NYU Grossman School of Medicine

DIVISION OF MEDICAL ETHICS
HIGH SCHOOL BIOETHICS PROJECT

Gender Variance

Overview

This module aims to give an umbrella understanding of ethical issues that underpin the medical and social treatment of gender-nonconforming and transgender individuals. Additionally, the module provides definitions of terms and phrases that can be used in conversations about gender variance to increase the visibility and accessibility of these topics. Through the examination of case studies and an introduction to topics including gender dysphoria and gender expression, gender variance is regarded through a lens that centers the stories of gender variant individuals to bring an ethical and humanist perspective to their treatment in clinical settings.

Contents

Procedures and Activities

This unit uses a student-centered and interactive approach to teaching. Activities are designed to allow for a maximum degree of student participation and collaboration. Each activity is marked as an individual, partner, or group activity, or as a teacher-directed class discussion.

The following terms are used to designate the different types of activities:

- Individual Activity
- Partner Activity
- Group Activity
- Teacher-Directed Class Discussion

1. Introduction to Topic

Teacher-Directed Class Discussion

Opening Discussion Questions

1. Before we begin, do you have any questions about what we mentioned in the overview?

Healthcare settings such as clinics, emergency rooms, and even pediatric offices can be intimidating for most of us. For gender-nonconforming, transgender, and other gender variant people, these types of settings can be extremely stressful, invalidating, and sometimes dangerous due to poor medical treatment, be it intentional or unintentional, by clinicians and other working professionals. Additionally, there has been an extensive history of transphobia in medicine, which is still pervasive in discourse around gender-affirming surgeries and the general medical treatment of non-cisgender people today.

The first American to obtain gender-affirming surgery was Christine Jorgensen in the early 1950s. She traveled to Denmark, where she had experimental gender-affirming surgery under the supervision of Dr. Christian Hamburger (1904–1992). Christine's story shined a spotlight on gender variance in the United States that hadn't been seen before. By the late 1970s, certain hormonal and surgical procedures had become integrated into the practices of a select number of progressive physicians and used in various clinics around the country for patients seeking gender-affirming treatments. However, most doctors in the US in the 1970s and 1980s did not support their patients' desires for gender-affirming therapies, and they often thought the character of these patients to be flawed, deceptive, and unreliable. John Money, who was the co-editor of the journal *Transsexualism and Sex Reassignment* (1969), wrote that transgender patients were "devious, demanding and manipulative" and "possibly also incapable of love" (Wills, 2).

Although this same language is no longer used widely by clinicians, transphobia and lack of knowledge about gender variance still persist in medicine today.

The U.S. Transgender Survey from 2022 showed that 48% of respondents who visited healthcare providers between 1 and 2 years ago reported at least one negative experience related to being transgender, including having a provider be physically rough or abusive while treating them.

Dr. Logan S. Casey, a researcher in the LGBTQ+-related healthcare space and a member of the LGBTQ+ community, writes that "transgender people who have experienced discrimination in healthcare are more likely than those who have not to subsequently avoid both preventative and urgent healthcare services, including needed care due to illness or injury. This leads to worse health outcomes, including higher likelihood of depression and suicidal ideation or attempts (Casey, 2)."

While posing a large threat to the equitable treatment of transgender people in medical settings, barriers to accessing gender-affirming treatments are only a contributing factor to the health inequities that exist for transgender people. It's becoming increasingly understood that social factors contribute to health outcomes of individuals and communities. These contributing factors are called social determinants of health (SDOH), a few examples of which include individuals' socioeconomic resources, social position, income, level of education, and quality of accessible outdoor recreation spaces available to them (Braveman, 2). Dr. Casey writes, "Transgender people, with their unique health concerns, may also face special health-related vulnerabilities as a result of discrimination, including social and economic vulnerabilities that increase health risks (Casey, 3)." The health of transgender people is tied closely to their experience of the SDOH and their interactions with the medical community as a result of their specific healthcare needs.

The intersectionality of identities can also compound transgender people's experience in medical settings, causing them to feel increasing mistrust in their clinicians. For example, if a transgender person is also a person of color, an other-abled person, or a person without health insurance, they could experience medical racism, ableism, or inaccessibility to treatment on top of mistreatment due to transphobia. In this module, we will review the unique healthcare needs that some transgender people experience and how individuals' experiences in medical settings can affect their treatment and overall health.

2. Definitions

(Quoted and adapted from Liszewski)

Teacher-Directed Class Discussion

Gender Identity

One's internal sense of one's gender and how it fits into societal categories, such as woman, man, or non-binary person. A person's

gender identity may change over time.

Cisgender
Having a gender identity that is aligned with one's sex assigned at birth. For example, identifying as a woman and having been born with female genitalia

Intersex
A biologic sex that does not fit typical definitions of female or male; it is also known as "differences of sex development." Intersex persons may have any gender identity (male, female, or nonbinary) or sexual orientation.

Nonbinary
Identifying as neither male nor female, having a gender other than male or female, having multiple genders, or not having a gender. Other common terms used to describe people who reject the binary gender model include gender-nonconforming, genderqueer, agender, third gender or third sex, and gender-fluid. Whereas cisgender people and some transgender people may clearly delineate their gender identity within the conventional gender binary (for example, exclusively identifying as female), nonbinary persons often maintain more expansive concepts of gender. Many nonbinary people have very fluid experiences and expressions of their gender identity as it evolves, changes, and grows with them.

Transgender
Having a gender identity that does not exclusively match one's sex assigned at birth. Some transgender persons identify exclusively with the sex "opposite" to the one they were assigned at birth. For example, a transgender woman is someone who was assigned as male at birth but identifies as female. Other transgender persons may identify with both genders or perhaps neither. This last possibility highlights that some transgender persons have a broad gender identity and may identify as

both transgender and nonbinary.

Gender Expression
Presentation of one's gender identity through actions and appearance.

Gender Minority
Persons and groups not identifying as cisgender. Gender minorities may identify as nonbinary, transgender, or both. Given that some identify as both, without specific demographic data it is difficult to discuss the healthcare needs of one group without including the other.

Sex
The reproductive phenotype; categorized as male, female, or intersex. Sex is typically assigned at birth on the basis of the appearance of external genitalia and, if necessary, by assessment of chromosomes and the presence of gonads.

Sexual Orientation
One's sexual identity in terms of the gender of people to whom one is attracted, such as heterosexual (straight), homosexual (gay or lesbian), bisexual, and others. Sexual orientation is a separate and distinct concept from gender.

Gender-Affirming Surgery (GAS)
Surgical intervention that gives gender-nonconforming and transgender people the opportunity for agency over their body so that it may align with their gender identity. GAS encompasses facial reconstructive surgery to make features more masculine or feminine; chest, or "top" surgery; and genital, or "bottom" surgery.

Gender Variance
An umbrella term that encompasses gender identity, behavior, and expression that does not conform to majoritarian norms associated with a specific gender.

LGBTQ+
LGBTQ+ is an acronym for lesbian, gay, bisexual, transgender, and queer or questioning. The words included in the acronym are terms are used to describe a person's sexual orientation or gender identity.

Transphobia
TransActual, an advocacy organization working to reduce transphobia and violence toward trans people, defines transphobia as including:

- Attempting to remove trans people's rights
- Misrepresenting trans people
- Abuse
- Systematically including trans people from discussions about issues that directly affect them

3. Case Study: Being Trans in High School

Teacher-Directed Class Discussion
(Quoted and adapted from Ehrensaft)

Daniel was 19 years old and in his first year of college when he announced to each of his parents, who were divorced, that he was transgender. For some years before that, he had been living as a girl, assuming that he was either a "butch dyke" or a masculine-identified bisexual young woman. His father and stepmother's response was, "Yes, of course, it makes perfect sense. We'll support you in whatever you need." His mother's response was quite different: "God gave you a body—why would you want to go against God's will? I am so ashamed. What will I ever tell my family? I've always supported you, but I can't do this."

Daniel reported that by the end of his sophomore year in high school he discovered that he was transgender. Before that, he never had the language for who he was. Up until second grade, when Daniel was "she" with the name Daisy, she truly believed that when she reached puberty,

she would simply switch gears, grow a penis, get a beard, and become a man. From early childhood Daisy dressed like a boy, insisted on wearing her hair short, and was perceived by all as the neighborhood tomboy. When she learned about the physical changes that accompanied being female—menstruating, growing breasts—she responded, by her own report: "Whew, I'm so glad I'll never have to go through that." When an older youth disabused her of her misconception, informing her that she would never grow to be a man because she was born a girl, she was temporarily devastated, coming to the realization that she was now doomed to walk the plank of female development. For her, this was a horrible thought. When she actually got her period in the sixth grade, she feared that her fate had been sealed: "I'm cooked, there's no turning back now."

In middle school, Daisy had her first girlfriend; she confided in her older brother about her new romance, and he promptly issued her a label: "You're a dyke." Except Daisy kept protesting, saying, "I like boys, too." For high school, Daisy chose to go to a boarding school, the prime reason being that she was tired of going back and forth between two houses in her post-divorce family and just wanted one place to settle into. It was a Catholic all-girls school, and she got in trouble for having a romantic relationship with another girl at school. She persisted in dating girls, just not ones from her school, and through her peer connections first learned about the concept of transgender. She surfed the internet, joined chat rooms, and came to discover that "transgender would be me." Her then girlfriend began to recognize who her partner really was and started referring to Daisy as D and using male pronouns for D. D never felt happier. D kept it a secret for two years, waiting for the end of high school and the opportunity to start a new life in college before affirming a male identity publicly. D chose a liberal arts college far away from home and within weeks came out at school as Daniel. By Thanksgiving break, Daniel was ready to disclose to his parents, and that circles back to the beginning of the story.

After disclosing to his parents, Daniel then wanted hormones to align his body with his male identity, envisioning surgeries, including top and bottom (genital) surgery, in his future, but not right then.

Teacher-Directed Class Discussion

Opening Discussion Questions

1. What are the barriers that you saw Daniel running into in this story? With family? Within his social circle? With other authority figures in his life?
2. What might the next steps look like for Daniel?
3. What questions might Daniel have for doctors in seeking gender affirming surgery?

4. The Models

Group Activity into Teacher-Directed Class Discussion

Divide the class into 3 groups; each group will be assigned one model of medical care used to treat gender nonconforming youth. Each group will read their assigned model and paraphrase it in their own words and present back to the group. After presentations, the entire group will answer the questions below, facilitated by the teacher.

1. What are the goals of each model?
2. What could the long-term implications of each model be on the children treated according to them?
3. Do you have any feelings about any of these models you'd like to share that haven't already been discussed?

A. The "live in your own skin" model

Developed by Drs. Ken Zucker and Susan Bradley, the "live in your own skin" model is based on the idea that young children have elastic and malleable gender identities that can be influenced by social

rationale. This model postulates that living life as an "out" transgender person is more difficult on the individual than accepting their gender assigned at birth due to social stigma and the danger associated with medical interventions that some transgender people receive including hormone therapy and gender-affirming surgery. Therefore, the "live in your own skin" model proposes that medical professionals treat the child with interventions including "behavior modification treatments" and "family system restructuring," with the overall goal of the child being comfortable with the gender they were assigned at birth. Treatments that fall under the category of "behavior modification treatments" include choosing playmates so that the child is surrounded by more same-sex contact and enrolling the child in "gender-appropriate" activities. "Family system restructuring" includes offering psychotherapy to the parents and advising the parent who is the same gender as the child to spend more one-on-one time with the child. Once a child reaches adolescence, this model no longer considers their mind as malleable and dictates that if they still identify as transgender, they should be allowed to live as a transgender person as they wish. This model has decreased in popularity among practitioners over the past decade and has been met with much backlash and criticism from transgender and gender-nonconforming advocates. Transgender youth are already at high risk of mental health conditions, with 79% of transgender boys/men and 71% of transgender girls/women experiencing symptoms of anxiety. This model may worsen the mental health of trans youth by not providing them the support they seek with their identity. Ethically, this model denies youth autonomy over their gender identity and expression, bringing up questions about when people should have autonomy over the two.

B. The watchful waiting model

This model encourages the practitioners and families of gender-nonconforming children to observe the children over time. If, after a period of observation by clinicians, the child is still expressing consistent gender-nonconforming behaviors, the child may be administered hormone blockers if they are going through puberty to give

them more time to self-identify without the pressure of continued development. As the child's family and clinicians see fit, the child may undergo social transition from one gender to another, and later in life be treated with further gender affirming hormone therapy and surgery. Creators of this model believe that intervening too early and treating a possibly gender-nonconforming child with affirming treatment may limit their actual gender expression and exploration later in life—an idea called "cognitive constriction."

C. The gender affirmative model

The gender affirmative model is related to the watchful waiting model. This model advocates that children should have agency over their gender expression and identity, and should be allowed by their community, family, and clinicians to evolve into whatever identity they choose. Further, children should be supported if they choose to socially transition from one gender to another, as well as be able to make educated decisions about the use of puberty blockers and later hormone therapy and gender affirming surgeries.

5. Testimonial Studies: Quotes from Patients

Partner Activity into Teacher-Directed Class Discussion

Students should divide into groups of 2. Each partner pair will be assigned one quote from below (assigning multiple pairs to one quote if there are more groups than quotes). Read over the quote that your group is assigned and answer the questions that follow it.

The following are quotes that are from trans and gender-nonconforming adult patients about experiences they've had in clinical settings.

Regarding feelings after doctors find out about their trans identity: "'I fear the perpetual discomfort I will feel after they know, and I hate having to consistently repeat it to every person I see in a hospital due to

things not being properly documented on paperwork. I feel like a sideshow freak."

1. Should professionals at the hospital accommodate the feelings and identities this patient holds?
2. Do medical professionals have an obligation to make this an easier experience for this patient?
3. Is this person's discomfort different from other patients' discomfort in hospital settings?

"I try not to see [my primary care provider] regularly because she referred to my transgender identity as a 'phase,' though she did say she will 'support me through any phase of my life.' Also, she and the rest of her staff do not use my preferred name or proper pronouns, even though they are in my file, and I have requested it verbally twice."

1. What are some of the options this patient has, given the problems they expressed?
2. Where does the responsibility for the patient's care lie: with the doctor to make sure that the patient is comfortable, or with the patient because it's their own health?

"It's the assumption that because I have a vagina that people read me as a person who is female who is getting checked up for feminine things that makes me uncomfortable. Does that make sense? I'm not a woman. I don't identify as female. A trans guy could be getting checked up for the exact same things."

1. What is the situation happening here? What could the doctor have been misunderstanding or misinterpreting about the patient?
2. Whose responsibility is it to identify a patient's potential gender variance? Is it the responsibility of the caregiver to ask their patients, or is it up to the patient to tell them?

"[LGBTQ clinics have] BEEN WAY BETTER. People have still made mistakes, but the simple fact that my chart says "non-binary, they/them/theirs" has drastically increased my trust in my care providers and my comfort seeking healthcare. I feel 'seen' in the LGBTQ clinic, whereas I feel invisible everywhere else. It makes an immense difference."

1. What differences does this patient identify between LGBTQ clinics and non-LGBTQ clinics?
2. Why do you think these differences are so significant?

5. Bioethics Consideration Study: High BMI as a Barrier to Access for Gender Affirming Surgery

Teacher-Directed Class Discussion

Opening Discussion Questions

4. At this point in the module, you have encountered issues in access in medicine. Please define, in your own words, what a *barrier to access* might mean.

Many barriers to access exist for transgender people who want gender-affirming surgery. One of these barriers is becoming increasingly discussed in both medical and social-justice fields. Throughout the US, a high body mass index (BMI) is one of the reasons used by doctors to turn down transgender and non-binary patients for gender affirming surgeries (GAS). The threshold for surgery varies across providers; some will do GAS on patients with BMIs in upper ranges while others won't. Thus, it remains the case that many people who want gender-affirming surgery are not able to receive it due to their BMI scores. Transgender and nonbinary patients are more likely than cisgender patients to have BMI scores in the obese range, making this barrier to access especially relevant.

Despite the expert consensus that GAS is often medically necessary

and is standard of care, and effective in reducing psychological distress in recipients by 42%, many doctors still view it as non-essential to the health of the patient. This view may impact doctors' risk assessment of the surgery, making them less inclined to expose patients with high BMI scores to undue risk by putting their bodies through GAS.

However, many new studies argue that this treatment is fatphobic—discriminating against people because of their weight—by nature, since there is very little evidence to support the stance that patients with higher BMIs have poorer GAS outcomes. Instead, these studies conclude that actual empirical evidence ought to support any reason a person is turned away from GAS.

Discussion Questions (continued)

1. What might a patient seeking GAS feel if turned away for having a high BMI?
2. Given that high BMI hasn't been shown to be associated with poor GAS outcomes, why do you think doctors might feel hesitant to perform GAS with high BMI?
3. Where does your opinion fall?
    a. Should there be further testing on a patient who wants GAS to see if empirical evidence supports them having surgery or not?
    ~~b.~~ All surgeries have inherent risk. Who is in the best position to assess the risks and benefits of GAS? Can you think of possible risks for someone who wants GAS but cannot access it?

6. Concluding Activity

Individual Activity

Write a 5-to-8-sentence reflection about what you've learned today, your takeaways from this module, and how you're feeling about this

material after doing these activities.

7. References and Additional Resources

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7. Acknowledgments

This module was written by Arisa Rei Marshall, during her senior year at the University of Washington, Seattle. She thanks Lisa Kearns and M. Sage Gustafson for their mentorship and work on this module, and Dr. Gwendolyn Quinn for her vital input and helpful instruction. This module was updated by Fatima Islam in 2025, under the supervision of Lisa Kearns.