



Literature Review

Re: Medical necessity of vaginoplasty in transgender women without full social transition

Date: July 27, 2018

Cited articles available upon request.

Table of Contents

| | |
|---|-----------|
| I. Vaginoplasty is clinically appropriate treatment for the illness or disease of gender dysphoria..... | 2 |
| A. Gender dysphoria is an illness or disease under the plan..... | 2 |
| B. Vaginoplasty is clinically appropriate and considered effective for gender dysphoria. For individuals who desire genital reassignment, it is required for the treatment of gender dysphoria; | 3 |
| II. Vaginoplasty prior to full social transition is in accordance with generally accepted standards of medical practice. | 7 |
| A. Physical transition and social transition relieve separate aspects of gender dysphoria and must be approached individually. | 7 |
| B. The patient’s surgery is in accordance with the WPATH Standards of Care, which emphasize an individualized approach. | 9 |
| C. Surgery is in accordance with the Endocrine Society guidelines, which also have an individualized approach..... | 10 |
| D. Rigidly requiring a “full-time real-life experience” is not in accordance with the SOC or clinical practice..... | 11 |
| E. The SOC themselves endorse a harm reduction approach, which favors intervention even in the absence of all of the standard criteria.... | 13 |
| F. Not being out as female at work does not negate the effectiveness of vaginoplasty in alleviating gender dysphoria. | 14 |
| III. Conclusion..... | 16 |

I. Vaginoplasty is clinically appropriate treatment for the illness or disease of gender dysphoria.

Gender reassignment surgeries are procedures that change male sex characteristics into female ones (or vice versa) for the purpose of treating gender dysphoria. Genital reassignment surgery (“GRS”), including vaginoplasty, has been shown to be highly effective in treating gender dysphoria.

A. Gender dysphoria is an illness or disease under the plan.

Gender dysphoria is a disease in which there is “incongruence between the individual’s own perception of his/her sex and their biological phenotype.”¹ Affected individuals have “a strong desire to undergo medical and surgical treatment ... in order to alleviate physical incongruence and gender dysphoria.”² Gender dysphoria “is a clinical term used to describe the symptoms of excessive pain, anguish, agitation, restlessness, and malaise” that transgender people often experience. It “describes the psychological discomfort experienced with the physiological body . . . as well as a presence of clinical [symptoms] associated with emotional difficulties.”³ Gender dysphoria is “[o]ften experienced as depression, anxiety, irritation, and/or agitation, [it] describes the sense that something is very wrong”⁴ Before treatment, individuals with gender dysphoria “live in a dissociated state of mind and body.”⁵ Transsexualism—an other term for gender dysphoria—is recognized under the International

¹ Ebba K. Lundqvist et al., *Quality of life improves early after gender reassignment surgery in transgender women*, 40 EUR. J. OF PLASTIC SURGERY 223 (2017).

² *Id.*

³ Arlene Istar Lev, TRANSGENDER EMERGENCE: THERAPEUTIC GUIDELINES FOR WORKING WITH GENDER-VARIANT PEOPLE AND THEIR FAMILIES 10 (2004).

⁴ Randi Kaufman, *Introduction to Transgender Identity and Health*, in THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH 331, 337 (Harvey Makadon et al. eds., 2008).

⁵ David Seil, *The Diagnosis and Treatment of Transgendered Patients* in TRANSGENDER SUBJECTIVES: A CLINICIAN’S GUIDE 115 (eds. Ubaldo Leli & Jack Drescher) (2004) (describing the diagnosis and treatment of 271 transgender patients between 1979 and 2001).

Classification of Diseases, Tenth Revision (ICD-10) as medical condition F.64.0.⁶

Gender dysphoria is thus a recognized “disease” under the plan. It is also an “illness” under the plan as a transgender woman with gender dysphoria has a female psychological sex, and the male sex characteristics of her body represent a pathological condition of the body.

B. Vaginoplasty is clinically appropriate and considered effective for gender dysphoria. For individuals who desire genital reassignment, it is required for the treatment of gender dysphoria;

There is no dispute that vaginoplasty is a safe, effective, clinically appropriate treatment for gender dysphoria. This overwhelming medical consensus is reflected in the fact that all insurance companies with clinical policies on gender dysphoria treatments recognize vaginoplasty as medically necessary.⁷

The World Professional Association for Transgender Health publishes the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*,⁸ (“SOC”) to help guide clinicians about decision-making on behalf of their transgender patients. The SOC endorse vaginoplasty as an appropriate treatment for gender dysphoria.⁹ WPATH also released a statement on medically necessary therapy and treatment

⁶ World Health Organization, International Statistical Classification of Diseases and Related Health Problems, 10th Revision (2016), <http://apps.who.int/classifications/icd10/browse/2016/en#/F60-F69> (“A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one’s anatomic sex, and a wish to have surgery and hormonal treatment to make one’s body as congruent as possible with one’s preferred sex.”).

⁷ TRANSCEND LEGAL, TRANSGENDER INSURANCE MEDICAL POLICIES, <https://transcendlegal.org/health-insurance-medical-policies> (providing links to over 110 insurance company clinical guidelines on gender reassignment surgery and related treatments).

⁸ WPATH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE (7th ed.) (2011) [hereinafter WPATH STANDARDS OF CARE] https://amo_hub_content.s3.amazonaws.com/Association140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf.

⁹ *Id.* at 57.

for trans people that specifically listed vaginoplasty as a medically necessary surgery.¹⁰

The safety of vaginoplasty is well-established.¹¹ Vaginoplasty for

¹⁰ WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, POSITION STATEMENT ON MEDICAL NECESSITY OF TREATMENT, SEX REASSIGNMENT, AND INSURANCE COVERAGE IN THE U.S.A. (Dec. 21, 2016), https://s3.amazonaws.com/amo_hub_content/Association140/files/WPATH-Position-on-Medical-Necessity-12-21-2016.pdf.

¹¹ See S. De Stefani et. al., *Microlaparoscopy in Sex Reassignment Surgery*, 4 THE SCIENTIFIC WORLD J. 100, 101 (2004) (Surgical techniques utilized for performing GRS on trans women are “well codified and relatively simple to perform.”); F. G. Bouman, *Sex Reassignment Surgery in Male to Female Transsexuals*, 21 ANNALS OF PLASTIC SURGERY, 526, 531 (1988) (“[v]aginal construction in male transsexuals . . . is a reliable technique”); Gennaro Selvaggi et al., *Gender Identity Disorder: General Overview and Surgical Treatment for Vaginoplasty in Male-to-Female Transsexuals*, 116 PLASTIC AND RECONST. SURGERY 135e, 143e (2005) (describing the variety of modern techniques available and noting that the “penile-scrotal skin flap technique is considered the state of the art for vaginoplasty”). See also Cameron Bowman & Joshua M. Goldberg, *Care of the Patient Undergoing Sex Reassignment Surgery*, 9 Int’l J. of Transgenderism 135, 142 (2006) (noting that it is safe to perform vaginoplasty and breast augmentation at the same time); Eric B. Gordon, *Transsexual Healing: Medicaid Funding of Sex Reassignment Surgery*, 20 ARCHIVES OF SEXUAL BEHAVIOR 61, 72 (1991) (noting that in 1991 GRS research was in the “‘refining’ stage”); Miroslav Djordjevic, *Rectosigmoid vaginoplasty: Clinical Experience and Outcomes in 86 Cases*, 8 J. OF SEXUAL MED. 3487, 3493 (2011) (“Rectosigmoid vaginoplasty presents a safe and reasonable choice with acceptable complications and satisfactory results” in both transgender and non-transgender women.).

transgender women has been performed since 1931, with modern vaginoplasty techniques emerging in the 1950's.¹² There is a low rate of complications¹³ and a high rate of good clinical outcomes and patient satisfaction with the results.¹⁴

Peer-reviewed medical literature has conclusively demonstrated that GRS is effective and of material clinical benefit to individuals with gender dysphoria. GRS has been found to lead to a “virtual absence of gender dysphoria,”¹⁵ and is proven to alleviate the psychological symptoms of

¹² See Jonathan Charles Goddard, et al., *Development of Feminizing Genitoplasty for Gender Dysphoria*, 4 J. OF SEXUAL MED. 981, 983-84 (2007).

¹³ See Ji-Xiang Wu et. al., *Laparoscopic Vaginal Reconstruction Using an Ileal Segment*, 107 INT'L J. OF GYNECOLOGY AND OBSTETRICS 258, 259 (2009) (finding no complications during surgery and only three post-operation complications, which were resolved, when vaginoplasties were performed on 80 trans and non-trans women); Ladislav Jarolím, *Gender Reassignment Surgery in Male-to-Female Transsexualism: A Retrospective 3-Month Follow-Up Study with Anatomical Remarks*, 6 J. OF SEXUAL MED. 1635, 1641 (2009) (reporting that for 128 trans women who underwent GRS, surgical complications were uncommon and were all successfully resolved); S. V. Perovic et al., *Vaginoplasty in Male Transsexuals Using Penile Skin and a Urethral Flap*, 86 BJU INT'L 843, 849 (2000) (reporting good results and only one major complication in a follow-up of eighty-nine vaginoplasties).

¹⁴ See P.A. Sutcliffe et. al, *Evaluation of Surgical Procedures for Sex Reassignment: A Systematic Review*, 62 J. OF PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY 294, 299 (2009) (concluding results of vaginoplasty are generally satisfactory); Ciro Imbimbo et al., *A Report from a Single Institute's 14-Year Experience in Treatment of Male-to-Female Transsexuals*, 6 J. OF SEXUAL MED. 2736, 2740 (2009) (reporting on the results of 139 patients over a 14-year period in which 94% of patients were satisfied and had no regrets); Anne A. Lawrence, *Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery*, 32 ARCHIVES OF SEXUAL BEHAVIOR 299, 309 (2003) (finding over 96% of transgender women participating in the study were happy with their GRS results); A. Michel et al., *The Transsexual: What About the Future?*, 17 EUROPEAN PSYCHIATRY 353, 354-55 (2002) (literature review finding that almost 90% of transgender people say they would make the decision to undergo GRS again); G. De Cuypere et al., *Long-term follow-up: psychosocial outcome of Belgian transsexuals after sex reassignment surgery*, 15 SEXOLOGIES 126, 131 (2006) (88% of transgender women “felt happy to very happy after surgery”); Jarolím, *supra* note 13, at 1635 (Czech study of 129 transgender women showed all were satisfied and the procedure was safe).

¹⁵ Yolanda L. S. Smith, *Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals*, 35 PSYCHOLOGICAL MED. 94 (2005). See also Mohammad Hassan Murad, *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*, 72 CLINICAL ENDOCRINOLOGY 216 (2010) (“Male-to-female

gender dysphoria, including depression.¹⁶ GRS has also been found to lead to a decrease in suicide attempts and drug use in post-operative populations.¹⁷ Due to stigma and discrimination, transgender women have a lower quality of life as compared to the general population, but GRS improves quality of life as compared to not having surgery.¹⁸

In the single controlled, randomized study available on GRS, one group of transgender women received genital surgery early while another group remained on the ordinary waitlist. Those who had surgery showed significant improvement in psychiatric symptoms, and social and sexual function, while those who had not yet had surgery showed no improvement.¹⁹

In 1998, a comprehensive review of the literature on GRS outcomes was conducted, which compiled data spanning thirty years of follow-up studies, reporting on eighty studies from twelve countries.²⁰ Treatment that included GRS was found to be effective in relieving gender dysphoria.

and FM individuals had the same psychological functioning level as measured by the Symptom Checklist inventory (SCL-90), which was also similar to the psychological functioning level of the normal population and better than that of untreated individuals with GID.”); Tiffany A. Ainsworth & Jeffrey H. Spiegel, *Quality of Life of Individuals with and without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 QUAL. LIFE RES. 1019, 1021 (2010) (“[T]ranswomen without surgical intervention had statistically significant ($P < 0.05$) lower mental health scores compared to the mental health scores for the general female population (mean 39.5 (SD 7.3) compared to mean 48.9). The mental health quality of life of transwomen without surgical intervention was significantly lower compared to the general population, while those transwomen who received FFS, GRS, or both had mental health quality of life scores not significantly different from the general female population.”).

¹⁶ See Murad, *supra* note 15, at 216 (“Pooling across studies shows that after sex reassignment, 78% of individuals with GID reported significant improvement in psychiatric symptoms.”).

¹⁷ See Jamil Rehman et al., *The Reported Sex and Surgery Satisfaction of 28 Postoperative Male-to-Female Transsexual Patients*, 28 ARCHIVES OF SEXUAL BEHAVIOR 71, 83 (1999).

¹⁸ Ebba K. Lundqvist et al., *Quality of life improves early after gender reassignment surgery in transgender women* 40 EUR. J. OF PLASTIC SURGERY 223 (2017).

¹⁹ See C. Mate-Kole et al., *A controlled study of psychological and social change after surgical gender reassignment in selected male transsexuals*, 157 BRITISH J. OF PSYCHIATRY 261, 264 (1990).

²⁰ Stan Monstrey et al., *Surgery: General Principles*, in *Principles of Transgender Medicine and Surgery* 89, 95 (Stan Monstrey et al. eds., 2007).

Additionally, “[t]here were few negative consequences, and all aspects of the reassignment process contributed to overwhelmingly positive outcomes.”²¹

II. Vaginoplasty prior to full social transition is in accordance with generally accepted standards of medical practice.

As detailed below, support from the following sources recognizes the patient’s care as medically necessary:

- Medical opinions of professional societies;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved.

A. Physical transition and social transition relieve separate aspects of gender dysphoria and must be approached individually.

Individuals who have no plans to ever socially transition in any context still “have a strong desire to change the gendered characteristics of their body for personal affirmation and comfort.”²² Katherine Rachlin, an expert in the field and the patient’s provider notes: “It is often assumed that the drive to resolve a gender-incongruent body will be matched with the drive to resolve a gender-incongruent social life and that these things coexist equally within an individual, yet there are a range of people who

²¹ *Id.*

²² Katherine Rachlin, *Medical Transition without Social Transition: Expanding Options for Privately Gendered Bodies*, 5 TSQ: TRANSGENDER STUDIES QUARTERLY 228, 228 (2018).

believe it is in their best interest to change their bodies, but not their social roles.”²³ Rachlin notes that “there are many factors that have nothing to do with gender identity that affect transition choices,” such as concerns surrounding career, cultural and social ostracism, loss of family, being a primary caretaker for others, and social hostilities.²⁴ She explains that those barriers may lead someone to limit social transition, but it doesn’t obviate their need for surgery.

The WPATH SOC recognize that while some people “find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria.”²⁵ They acknowledge that for the latter group, “relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.”²⁶ This need for surgery is independent of any relief that comes from social transition, which cannot bring about physical bodily congruence.

It is widely accepted in the field of transgender medicine that an individual may socially transition without having medical intervention and the two have long been de-linked.²⁷ Ninety-five percent of transgender men transition from female to male social roles without ever having genital surgeries.²⁸ If gaining a male social role while retaining a vagina is acceptable treatment for a male-identified person, the converse, retaining a male social role while gaining a vagina, is an equally logical treatment for a female-identified person.²⁹

²³ *Id.* at 231.

²⁴ *Id.* at 232-33.

²⁵ WPATH STANDARDS OF CARE *supra* note 8, at 54.

²⁶ *Id.* at 55.

²⁷ *Id.* at 237.

²⁸ Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey*, 101 (2016) <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

²⁹ *See* Rachlin, *supra* note 22, at 237.

B. The patient’s surgery is in accordance with the WPATH Standards of Care, which emphasize an individualized approach.

While WPATH recommends that patients wait until after 12 months of living as the affirmed sex in all social contexts, the SOC as a whole emphasize individualized care, meaning that providers must do what is clinically appropriate for a given patient, not rigidly follow the SOC. In the opening section on “Purpose and Use of the Standards of Care,” WPATH emphasizes that the “Standards of Care Are Flexible Clinical Guidelines[.] The SOC are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people.”³⁰

The SOC criteria are “clinical guidelines; individual health professionals and programs *may modify them*. Clinical departures from the SOC may come about because of a patient’s unique anatomic, social, or psychological situation; an experienced health professional’s evolving method of handling a common situation; ... or the need for specific harm reduction strategies.”³¹ Such factors include concerns about career concerns, avoiding surgical risks caused by advancing age, the need to reduce suffering and reduce the risk of suicidality associated with delayed surgery.

The SOC explicitly recognize and expect that departures from the SOC will be necessary. These “departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care—and the SOC—to evolve.”³² This individualized approach is reflected by the fact that “virtually all of the major texts in transgender health are highly supportive of individualized care for transgender and gender-nonconforming individuals.”³³

³⁰ WPATH STANDARDS OF CARE *supra* note 8, at 2.

³¹ *Id.* (emphasis added).

³² *Id.*

³³ Rachlin, *supra* note 22, at 237.

The SOC in fact explicitly endorse one form of medical without social transition: “Hormone therapy must be individualized based on a patient’s goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so.”³⁴

C. Surgery is in accordance with the Endocrine Society guidelines, which also have an individualized approach.

The Endocrine Society—the world’s oldest, largest, and most active organization devoted to research on hormones and the clinical practice of endocrinology—has published clinical guidelines for treatment of gender dysphoric people.³⁵

They have five criteria for when genital reassignment surgery should be performed:

1. The mental health provider and hormone provider “both agree that surgery is medically necessary and would benefit the patient’s overall health and/or well-being.
2. Completion of “1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated.”
3. The patient is medically cleared to undergo surgery.
4. “We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes.”
5. Delay surgeries affecting fertility until the age of majority.

³⁴ WPATH STANDARDS OF CARE *supra* note 8, at 39.

³⁵ Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 26 (2017).

Under these criteria, there is not a rigid requirement either that the person live “full-time” or for any particular length of time. The requirement is simply a “satisfactory social role change,” that is, satisfactory to and for that individual. In this case, the patient’s social role change is satisfactory to her, her family, her mental health providers, and her surgeon. That is what matters—not a generic, arbitrary requirement.

D. Rigidly requiring a “full-time real-life experience” is not in accordance with the SOC or clinical practice.

The SOC list “12 continuous months of living in a gender role that is congruent with their gender identity” as a recommended criterion for vaginoplasty.³⁶ The rationale for this recommendation is that “the social aspects of changing one’s gender role are usually challenging—often more so than the physical aspects.”³⁷ The SOC recognize that “[c]hanging gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be.”³⁸ What the rationale does not discuss, however, is an individual who may not require full social transition to treat her gender dysphoria. This is the situation of the patient.

Experts in this field note that “some clients with traditional gender identities may not choose to fully socially or medically transition. The measure of the success of a client’s social transition is not how ‘complete’ it is, but whether a client has achieved a sustainable gender role that is likely to continue to meet his needs in the future.”³⁹ It is up to the individual and her clinicians, then, to determine what constitutes a sufficient real-life experience that is in accordance with the patient’s needs, which may never include full social transition. The real-life experience is best

³⁶ WPATH STANDARDS OF CARE *supra* note 8, at 60. The term “real-life experience” is outdated and is from the 2001 6th edition of the SOC.

³⁷ *Id.* at 61.

³⁸ *Id.*

³⁹ Randall D. Ehrbar & R. Nicholas Gorton, *Exploring Provider Treatment Models in Interpreting the Standards of Care*, 198 INT. J. OF TRANSGENDERISM 198, 206 (2010).

defined as “living before surgery the way one expects to live after surgery.”⁴⁰

Clinical practice reflects this flexibility, and “gender specialists are often comfortable tailoring treatment to exceptional cases with the knowledge that such treatment is potentially life enhancing.”⁴¹ Surgeons practicing in the field recognize that vaginoplasty is an option for a person who is not intent on full social transition.⁴²

If the purpose of the 12-month delay is to ensure that the person does not regret undergoing surgery, such a concern is not present where the person has the full support of three providers and also has a well-established history of and treatment for gender dysphoria. Research indicates that regret does not correspond to length of real-life experience and that many individuals who lived openly as female for less than 12 months had no regrets about undergoing surgery.⁴³ In a study of 232 vaginoplasty patients from a single surgeon, there was no difference in satisfaction between women who had 12 months of real-life experience and those who had less.⁴⁴ In the study, 16% of participants had not completed 12 months of real-life experience.⁴⁵ Studies aside, what is more important is the patient’s individual consideration and the fact that *her* providers have no reason to believe she is at risk of regretting surgery.

There were a variety of ways in which the study participants did not comply with the SOC, including not being on hormones for 12 months and having minimal psychotherapy, but all study participants did comply with

⁴⁰ Rachlin, *supra* note 22, at 241.

⁴¹ *Id.* at 233.

⁴² *Id.* at 239.

⁴³ Anne Lawrence, *SRS without a One Year RLE: Still no regrets*. Paper presented at the XVII Harry Benjamin International Symposium on Gender Dysphoria, Galveston, TX (Nov. 4, 2001), <http://www.annelawrence.com/hbigda2001.html>.

⁴⁴ Anne A. Lawrence, *Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery*, 32 ARCHIVES OF SEXUAL BEHAVIOR 299, 311 (2003).

⁴⁵ *Id.* at 313.

the SOC “in one important respect: They all received letters of recommendation for SRS from two mental health professionals.”⁴⁶ The trend toward *more* favorable outcomes in the patients where the minimum SOC criteria were not met can be explained by the fact that therapists “may be more willing to waive such requirements for persons they otherwise regard as especially favorable surgical candidates.”⁴⁷ This is the case for the patient.

Moreover, a 12-month minimum real-life experience “has never been demonstrated to be associated with more favorable outcomes in a published, peer-reviewed follow-up study.”⁴⁸ Indeed, as of 2009, “no scholarly journal article devoted to the [real-life test] or the [real-life experience] ha[d] ever been published,” so the requirement had no scientific basis in the first place.⁴⁹ An ethical objection may be raised as “employment of the scientifically unsubstantiated requirement of a [real-life experience] can be a needless, cruel and harmful obstacle for patients who are eager to use hormones or undergo genital surgery.”⁵⁰ The particular lack of evidence mandating this criterion is all the more reason to be comfortable waiving it.

E. The SOC themselves endorse a harm reduction approach, which favors intervention even in the absence of all of the standard criteria.

Finally, the SOC “articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches.”⁵¹ Harm reduction means that exceptions “may be made if it can be shown that withholding treatment will put the patient at great

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*; Lawrence, SRS without a One Year RLE, *supra* note 43

⁴⁹ Stephen B. Levine, *Real-Life Test Experience: Recommendations for Revisions to the Standards of Care of the World Professional Association for Transgender Health*, 11 INT’L J. OF TRANSGENDERISM 186, 186 (2009).

⁵⁰ *Id.*

⁵¹ WPATH STANDARDS OF CARE *supra* note 8, at 2.

risk.”⁵² This means that surgery may be performed even before certain criteria are met in order to reduce the risk of continued suffering, increased harm, or in the case of an older patient, a worse surgical outcome caused by a year of delay. A harm reduction approach is thus an independent basis for the surgery’s medical necessity.

F. Not being out as female at work does not negate the effectiveness of vaginoplasty in alleviating gender dysphoria.

Insurance companies recognize that GRS is medically appropriate to treat gender dysphoria in people who have completed 12 months of living openly as female and would cover the procedure if the patient had socially transitioned in all contexts 12 months ago.

For someone who has persistent, well-documented gender dysphoria, the dysphoria will not abate by waiting another 12 months. Substantial evidence reveals that a person’s gender identity is fully formed in youth⁵³ and that it is not possible to change gender identity.⁵⁴ Gender identity is stable by age four,⁵⁵ and transgender children know and express their genders as clearly and consistently as non-transgender children express their genders.⁵⁶

While the exact biological root causes of gender dysphoria have not been identified, magnetic resonance imaging studies have shown that the

⁵² Rachlin, *supra* note 22, at 239.

⁵³ See, e.g., Sarah M. Burke et al., *Hypothalamic Response to the Chemo-Signal Androstadienone in Gender Dysphoric Children and Adolescents*, 5 FRONTIERS IN ENDOCRINOLOGY 1 (2014) (demonstrating that adolescents with gender dysphoria have sex-linked olfactory responses congruent with their affirmed sex rather than their sex assigned at birth indicating that their brain sex was formed during early brain development).

⁵⁴ See generally Milton Diamond & H. Keith Sigmudson, *Sex Reassignment at Birth: Long-term Review and Clinical Implications*, 151 ARCH. PEDIATRIC MED. 298 (1997) (arguing that gender identity is formed at an early age and cannot be changed through therapy).

⁵⁵ David A. Levine and the Committee on Adolescence, *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, 132 PEDIATRICS e297, e299 (2013).

⁵⁶ Kristina R. Olson et al., *Gender cognition in transgender children*, 26 PSYCHOLOGICAL SCIENCE, 467–474 (2015).

brains of transgender children, adolescents, and adults match the patterns associated with their affirmed sex rather than sex assigned at birth, even before any hormonal treatment.⁵⁷ The regions affected play a role in body perception and self-awareness.⁵⁸ Separately, family and twin studies indicate a strong genetic component.⁵⁹ This biological origin of brain sex is reflected in the new ICD-11, in which the re-named “gender incongruence” diagnosis has been moved from a mental health diagnosis to a physical one.⁶⁰ The widespread endorsement of and insurance coverage of gonadotropin-releasing hormone (GnRH) analog treatment at the start of puberty⁶¹ is based on this stability of gender dysphoria that exists at the time of puberty.

In short, the patient is not at risk of changing her mind about wanting the surgery if she were forced to wait another 12 months, and the only thing waiting would accomplish would be an unnecessary prolonging of suffering.

The symptoms of gender dysphoria are consistent whether an individual is living as female in some or all contexts and stem in part from the physical condition of having a penis. While interventions such as talk therapy

⁵⁷ Elyse Pine-Twaddle, *Medical Management Updates for Gender Minority Youth and Difficult Cases*, 29 ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS 97, 98 (2018) (compiling the literature).

⁵⁸ *Id.*

⁵⁹ *Id.*; Tinca J. C. Polderman et al., *The Biological Contributions to Gender Identity and Gender Diversity: Bringing Data to the Table*, 48 BEHAVIOR GENETICS 95-108 (2018).

⁶⁰ World Health Organization, *ICD-11: Classifying disease to map the way we live and die* (2018), <http://www.who.int/health-topics/international-classification-of-diseases> (“Gender incongruence, meanwhile, has also been moved out of mental disorders in the ICD, into sexual health conditions. The rationale being that while evidence is now clear that it is not a mental disorder, and indeed classifying it in this can cause enormous stigma for people who are transgender, there remain significant health care needs that can best be met if the condition is coded under the ICD.”).

⁶¹ TRANSCEND LEGAL, MEDICAL POLICIES ON YOUTH SERVICES, <https://transcendlegal.org/health-insurance-medical-policies/youth-services> (linking to dozens of policies covering GnRH analogs for treating gender dysphoria).

and hormones may be sufficient to relieve some symptoms of gender dysphoria, the only way to permanently treat dysphoria caused by having a penis is genital reassignment surgery—not social transition. The fact that the patient had not informed everyone in her life about her transgender status does not make gender reassignment surgery any less effective or any less medically necessary in resolving the cognitive dissonance caused by having incongruent genitals. At issue should be the provider’s assessment of whether the individual has gender dysphoria, is ready for treatment, and can provide informed consent—not the patient’s personal decision to jeopardize or complicate her career late in life.⁶² In this case, the patient has presented robust evidence that the surgery was appropriate *for her*.

III. Conclusion

As Dr. Rachlin notes, “People should not have to sacrifice their worldview, community, family, or faith to receive treatment,” and nor should they have to sacrifice their medical privacy or jeopardize their careers, especially close to retirement. The widely-accepted standards of care adopt a flexible approach, and experts in the field routinely make exceptions to standard treatment approaches in order to ensure the best care for any given individual. That approach must be adopted here. The patient’s situation must not be given a blanket dismissal, but rather individualized consideration, which in this case is well-supported by clinical evidence that this was medically necessary care for this patient.

⁶² *Id.* at 436.