risk. Clinical researchers should ask themselves whether patients/clients/participants understand that their medical records may be reviewed, anonymized (de-identified), and reported on at a future date without them having to give informed consent.

Researchers may need to consider alternative consent procedures for adolescent transgender participants who may not be able to obtain parental or guardian consent for a number of reasons, including not having disclosed they are transgender to their family, having parents who are unsupportive of a child's transgender identity, being involved in parental disagreement/disputes, etc. Alternatives that can be employed independently or together include considering the mature-minor research consent principle, involving independent advocates to safeguard young participants' rights, and using a questionnaire to assess comprehension for obtaining informed consent (Adams et al., 2017). Different countries may have different legal provisions for minors concerning consent to participate in research.

### **WPATH's Role in Claims of Ethical Misconduct**

WPATH is not a mediator nor does the association have any authority to investigate or adjudicate claims of ethical misconduct. State licensing boards, other government agencies, employers, and hospital (or clinic) administrators are the bodies with authority to investigate or prosecute claims of unethical conduct, malfeasance, negligence, or malpractice. When issues are brought to the association's attention, WPATH can suggest referring the issue to the proper regulatory body, offer to explain the SOC, provide a member with an opportunity to discuss a problem, offer education (for individuals, teams, or institutions) to assist in remediating problems, and potentially sanction or expel a member from WPATH.

The role of the Ethics Committee within WPATH is to raise issues of ethical import and provide advice on ethical issues to the WPATH Board, generate discussion on ethical issues for WPATH member engagement, and to develop continuing education training content and materials. The Ethics Committee consists of a maximum of twelve members and includes mental health providers, surgeons, researchers, professional ethicists, and transgender advocates.

### **Conclusion**

Ethics is a conversation that has been ongoing in the medical and medicolegal professions since the origins of practice. Negotiating new developments in the care of people and in the treatment of their conditions, particularly regarding aspects of life that are not well understood, or are regarded as morally contentious, is always problematic, especially for individuals in need of care. WPATH's interests are to promote responsible research and clinical practice that are helpful—not harmful—to people whose gender identity differs from their sex assigned at birth. SOC are an important component of establishing the field of practice, the literature, and the evolution of the field. The ethical foundations of the field are now well-established, and the evolving questions only deepen the richness of the endeavor. Providers who are dedicated to this field and who are engaged in interdisciplinary care and committed to sound research and robust continuing education in the area of transgender health have done much to advance the field. The increased involvement of transgender people in the ongoing dialogue, both as health care providers and as patients/clients and participants in research, has been a catalyst for exponential improvement in the quality of transgender health around the globe.

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