AN OFFER YOU CAN'T REFUSE: COERCING CONSENT TO SURGERY THROUGH THE MEDICALIZATION OF GENDER IDENTITY

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Abstract

Can consent to medical treatment be voluntary when legal rights, benefits, and protections are conditioned on the completion of surgery? This Note will analyze this question by applying the doctrine of informed consent and basic bioethical principles to the "medical model" that has emerged as the dominant method for determining the legal status of transgender and intersex individuals. Under the medical model, reclassification of legal sex—a process that provides access to legal rights, resources, and benefits—is available to trans persons only after the individual has undergone permanent, body-altering surgery. This Note will argue that conditioning legal status on the completion of surgery coerces or manipulates consent in such a manner as to render consent involuntary under the doctrine of informed consent. This Note will suggest alternatives to the medical model that do not violate the doctrine of informed consent and basic bioethical norms.

INTRODUCTION

The right to bodily integrity is a right deeply ingrained in Western consciousness and culture.[1] A fundamental aspect of this right is the ability to make individual decisions about

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1 *See, e.g.*, Washington v. Glucksberg, 521 U.S. 702, 720 (1997) (holding that due process rights include the right to bodily integrity); Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) (describing "the root premise" of informed consent doctrine as "the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . '") (quoting Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129 (1914)); Olmstead v. United States, 277 U.S. 438 (1928) (describing the "right to be left alone" by the government as a comprehensive right "most valued by civilized men"); X. and Y. v. Netherlands, 91 Eur. Ct. H.R. 1, 11 (1985) (holding that the right

medical care with limited governmental interference. To illustrate the importance of this principle, consider the following hypothetical. Imagine that the federal or state government provided important legal protections, benefits, and access to social programs to minorities only if the person conformed to a predetermined set of physical characteristics that were more typical in non-minorities. Individuals whose traits did not match the stipulated requirements could obtain legal protection and access to public resources only if they underwent invasive reconstructive surgeries to alter their physical traits. The overwhelming majority of people would consider such a policy to be abhorrent and in violation of basic Western norms of individual autonomy and human dignity. It would also raise the question of whether consent to surgery given under such a policy would be voluntary. While the government may regulate healthcare policies and standards, the idea of a government using its regulatory power to induce consent to an unwanted medical treatment is deeply troubling.

Despite the clear violation of fundamental Western principles regarding individual autonomy raised by the hypothetical in the preceding paragraph, intersex and transgender individuals are placed in a comparable position. Such individuals are excluded from numerous legal benefits, protections, and rights because of their gender identity. These benefits may be obtainable after the person has taken the steps required by law to reclassify legal sex. However, reclassification is generally available only to those who have completed specified surgical procedures.[2] Surgical intervention is required for legal reclassification regardless of whether such procedures are wanted or medically advisable. This Note will address this legal system through the lens of medical ethics and will argue that conditioning benefits on surgery renders consent to medical procedures involuntary in clear violation of basic bioethical norms and principles.

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to private life under European Convention Article 8 "covers the physical and moral integrity of the person"); *see also* David Johnston, *A History of Consent in Western Thought*, *in* THE ETHICS OF CONSENT 25, 45 (Franklin G. Miller & Alan Wertheimer eds., 2010) (describing an ideal society as one where virtually all entitlements and obligations arise out of the wills of individuals through agreements to which all had consented freely).

2 *See generally* Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731 (2008) [hereinafter Spade, *Documenting Gender*]; Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265 (1999) [hereinafter Greenberg, *Defining Male and Female*]; Julie A. Greenberg & Marybeth Herald, *You Can't Take it with You: Constitutional Consequences of Interstate Gender-Identity Rulings*, 80 WASH. L. REV. 819, 837 (2005); Franklin H. Romeo, Note, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713, 726–28 (2005); Harper Jean Tobin, Note, *Against the Surgical Requirement for Change of Legal Sex*, 38 CASE W. RES. J. INT'L L. 393, 402–24 (2006–2007).

Part I will explore the contours of this legal structure that bases the provision of rights and benefits on surgical intervention by discussing the need for reclassification, the legal requirements for reclassification, and the benefits derived from reclassification. Part II will analyze this system through the "voluntariness" requirement of informed consent and underlying bioethical principles. Finally, Part III will discuss alternatives to the current medicalized system of gender identity, including adopting a model of self-identification that does not require medical intervention.

I. The Medicalization of Gender Identity

Gender identity is a fundamentally different classification than legal sex. Gender identity reflects a personal conception of oneself as male or female, whereas legal sex is determined at birth by a cursory examination of external genitalia.[3] This system leaves open the possibility that there will be people for whom the legal designation of sex does not conform to gender identity or a more rigorous biological determination of sex. This Part will discuss the effects created by this incongruence, the process for reclassifying legal sex, and the benefits derived from such reclassification.

A. Sex, Gender, and Legal Sex: Three Distinct Inquiries

Sex is generally considered to be a biological determination.[4] Legal sex is designated at birth, typically based on just one factor—external genitalia.[5] By contrast, medical experts determine biological sex in a much more nuanced fashion by looking to a number of biological factors, including genetic or chromosomal sex (XX or XY); gonadal sex (reproductive sex glands); internal morphological sex (prostate, seminal vesicles, vagina, uterus, and fallopian tubes); external morphological sex (genitalia); hormonal sex; and phenotypic sex (secondary sex characteristics).[6] Some experts also include assigned sex

3 Greenberg, *Defining Male and Female*, *supra* note 2, at 271. This examination ignores other biological markers, such as chromosomal sex.

4 *See id.*; *see also* Francisco Valdes, *Queers, Sissies, Dykes, and Tomboys: Deconstructing the Conflation of "Sex," "Gender," and "Sexual Orientation" in Euro-American Law and Society*, 83 CAL. L. REV. 1, 20–21 (1995).

5 *See* Chinyere Ezie, *Deconstructing the Body: Transgender and Intersex Identities and Sex Discrimination—The Need for Strict Scrutiny*, 20 COLUM. J. GENDER & L. 141, 146–147 (2011) (criticizing this process as being based on an arbitrary and crude examination of penis or clitoris size regardless of any other biological indications of sex).

6 *See* Greenberg, *Defining Male and Female*, *supra* note 2, at 278–90. Greenberg notes that while females are usually born with the XX chromosome combination, and males with the XY chromosome combination, some

or gender of rearing and gender identity as part of the inquiry into biological sex.[7] For the purposes of this Note, it is sufficient to observe that there is no simple or singular test for biological sex.[8] Medical professionals often urge parents to surgically "correct" ambiguities in external genitalia at birth, often basing sex determination on whether the genitals are capable of penetrative sex.[9] Implicit in this process is the assumption that sex will always conform neatly to "male" or "female."[10] The determination of sex in the context thus ignores the possibility that sex markers may not be congruent.[11]

The process of assigning legal sex also disregards the possibility that gender identity may not conform to legal sex as determined by external genitalia. Gender refers to the "cultural or attitudinal characteristics (as opposed to physical characteristics) distinctive to the sexes,"[12] and reflects the "social dimensions of personhood."[13] Gender identity refers to a person's own conception of how one fits into the social construct. As gender identity is an individual identification based on social characteristics, it is not inevitably linked to biological markers of sex. "Transgender" and other similar terms have emerged to describe people whose gender identity does not conform to biological sex markers.[14] For the purposes

people are born with other combinations, such as XXX or XXY. The combination of chromosomes will alter physical development. For instance, a person with XXY chromosomes may have primary sex characteristics of one sex and secondary sex characteristics of another. *Id:* There is no singular factor that is determinative of biological sex.

7 *See* JULIE A. GREENBERG, INTERSEXUALITY AND THE LAW: WHY SEX MATTERS 11–13, 139 n.2 (2012); JOHN MONEY, SEX ERRORS OF THE BODY AND RELATED SYNDROMES: A GUIDE TO COUNSELING CHILDREN, ADOLESCENTS AND THEIR FAMILIES 4–5 (1994). While this is a controversial position, it serves to illustrate the lack of consensus among experts as to how biological sex should be determined.

8 *See* Greenberg, *Defining Male and Female*, *supra* note 2, at 271. Similarly, there is no consensus among the states and federal government regarding the standards for determining legal sex, even when purporting to apply a "biological" test. *See infra* Part I.C.

9 *See* Ezie, *supra* note 5, at 147–50; Greenberg, *Defining Male and Female*, *supra* note 2, at 272.

10 *Id.*

11 Greenberg, *Defining Male and Female*, *supra* note 2, at 275. Individuals whose sex markers are ambiguous may be defined as "intersex." Julie A. Greenberg, *When is a Same-Sex Marriage Legal? Full Faith and Credit and Sex Determination*, 38 CREIGHTON L. REV. 289, 291 (2005).

12 J.E.B. v. Alabama ex rel. T.B., 511 U.S. 127, 157 n.1 (1994) (Scalia, J., dissenting).

13 Valdes, *supra* note 4, at 21.

14 The word "transgender" has emerged as an umbrella term to describe people who "transgress the gender binary in some way." *See* Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 15 n.2 (2003) [hereinafter Spade, *Resisting Medicine*].

of analysis to follow in this Note, the word "transgender"[15] will be used to describe all individuals who fall outside the standard sex binary in some way, including both those whose gender identity is inconsistent with biological sex and those whose biological sex is ambiguous, as the processes for altering legal sex designations are identical for both groups.[16]

B. The Need for Reclassification: Benefits, Rights, and Protections Linked to Legal Sex

There is much at stake in the legal classification of sex. Numerous legal protections, benefits, and rights are linked to sex,[17] and congruency between gender expression and legal sex reduces the likelihood that a trans person will be subjected to harassment and discrimination because of gender identity.[18] In states that do not permit same-sex marriage, legal sex is a crucial component in determining whom a person may marry.[19] Legal sex

15 Variations like "trans," "gender nonconforming," and "gender transgressive" may be used synonymously with "transgender" for the purposes of this Note.

16 Informed Consent for Access to Trans Health (ICATH) is a recognized medical standard of care for gender-confirming healthcare. ICATH specifically defines "trans" to include "multiple transgender, transsexual, intersex, and other gender non-conforming identities." ICATH, www.icath.org (last visited Apr. 16, 2014). While it is not certain how many people in the United States are transgender, estimates have ranged from .1% to 4% of the population. *See* Greenberg, *Defining Male and Female*, *supra* note 2, at 267 n.7. Even at its lowest estimate of .1%, intersexuality or gender nonconformity is as common as conditions like Down's Syndrome and cystic fibrosis. *See* ALICE D. DREGER, HERMAPHRODITES AND THE MEDICAL INVENTION OF SEX 42–43 (1998).

17 *See, e.g.*, Spade, *Documenting Gender*, *supra* note 2; Saru Matambanadzo, *Engendering Sex: Birth Certificates, Biology and the Body in Anglo American Law*, 12 CARDOZO J.L. & GENDER 213 (2005); Alice Newlin, *Should a Trip from Illinois to Tennessee Change a Woman into a Man?: Proposal for a Uniform Interstate Sex Reassignment Recognition Act*, 17 COLUM. J. GENDER & L. 461 (2008).

18 *See* JAIME M. GRANT ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL. & THE NAT'L GAY & LESBIAN TASK FORCE, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 116 (2011), *available at* http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf. Discrimination against trans people is pervasive. *See also Systems of Inequality: Poverty and Homelessness (Flowchart)*, SYLVIA RIVERA LAW PROJECT, http://srlp.org/wp-content/uploads/2012/08/disprop-poverty.pdf (last visited Apr. 16, 2014) [hereinafter *Systems of Inequality Flowchart*] (depicting the relationship between barriers to education, poverty, inadequate health care, and homelessness that result in an interlocking system that keeps many trans and gender non-conforming people in situations that are vulnerable and unequal).

19 This inquiry is particularly complicated with a trans partner. In states that do not allow same-sex marriage, it is not immediately apparent whom a trans person would be legally allowed to marry. *See In re* Ladrach, 513 N.E.2d 828 (Ohio Prob. Ct. 1987) (holding that legal sex could not be changed for the purpose of marriage); M.T. v. J.T., 355 A.2d 204 (N.J. App. Div. 1976) (finding that a post-operative transwoman had legally changed her sex for the purposes of marriage); Anonymous v. Anonymous, 325 N.Y.S.2d 499 (Sup. Ct. 1971) (holding

designations also impact the determination of parental rights.[20] Placement in sex-segregated facilities, including prisons, shelters, and social programs, is typically based on legal sex, which may put trans people in danger.[21] Some social services facilities, including homeless shelters, may deny access entirely to trans people.[22] Transgender individuals also report being denied housing, employment, healthcare, and public accommodations as a result of their gender identity.[23] Except in the handful of states that list gender identity as a protected category, trans people can be fired for their gender identity.[24] Transgender students may be expelled from schools, and others fear applying for higher education will reveal old names and sex assigned at birth.[25]

Reclassifying legal sex allows trans people to obtain identification congruent with expressed gender, thereby decreasing the likelihood of being denied access to services, resources, and facilities.[26] Gender-confirming identification[27] allows trans people to

a marriage between a pre-operative transwoman and a man invalid as the woman was legally a man at the time of the marriage).

20 *See In re* Marriage of Simmons, 825 N.E.2d 303 (Ill. App. Ct. 2005) (finding that a transman married to a woman was not entitled to a presumption of paternity); Daly v. Daly 715 P.2d 56 (Nev. Sup. Ct. 1986) (terminating the parental rights as a trans parent and characterizing the decision to transition as "selfish").

21 *See* Spade, *Documenting Gender*, *supra* note 2, at 752–53; *see also* SYLVIA RIVERA LAW PROJECT, IT'S WAR IN HERE: A REPORT ON THE EXPERIENCES OF TRANSGENDER AND INTERSEX PEOPLE IN NYS MEN'S PRISONS (2007), http://www.srlp.org/files/warinhere.pdf; Gabriel Arkles, *Safety and Solidarity Across Gender Lines: Rethinking Segregation of Transgender People in Detention*, 18 TEMP. POL. & CIV. RTS. L. REV. 515 (2009); Dean Spade, *Compliance Is Gendered: Struggling for Gender Self-Determination in a Hostile Economy*, *in* TRANSGENDER RIGHTS 217, 227–28 (Paisley Currah et al. eds., 2006) [hereinafter Spade, *Compliance Is Gendered*]; Sydney Tarzwell, Note, *The Gender Lines Are Marked with Razor Wire: Addressing State Prison Policies and Practices for the Management of Transgender Prisoners*, 38 COLUM. HUM. RTS. L. REV. 167 (2006).

22 Spade, *Compliance Is Gendered*, *supra* note 21, at 219. In a survey of transgender individuals, 29% of respondents reported being denied access to homeless shelters because of gender identity. GRANT ET AL., *supra* note 18, at 116.

23 *See* GRANT ET AL., *supra* note 18; Spade, *Compliance Is Gendered*, *supra* note 21; *Systems of Inequality Flowchart*, *supra* note 18.

24 *See* Oiler v. Winn-Dixie Louisiana, Inc., 2002 WL Civ.A. 00-314, 321098541 (E.D. La. Sept. 16, 2002) (holding that a truck driver may be fired for cross dressing off the job).

25 Spade, *Compliance Is Gendered*, *supra* note 21, at 219; *see generally* GRANT ET AL., *supra* note 18 (discussing harassment, discrimination, and dropout and expulsion rates of trans students).

26 GRANT ET AL., *supra* note 18, at 138.

27 "Gender-confirming identification" refers to identification where the sex designation matches expressed gender.

navigate the world without being "outed."[28] This is particularly true in the employment context where:

> [a]ccess to participation in the US economy has always been conditioned on the ability of each individual to comply with norms of gendered behavior and expression, and the US economy has always been shaped by explicit incentives that coerce people into normative gender and sexual structures, identities, and behaviors.[29]

In a survey conducted by the National Center for Transgender Equality, 47% of respondents reported experiencing an adverse job outcome, such as being fired, not being hired, or being denied a promotion due to gender identity.[30] An overwhelming 90% of respondents reported being harassed or discriminated against in the workplace.[31] Legal reclassification serves to mitigate economic and social marginalization, and permits trans people to participate more fully in society.

C. Legal Requirements for Sex Reclassification

Reclassifying legal sex provides trans people with greater access to resources, protection, and privileges, and represents legal recognition of a fundamental aspect of identity. Unsurprisingly, many trans people seek to alter assigned legal sex to obtain these benefits. Through statutory and judicial intervention, states have devised criteria for determining when legal sex can be amended.[32] Jurisdictions that do not permit amendments are said to follow a "biological model" where legal sex is fixed at birth and cannot be changed.[33] Early cases applying the biological model emerged in the context of Title VII

28 *See* Spade, *Documenting Gender*, *supra* note 2, at 799.

29 Spade, *Compliance Is Gendered*, *supra* note 21, at 221.

30 GRANT ET AL., *supra* note 18, at 51.

31 *Id.* at 3, 51.

32 *See* Spade, *Documenting Gender*, *supra* note 2, at 735 (depicting the spectrum of state requirements for reclassification); Greenberg & Herald, *supra* note 2, at 836–43 (discussing various state requirements for amending birth certificates).

33 *See* Greenberg, *Defining Male and Female*, *supra* note 2, at 294 ("The vast majority of reported cases involving sex classification have rejected self-identification as the critical sex determinant. Instead, the judicial system has relied on biological factors like chromosomes, gonads, and genitalia that it believes are objective and fixed."); *see also* Corbett v. Corbett, (1970) 2 All E.R. 33 (Eng.) (establishing the rule that unless there was an error in initial determination of sex, legal sex may not later be changed).

as federal courts interpreted Title VII to apply only to "immutable" characteristics, like biological sex; adverse consequences resulting from nonconformity with "biological" sex fell out of Title VII's purview.[34] Only three states follow the biological model for the purposes of amending birth certificates.[35] Other states have applied the biological model when called upon to determine the validity of a marriage involving a trans partner.[36] While the biological model is problematic in a number of ways, this Note focuses instead on the jurisdictions that follow the medical model, meaning that legal sex may be amended based on the completion of specified medical procedures.

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34 *See, e.g.*, Ulane v. Eastern Airlines, 742 F.2d 1081, 1087 (7th Cir. 1984) ("... Title VII is not so expansive in scope as to prohibit discrimination against transsexuals."); Holloway v. Arthur Andersen & Co., 566 F.2d 659, 664 (9th Cir. 1977) ("A transsexual individual's decision to undergo sex change surgery does not bring that individual, nor transsexuals as a class, within the scope of Title VII."); Grossman v. Bernards Twp. Bd. of Educ., No. 74-1904, 1975 WL 302, at *4 (D.N.J. Sept. 10, 1975) *aff'd* 538 F.2d 319 (3d Cir. 1976) ("In the absence of any legislative history indicating a congressional intent to include transsexuals within the language of Title VII, the Court is reluctant to ascribe any import to the term 'sex' other than its plain meaning."); Voyles v. Ralph K. Davies Med. Ctr., 403 F. Supp. 456, 457 (N.D. Calif. 1975) ("The legislative history of as well as the case law interpreting Title VII nowhere indicate that 'sex' discrimination was meant to embrace 'transsexual' discrimination, or any permutation or combination thereof.").

35 Tennessee is the only state to statutorily deny people the ability to amend legal sex on birth certificates. TENN. CODE ANN. §68-3-203(d) (2001). Idaho and Ohio have arrived at the same conclusion through judicial interpretation. *See* Spade, *Documenting Gender*, *supra* note 2, at 768.

36 *See* Kantaras v. Kantaras, 884 So. 2d 155 (Fla. Dist. Ct. App. 2004) (overruling the application by the trial court of a multifactorial test for determining legal sex); *In re* Estate of Gardiner, 42 P.3d 120, 135 (Kan. 2002) ("The plain, ordinary meaning of 'persons of the opposite sex' contemplates a biological man and a biological woman and not persons who are experiencing gender dysphoria."); *In re* Nash, Nos. 2002-T-0149, 2002-T-0179, 2003 WL 23097095 (Ohio Ct. App. Dec. 21, 2003) (holding that the policy against same-sex marriage justified the denial of a marriage license to a transman and a woman); Littleton v. Prange, 9 S.W.3d 223 (Tex. App. 1999) (holding that legal sex cannot be changed as chromosomal sex is not altered by surgical or hormonal intervention). The *Gardiner* decision raises particular constitutional concerns as it suggests that trans people are excluded entirely from the institution of marriage in Kansas.

In theory, adherence to the biological model should permit a trans person to marry someone of the opposite assigned sex, but same expressed gender even though such a union would outwardly present as a same-sex relationship. Much as trans people are sometimes able to obtain a marriage license because of the appearance of heterosexuality, such a couple could be denied a marriage license due to the appearance of homosexuality. While there are publicized reports of a pre-operative transsexual marrying a partner of the opposite birth sex, American courts have yet to confront this possibility in the context of litigation. There is the possibility that the logic of *M v. M.*, a Canadian case, would prevail. 42 R.F.L. (2d) 55 (1984). The Canadian court held as void a marriage between a male and non-operative transman despite the fact that he retained female genitalia. *Id.* at 59. The court found this relationship to be incompatible with the inherent heterosexual nature of the institution of marriage. *Id.* Thus, under such reasoning, adherence to the biological model could exclude trans people from the institution of marriage entirely, a possibility that raises significant constitutional concerns.

The medical model is premised on the recognition of "gender identity disorder" (GID) in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) as a psychiatric condition that can be treated medically.[37] Much of the medical model was built around this diagnosis. The Diagnostic and Statistical Manual of Mental Disorders V (DSM-V), published in May 2013, replaced this term with the less stigmatizing "gender dysphoria," but retained the same diagnostic criteria.[38] Gender dysphoria and GID require a strong identification with the opposite gender.[39] Persistent gender dysphoria and GID require this identification to be sustained over some period of time.[40] The medical model, like the biological model, recognizes only two possibilities for gender identity.

The medical model thus places legal significance on the treatments and surgery that a person has completed.[41] Legal rights are inextricably bound up with medical treatment:

> In almost every trans-related case, whether it be about the legitimacy of a trans person's marriage, the custody of hir children, hir right not to be discriminated against in employment, hir right to wear gender appropriate clothing in school or foster care, hir rights in prison, or whatever other context brings hir to court, medical evidence will be the cornerstone of the determination of hir rights.[42]

Early examples of the medical model emerged in the context of marriage. In *Anonymous v. Anonymous*, the trans partner underwent sex reassignment surgery after the marriage. The

37 THE AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 532–38 (4th ed. 1994) [hereinafter DSM-IV].

38 *Gender Dysphoria*, AM. PSYCHIATRIC ASS'N (2013), *available at* http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf [hereinafter *Gender Dysphoria Fact Sheet*]. The American Psychiatric Association made it clear that reducing stigma was a driving factor behind this change in terminology. *Id.* The cultural effect of this change has yet to be realized. However, as the general definition and description of gender dysphoria is virtually identical to the definition and description of GID, it appears that the conception of transgenderism will remain framed in medical terms. For the purposes of this Note, the term "gender dysphoria" will be used, though sources predating the DSM-V will refer to GID. However, it is essential to note that these terms may be regarded, for the purposes of this Note, as identical in the role they play in forming and sustaining the medical model.

39 *Gender Dysphoria Fact Sheet*, *supra* note 38; DSM-IV, *supra* note 37, at 532–33.

40 *Gender Dysphoria Fact Sheet*, *supra* note 38; DSM-IV, *supra* note 37, at 532–33.

41 Spade, *Resisting Medicine*, *supra* note 14, at 15–16 ("Everywhere that trans people appear in the law, a heavy reliance on medical evidence to establish gender identity is noticeable.")

42 *Id.* at 17–18. "Hir" is a gender-neutral pronoun used in place of "his" and "her."

court reasoned that because she was incapable of vaginal sex at the time of the marriage, she had been legally male at that time, rendering the marriage invalid.[43] In *M.T. v. J.T.*,[44] the court upheld a marriage involving a post-operative transsexual because she was capable of fulfilling the sexual role of "wife" at the time of marriage.

Most states have followed a similar course in determining whether a birth certificate may be amended. Amending a birth certificate is often considered the functional equivalent of amending legal sex.[45] Nearly all jurisdictions issuing birth certificates[46] permit amendments to sex-designation on birth certificates.[47] Though requirements vary, all states that permit amendment require some form of medical intervention, typically genital surgery.[48] Thus, amending legal sex on a birth certificate requires highly invasive surgery. Many trans people also seek to amend sex designation on driver's licenses as the most commonly used form of identification on a day-to-day basis.[49] While no state entirely bars sex reclassification

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43 325 N.Y.S.2d 499, 500 (Sup. Ct. 1971).

44 355 A.2d 204 (N.J. Sup. Ct. App. Div. 1976).

45 However, cases such as *In re Heilig*, 816 A.2d 68 (Md. 2003) (holding that legal sex could be amended even though the birth certificate could not), and *In re Marriage of Simmons* 825 N.E.2d 303 (Ill. App. Ct. 2005) (holding that an amended birth certificate did not change legal sex) caution against overreliance on this presumption.

46 This includes the District of Columbia and New York City in addition to the fifty states. Spade, *Documenting Gender*, *supra* note 2, at 767.

47 The three exceptions are Tennessee, Ohio, and Idaho. *See supra* note 35 and accompanying text. The remaining forty-nine jurisdictions, forty-seven states plus New York City and Washington DC, permit reclassification by statute, administrative ruling, or in practice. Spade, *Documenting Gender*, *supra* note 2, at 767–78.

48 *Id.* at 768. A number of states require a court order for amendment, though some permit amendment with a doctor's letter stating that the individual has undergone the required procedure. *Id.* at App. Three. Some statutes lack specificity as to what treatment is required. *See, e.g.*, COLO. REV. STAT. §25-2-115(4) (2001) (requiring sex to be changed by "surgical procedure"); GA. CODE ANN. §31-10-23(e) (2005) (requiring sex to be "changed by surgical procedure"); VA. CODE ANN. §32.1-269(E) (2004) (requiring that the sex be "changed by medical procedure"). Some courts have interpreted this to permit reclassification based on non-genital surgeries, such as mastectomies, while others have interpreted this to require genital surgery. Spade, *Documenting Gender*, *supra* note 2, at 768. Illustrating the lack of uniformity in this area of law, New York City and New York State apply different standards for birth certificate amendment. New York City requires either vaginoplasty or phalloplasty, while New York State permits reclassification when the person has undergone penectomy or hysterectomy and mastectomy. *Id.* at 769. Jurisdictions also vary in how amendment is accomplished; some issue a new birth certificate, while others provide an amended certificate with the original sex designation crossed out. *Id.* at 770.

49 Spade, *Documenting Gender*, *supra* note 2, at 771.

on driver's licenses, reclassification typically requires some type of surgery.[50] Thus, for the vast majority of trans people, obtaining gender-confirming identification in the form of a birth certificate or driver's license is impossible without undergoing major surgery. This creates a potentially coercive environment which could implicate the voluntariness of a decision to undergo medical treatment.

D. Problems with the Medical Model: Access and the Need for Individualized Choice

The medical model thus establishes a system where legal benefits and recognition are available to trans persons only after the individual undergoes major, body-altering surgery. There are two overarching problems with such a system: not all trans people will have access to the required procedures and not all trans people will want the required procedures. The majority of this Note focuses on the second concern—whether the medical model, by conditioning legal rights on the completion of surgery, coerces or manipulates individuals into undergoing the procedures required for legal reclassification. However, it is worthwhile to highlight briefly the challenges many trans people face in obtaining access to the required surgical procedures.

Sex reassignment surgery—and consequently the reclassification of legal sex—is not available to all trans people. The cost of surgery is often prohibitive, particularly as many procedures are not covered by insurance.[51] Legal rights are thus only available for

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50 *Id.* at 771–72, App. Two. License reclassification requirements vary state to state, but fall into four main categories: amended birth certificate, court order, doctor's letter and surgery, and doctor's letter without surgery. *Id.* at App. Two. Some trans people have had success in obtaining an amended driver's license by presenting the original designation as a clerical mistake, and asking the DMV employee to correct it. However, such "corrections" are issued inconsistently and may become more difficult as more records become digitized. *Id.* at 772–73.

51 Male-to-female surgical transition is estimated to cost between $18,000 and $35,000. Newlin, *supra* note 17, at 489. One surgeon estimates the cost of vaginoplasty (the surgical creation of a vagina) alone to be $19,150. *Male to Female Price List*, THE PHILADELPHIA CENTER FOR TRANSGENDER SURGERY, http://www.thetransgendercenter.com/index.php/maletofemale1/mtf-price-list.html (last visited Apr. 16, 2014). Estimates of the cost of female-to-male surgical transition are significantly higher. Phalloplasty (the surgical creation of a penis) alone costs $50,000. Other procedures, including mastectomy (removal of the breasts), oophorectomy (removal of the ovaries), and hysterectomy (removal of the uterus) increase the costs of female-to-male surgical transition. Newlin, *supra* note 17, at 489–90; *Hudson's FTM [Female-to-Male] Resource Guide*, FTM GENITAL RECONSTRUCTION SURGERY (GRS), http://www.ftmguide.org/grs.html (last visited Apr. 16, 2014) (listing the cost of phalloplasty as being between $50,000 and $150,000).

These procedures are typically not covered by insurance. *See* Jerry L. Dasti, Note, *Advocating A Broader Understanding of the Necessity of Sex-Reassignment Surgery Under Medicaid*, 77 N.Y.U. L. REV. 1738 (2002)

those wealthy enough to pay for medical care.[52] Furthermore, the medical model forces individuals to fit their gender identities into a pathological framework, and conform to a set definition of gender dysphoria irrespective of actual experience or desires.[53] Many trans people do not view gender identity as a psychiatric disorder to be treated.[54] Those who fall outside the narrow gender dysphoria narrative are unable to take advantage of any of the protections offered by the medical model.[55] This perpetuates the myth that trans people are defined by medical treatments and cannot be considered to have transitioned to the "new" gender until treatments are completed.[56] It also establishes medical authorities as gatekeepers with the power to regulate gender identity, as sex reassignment is a rigidly controlled process that not every trans person will be allowed to access.[57] While non-trans

(discussing the exclusion of gender-confirming healthcare, such as surgical intervention and hormone therapy, from Medicaid coverage); Liza Khan, Note, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL'Y L. & ETHICS 375 (2011) (discussing the ways that insurance providers have been able to exclude transgender patients from coverage). While the Affordable Care Act will prevent insurers from excluding trans patients from coverage on the grounds that transgender identity is a preexisting condition, the Department of Health and Human Services has explicitly stated that the Act does not require insurers to cover transition-related surgery. *U.S. Department of Health and Human Services (USA), Questions and Answers on Section 1557 of the Affordable Care Act*, GEND. IDENTITY WATCH (Sept. 12, 2012), http://genderidentitywatch.com/2012/09/12/u-s-department-of-health-and-human-services-usa/.

The cost of gender-confirming health care also presents an argument in favor of the continued medicalization of gender identity. If gender identity is not defined in medical terms, it will not be "medically necessary" for insurance purposes and thus would not be covered. For a discussion of this debate, see Judith Butler, *Undiagnosing Gender*, *in* TRANSGENDER RIGHTS, *supra* note 21, at 274, 274–298.

52 Romeo, *supra* note 2, at 736 ("[I]f the rights of transgender people are contingent upon their ability to access medical care, health care becomes a threshold issue to a wide spectrum of other rights.").

53 *See* Spade, *Resisting Medicine*, *supra* note 14, at 23–24:

> The medical model, ultimately, was what I had to contend with in order to achieve the embodiment I was seeking. I learned quickly that to achieve that embodiment, I needed to perform a desire for gender normativity, to convince the doctors that I suffered from GID and wanted to "be" a "man" in a narrow sense of both words. My quest for body alteration had to be legitimized by a medical reference to, and pretended belief in, a binary gender system that I had been working to dismantle since adolescence.

54 *See* Newlin, *supra* note 17, at 491.

55 *Id.*

56 Dean Spade, *Trans Formation: Three Myths Regarding Transgender Identity Have Led to Conflicting Laws and Policies That Adversely Affect Transgender People*, L.A. LAW., Oct. 2008, at 34, 37 [hereinafter Spade, *Three Myths*].

57 *See* Dean Spade, *Mutilating Gender*, *in* THE TRANSGENDER STUDIES READER 315, 321 (Susan Stryker &

people are free to modify their bodies at will through cosmetic surgery, trans people must first demonstrate that they fulfill a fixed set of criteria.[58] Unlike other procedures, access to gender-confirming healthcare[59] typically requires trans people to attend therapy and live as the "opposite" sex for as long as two years.[60]

Lack of access to the required procedures is only one way in which the medical model fails to serve the needs of trans people. The medical model also fails to recognize the need for individual choice in deciding what procedures are necessary to express gender. Gender-confirming healthcare is a personalized process that must be tailored to meet individual needs and desires. As Dean Spade explains:

> There are several reasons that the majority of transgender people do not undergo surgeries. Most obviously, people have different aims and desires for their bodies and express gendered characteristics in the ways that make the most sense to those needs and desires. For those who wish to enhance the masculinization or feminization of their appearance, changing external gender expressions such as hairstyle, clothing, and accessories is often an

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Stephen Whittle eds., 2006).

> What sense does it make to label some people as true transsexuals, and others as secondary, or confused, or imitation? Whom does such an attitude serve? I can think of no one but the gatekeepers, those who would seize the power of life and death by demanding that transsexuals satisfy an arbitrary standard. To accept such standards, to rank ourselves and others according to a hierarchy of true transsexuality, to try to recast our own histories to make sure they fit the approved model, can only tear us down, all of us, even the ones lucky enough to match that model.

Id. (quoting Rachel Pollack, *The Varieties of Transsexual Experience*, 7 TRANSSEXUAL NEWS TELEGRAPH 18, 20 (1997)).

58 Newlin, *supra* note 17, at 492.

59 Gender-confirming healthcare refers to any medical treatment used to express gender identity. Gender-confirming healthcare may include, but is not limited to: bilateral mastectomy, orchiectomy, phalloplasty, hysterectomy, vaginoplasty, hormone therapy treatment, brow reduction, facial implants, vaginal closure, voice surgery, metaodioplasty, augmentation mamaplasty, tracheal shave, liposuction, hormone therapy, group or individual counseling, and/or psychotherapy. *Birth Certificate Sex Designation: An Overview of the Issues*, SYLVIA RIVERA LAW PROJECT, http://archive.srlp.org/birth-certificate-sex-designation-overview-issues (last visited Apr. 16, 2014).

60 ICATH, http://www.icath.org (last visited Apr. 16, 2014). ICATH is a collaboration of gender-confirming providers, including therapists and medical doctors, who reject the diagnosis of GID and gender dysphoria as a means for accessing gender-confirming health care.

> effective, affordable, non-invasive way to alter how they are perceived in day-to-day life. For those who seek medical treatment, the most common medical treatment is not surgery but masculinizing or feminizing hormone therapy, which is an effective step for enhancing feminine or masculine secondary sex characteristics (e.g., voice, facial hair, breast tissue, muscle mass). For surviving daily life—work, school, street interactions—these external markers of gender are far more important than genital status, which is usually only known to one's closest intimates. Additionally, genital surgeries are not recommended medical treatment for all transgender people. Many do not want to undergo such procedures, or because of other medical issues, are not eligible.[61]

The need for individual choice is obvious: surgical intervention is highly invasive and can have serious side effects.[62] For a number of individuals, the benefits of surgery will normally not outweigh the risks. The medical model changes this balance by increasing the benefits obtained through surgery. Under such a legal structure, it is possible that a decision to undergo medical treatment in order to access benefits may not be voluntary.

II. The Application of the Doctrine of Informed Consent to the Medical Model

If legal rights, benefits, and privileges are based on the completion of medical treatment, can consent to that treatment truly be voluntary? This Part will discuss this question through the doctrine of informed consent, which requires voluntary consent prior to every medical intervention.[63] This Part will first analyze this question by discussing the degree to which the medical model serves the basic principles of bioethics underpinning the doctrine of informed consent before discussing whether consent given under the medical model can be voluntary.[64] This Part will also discuss the constitutionality of the medical model through the parallel application of the unconstitutional conditions doctrine.

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61 Spade, *Documenting Gender*, *supra* note 2, at 754–55 (citations omitted).

62 For example, risks of phalloplasty include scarring, death of the transplanted tissue, difficulty urinating, loss of sexual sensation, and other problems. *Hudson's FTM [Female-to-Male] Resource Guide*, FTM GENITAL RECONSTRUCTION SURGERY (GRS), http://www.ftmguide.org/grs.html (last visited Apr. 16, 2014).

63 Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, WIS. L. REV. 413, 433 (1979). There are rare exceptions to this general rule, such as when the patient is unconscious.

64 TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 12 (5th ed. 2001); RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 7 (1986).

A. An Overview of the Doctrine of Informed Consent and Underlying Bioethical Principles

In a number of circumstances, consent serves a morally transformative function, allowing one party to act in a manner that would otherwise be illegal or forbidden.[65] Informed consent changes what would otherwise be a tort and violation of constitutional rights into a legitimate medical intervention.[66] Informed consent is required prior to every medical intervention where the patient is capable of giving consent.[67] This requirement allows patients—rather than physicians—to make decisions about their own medical treatment, serving one of the basic principles of medical ethics: respect for autonomy.[68] To be effective, consent to a medical procedure requires competency, knowledge, and voluntariness.[69] For the purposes of analysis to follow in this Note, it is presumed that trans people undergoing surgery are both informed and competent.[70] The primary inquiry is into the voluntariness of consent.

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65 Franklin G. Miller and Alan Wertheimer, *Preface to a Theory of Consent Transactions: Beyond Valid Consent*, *in* THE ETHICS OF CONSENT, *supra* note 1, at 79. The right to *refuse* medical treatment is a necessary corollary to the right to consent to treatment. Maya Manian, *The Irrational Woman; Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223, 239 (2009) ("[T]he term informed 'consent' is a bit misleading, because patients have the right not only to make the ultimate decision whether to accept treatment (consent), but also to refuse treatment entirely.").

66 *See* FADEN & BEAUCHAMP, *supra* note 64, at 23–39 (discussing the legal recognition of the right to consent to treatment as a tort claim in state law and as the right to liberty and privacy constitutionally).

67 *See* Meisel, *supra* note 63, at 433.

68 *See* Erin Talati, *When A Spoonful of Sugar Doesn't Help the Medicine Go Down: Informed Consent, Mental Illness, and Moral Agency*, 6 IND. HEALTH L. REV. 171, 174–76 (2009); *see also* BEAUCHAMP & CHILDRESS, *supra* note 64, at 77.

69 *See* Talati, *supra* note 68, at 176–82. It should be noted that some scholars define the elements of informed consent differently. For example, Beauchamp and Childress list the elements of informed consent as: (1) competence; (2) disclosure; (3) understanding; (4) voluntariness; and (5) consent. BEAUCHAMP & CHILDRESS, *supra* note 64, at 79. However, it is more common to see these element condensed into the three core requirements of competence, understanding, and voluntariness.

70 It is possible that doctors are not effectively informing patients about risks and benefits of sex reassignment surgery under the mistaken assumption that sex reassignment surgery is the best possible treatment for gender dysphoria or GID. *See* Spade, *Three Myths*, *supra* note 56, at 37–38. However, for the purposes of this Note, it is presumed that trans patients are competent and knowledgeable about the procedure, and doctors are providing adequate information about the benefits and risks of surgery.

The modern doctrine of informed consent emphasizes patient autonomy to a greater extent than its previous incarnations.[71] Prior models of consent permitted courts and medical associations to defer to the professional judgment of physicians rather than require physicians to solicit and follow patient preferences.[72] The idea that the patient, rather than the physician, should be the ultimate decision maker began to take hold in the 1900s, expressed as the idea that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[73] In the 1950s, the concept of "informed" consent emerged as courts began to require physician disclosure, enabling consent to be given by a layperson with knowledge of the procedure, its benefits, and its risks.[74] The justification for the doctrine of informed consent shifted from a desire to minimize harm to patients to a desire to protect autonomous choice.[75]

In its modern version, the doctrine of informed consent serves four fundamental bioethical norms: respect for autonomy, nonmaleficence, benefice, and justice.[76] These

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71 *See* Talati, *supra* note 68, at 174–76 (discussing the emergence of the requiremenet of informed consent following a period of deference to physician judgment); *see also* BEAUCHAMP & CHILDRESS, *supra* note 64, at 77 (desribing an emphasis in modern informed consent doctrine on autonomous choice rather than the minimization of harm).

72 *See* Talati, *supra* note 68, at 174–76. For an illustration of a model of deference to professional judgment, see THOMAS PERCIVAL, MEDICAL ETHICS (1803), which privileged the principles of nonmaleficence (physician avoidance of harm) and benefice (physician prevention of harm or promotion of good) over principles of respect for autonomy and justice. *Medical Ethics* formed the basis of the American Medical Associations first code of ethics in 1847. BEAUCHAMP & CHILDRESS, *supra* note 64, at 12. Thus, a physician's primary obligations were to avoid harm and promote patient welfare rather than to defer to patients' preferences. *Id.*

73 Schloendorff v. Soc'y of N.Y. Hosp., 211 N.Y. 125, 129 (1914).

74 *See* Canterbury v. Spence, 464 F.2d 772, 781–82 (D.C. Cir. 1972) (requiring all reasonable disclosure rather than deferring to professional expertise); Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 578 (Ct. App. 1957) (requiring disclosure of "any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment").

75 BEAUCHAMP & CHILDRESS, *supra* note 64, at 77; *see also* Roger B. Dworkin, *Getting What We Should From Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship*, 13 HEALTH MATRIX 235, 239–42 (2003).

76 BEAUCHAMP & CHILDRESS, *supra* note 64, at 12; FADEN & BEAUCHAMP, *supra* note 64, at 7. Nonmaleficence (the obligation to avoid inflicting harm) and benefice (the obligation to promote the patient's welfare) are sometime presented as a single guiding principle. However, the model of four prima facie principles has been widely and enthusiastically adopted by medical professionals, and is widely taught in clinics. *See* Gregg Bloche, *Beyond Autonomy: Coercion and Morality in Clinical Relationships*, 6 HEALTH MATRIX 229, 244 n.53 (1996). Consequently, this Note will frame its analysis in terms of the four bioethical principles.

norms derive from both medical tradition and common morality.[77] In privileging certain treatment options, the medical model violates these fundamental bioethical principles.

1. Respect for Autonomy

Respect for autonomy may be construed as the most important bioethical principle in the modern version of the doctrine.[78] This principle is deeply rooted in a Western tradition that celebrates individual choice and freedom.[79] It is also a constitutional value, implicit in the protected right to make medical decisions and refuse medical treatment.[80] At a minimum, respect for autonomy requires acknowledgement of an autonomous agent's right to hold views, make choices, and take actions based on personal values and beliefs.[81]

The medical model fails to respect the autonomy of trans people to decide what medical care is needed to express gender. The medicalization of gender identity interferes with this principle by failing to recognize the right of trans people to formulate their own views of gender identity, including the view that gender identity is not a medical condition to be treated with medical intervention. By requiring a specific medical treatment, the government instructs trans people as to what type of medical care they should seek, regardless of what kind of care they want or need. Such a system implies that trans people are incapable of judging for themselves what care and treatment is necessary to express gender. By failing

77 BEAUCHAMP & CHILDRESS, *supra* note 64, at 23.

78 *See supra* notes 71–72 and accompanying text. For an example of how the United States has embraced this view of medical ethics, see Omnibus Budget Reconciliation Act of 1990, PL 101–508, Nov. 5, 1990, 104 Stat. 1388 (requiring that health care institutions inform patients about institutional policies to accept or refuse medical treatment and about their rights under state law).

79 FADEN & BEAUCHAMP, *supra* note 64, at 7; Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 364 (1974).

80 *See* Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965). The right to refuse medical treatment is a liberty right protected by the Due Process Clause. Cruzan v. Dir., Mo. Dept. of Health, 497 U.S. 261, 289 (1990) ("Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment.").

81 BEAUCHAMP & CHILDRESS, *supra* note 64, at 63. For a discussion of why such respect is due, see IMMANUEL KANT, FOUNDATIONS OF THE METAPHYSICS OF MORALS (Lewis White Beck trans., 1959). Respect for autonomy is also a way for physicians and researchers to respect the humanity of their patients. *See* Capron, *supra* note 79, at 366; *see also* Margaret Mead, *Research with Human Beings: A Model Derived from Anthropological Field Practice*, 98 DAEDALUS 361, 375 (1969) ("To fail to acquaint a subject of observation or experiment with what is happening—as fully as is possible within the limits of the communication system—is to that extent to degenerate him as a full human being and reduce him to the category of dependency in which he is not permitted to judge for himself.").

to respect the rights of trans people to seek whatever care the individual thinks necessary, the medical model undermines the ability of trans people to exercise autonomous choice.

2. Nonmaleficence

By requiring treatments that may not be medically advisable, the medical model violates the principle of nonmaleficence, the requirement that a physician do no harm in treating a patient.[82] Nonmaleficence is implicated when physicians treat patients according to a protocol designed by courts and legislatures.[83] The physician must still ensure that a treatment required by a legislative body or court in order to obtain legal recognition will not harm the patient.[84] For many individuals, the treatment required by the medical model—some form of surgery—is not medically advisable.

Applying a legislative and court-identified treatment protocol for reclassifying gender may actively harm a patient both mentally and physically. In this case, a physician is obligated not to proceed. However, the legal framework of the medical model does not permit a patient to obtain the benefits of reclassification should the physician decline to proceed. In creating this dilemma, the medical model violates the principle of nonmaleficence by requiring a physician to administer a treatment that may harm a patient should that patient wish to receive the legal benefits of reclassification.

3. Benefice

The concept of benefice is closely linked to nonmaleficence. However, nonmaleficence is a norm of avoidance: a physician should not inflict harm on his patients.[85] Benefice, by contrast, requires action: a physician should act to promote the welfare of his patients.[86]

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82 FADEN & BEAUCHAMP, *supra* note 64, at 10.

83 *See* AM. MED. ASS'N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, COURT-INITIATED MEDICAL TREATMENT IN CRIMINAL CASES, CEJA REPORT 4-A-98, (1998), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/code-medical-ethics/2065a.pdf [hereinafter CEJA REPORT].

84 *Id.*

85 BEAUCHAMP & CHILDRESS, *supra* note 64, at 115.

86 *Id.* Benefice has, at times, been regarded as the paramount obligation of a medical provider. *Id.* at 176. Under this view, benefice may be regarded as competing with respect for autonomy (if one believes that the patient's wishes are irrelevant to determining which course of action is in the best interests of the patient) or incorporating respect for autonomy (in the sense that the best medical interests of the patient will be informed by autonomous decision making). *Id.*

If nothing else, benefice requires that a practitioner deem a specified medical treatment as effective in treating the underlying condition of the individual patient.[87] This is true even if the procedure is court ordered.[88] Legislatures, administrative agencies, and courts may identify certain policy goals to be promoted by medical treatment, but they are incompetent to determine individual diagnoses or treatments.[89]

The medical model thus violates the principle of benefice by requiring a procedure that may not promote the welfare of the patient. In terms of treating trans patients, there is genuine uncertainty as to whether the procedures required by the government for legal recognition and associated benefits are effective in "treating" the underlying condition.[90] This medical model is premised on the assumption that gender identity is a medical condition to be treated rather than a fundamental aspect of identity. Policies requiring surgery for reclassification reflect an incorrect cultural myth that trans people can only be understood and defined through a medical narrative.[91] Even if one accepts that nonconforming gender identity requires medical treatment, reclassification requirements do not always match the medical needs of an individual patient. An inflexible legal understanding of what constitutes sex does not provide a physician with the necessary latitude to make an independent determination about the benefits of a particular treatment for an individual.

4. Justice

Justice is another important bioethical norm promoted by the doctrine of informed consent. A person is treated justly if he is treated according to what is "fair, due, or owed."[92] Justice is implicated when an individual's legal and moral rights are violated.[93]

The medical model violates the principle of justice by impermissibly interfering with the legal rights of trans people in a number of ways. For one, the medical model can

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87 CEJA REPORT, *supra* note 83.

88 *Id.*

89 *Id.*

90 *See, e.g.*, Newlin, *supra* note 17; Spade, *Documenting Gender*, *supra* note 2; Spade, *Resisting Medicine*, *supra* note 14; Spade, *Three Myths*, *supra* note 56.

91 *See* Spade, *Three Myths*, *supra* note 56, at 37.

92 FADEN & BEAUCHAMP, *supra* note 64, at 14.

93 *Id.*

be viewed as an unconstitutional invasion of privacy, which must encompass "autonomy with respect to the most personal of life choices."[94] There is a strong argument that the appearance of one's genitals should be encompassed in this "realm of personal liberty which the government may not enter."[95] Even more invasively, the medical model allows for a public discussion of one's genitalia in court even though the decision whether or not to undergo genital surgery is an inherently private choice.[96] Additionally, the medical model also implicates concerns about the right to travel,[97] equal protection,[98] and due process.[99]

The medical model may also violate the principle of justice in a much more obvious way: if consent to medical treatment is coerced or manipulated in such a way as to render it involuntary, it may violate the constitutionally protected right to refuse medical treatment. The next section will take up the question of whether consent to treatment under the medical model may be involuntary.

B. Coercion and Manipulation: Rendering Consent Involuntary

By conditioning legal benefits and recognition on the completion of surgery, the medical model has the potential to render consent involuntary. As the American Medical Association noted, a decision is rendered involuntary "when some element is involved that prevents an individual from acting freely."[100] The problem with this definition is that it is circular; much of this Part is concerned with giving substance and meaning to this imprecise definition. In addition to the problems in defining the term "involuntary," it becomes very difficult to apply this principle in a policy context, as the degree to which a person acts

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94 *See* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1302 (2d ed. 1988).

95 Lawrence v. Texas, 539 U.S. 558, 578 (2003).

96 *See* Deborah J. Anthony, *Caught in the Middle: Transsexual Marriage and the Disconnect Between Sex and Legal Sex*, 21 TEX. J. WOMEN & L. 153, 185 (2012).

97 *See* Greenberg & Herald, *supra* note 2, at 855–62 (discussing the unwillingness of some states to recognize amended sex designations as a burden on the right to travel).

98 *See* Anthony, *supra* note 96, at 179–84 (discussing discrimination against trans people as sex discrimination in violation of the Equal Protection Clause); Greenberg & Herald, *supra* note 2, at 862–72 (discussing the imposition of a sex-classification system that relies on chromosomes, the ability to reproduce, or gender stereotypes as a violation of the Equal Protection Clause).

99 *See* Greenberg & Herald, *supra* note 2, at 872–84 (discussing the unwillingness to amend legal sex as an unwarranted burden imposed on trans people in violation of substantive due process).

100 *See* CEJA REPORT, *supra* note 83.

freely is a subjective analysis: the coercive effect is measured by the victim's response.[101] Bioethical scholarship provides guidance both for evaluating when an individual decision is involuntary, and for analyzing systematic defects. A common approach in modern ethical scholarship is to approach the requirement of voluntariness as an issue of autonomy.[102] When autonomy is negated, consent may not be voluntary.[103] The advantage of an autonomy-negating approach is that it provides an objective method of distinguishing between permitted and forbidden influences.[104] While autonomy theories vary, virtually all require independence from controlling influences and the capacity to act intentionally.[105] One common formulation, widely adopted by the medical community, adds the element of understanding to the requirements of autonomous action.[106] This formula does not require knowledge of the patient's internal values, and thus presents a more pragmatic model that can be more easily applied by practitioners.[107]

As it is presumed that trans patients are capable of acting intentionally, the driving question is whether a decision to undergo surgery is "free from controlling influences" given that consent to surgery will result in numerous benefits.[108] It is generally presumed that the pressures exerted by the underlying condition do not affect the voluntariness of a decision.[109] Thus, controlling influences must be external. External influences may be classified into three categories based on degree: coercion, manipulation, and persuasion.[110]

101 Rubenstein v. Rubenstein, 20 N.J. 359, 368 (1956) (stating that duress is measured "not by the nature of the threats, but rather by the state of mind induced thereby in the victim").

102 The shift from a paternalistic model to a model of self-determination has inspired a great deal of bioethical scholarship and activism around the idea of patient autonomy. *See* DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING 241–46 (1991).

103 *See* Bloche, *supra* note 76, at 244.

104 *Id.* at 250.

105 BEAUCHAMP & CHILDRESS, *supra* note 64, at 62.

106 *See* Bloche, *supra* note 76, at 246 n.52. Other scholars have adopted a more stringent definition of autonomy. *See, e.g.*, JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 116 (1984) (arguing for "psychological autonomy" that focuses on the chooser's ability to consider unconscious mental processes and irrational beliefs).

107 Bloche, *supra* note 76, at 246 n.52; *see also* Edmund D. Pellegrino, *The Metamorphosis of Medical Ethics: A 30-Year Retrospective*, 269 JAMA 1158, 1160 (1993).

108 *See* FADEN & BEAUCHAMP, *supra* note 64, at 54.

109 Franklin G. Miller & Alan Wertheimer, *Preface to a Theory of Consent Transactions: Beyond Valid Consent*, *in* THE ETHICS OF CONSENT, *supra* note 1, at 79–80.

110 BEAUCHAMP & CHILDRESS, *supra* note 64, at 94.

Coercion inevitably negates autonomy even when the agent is informed and acting intentionally.[111] Persuasion is a successful and intentional attempt to induce a person to *freely* accept the beliefs, attitudes, values, intentions, or actions advocated by the persuader and never negates autonomy.[112] Manipulation is a class of activities between persuasion and coercion.[113] Manipulation, like coercion, can negate autonomy if sufficiently controlling.

1. Coercion

A coerced decision cannot be voluntary because it is controlled by the influencer.[114] In an individual context, one might apply a purely subjective approach to evaluating the degree of control. However, to evaluate the degree of systematic coercion, a subjective approach is impossible to apply. Instead, one might evaluate coercion by the intent of the influencing agent and the impact the threat is likely to have on a reasonable person, meaning that the threat is credible and irresistible.[115] The threat, implicit in the medical model, is that the government will deny a trans person access to the economy, public resources, and legal protection if the individual elects not to follow the government's preferred course of action, namely surgical intervention.

a. Intent Is Implicit in the Medical Model

The intent to coerce a decision is implicit in the medical model. The requirement of intent ensures that internal or situational factors are not deemed coercive.[116] In one sense, one might construe the medical model to be a "situational" factor lacking the requisite purpose.[117] From this perspective, the medical model exists solely as a method of providing

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111 *Id.*

112 FADEN & BEAUCHAMP, *supra* note 64, at 347.

113 BEAUCHAMP & CHILDRESS, *supra* note 64, at 95.

114 *See* FADEN & BEAUCHAMP, *supra* note 64, at 338.

115 *Id.* at 339.

116 *See* Bloche, *supra* note 76, at 249. Intent is an element of some philosophical models of coercion. *See, e.g.*, Michael D. Bayles, *A Concept of Coercion*, *in* COERCION : NOMOS XIV 16, 19–20 (J. Roland Pennock & John W. Chapman eds., 1972); Richard Nozick, *Coercion*, *in* PHILOSOPHY, SCIENCE, AND METHOD 440 (Sidney Morgenbesser et al. eds., 1969). However, models that focus solely on the experience of the coerced person lack this element. *See, e.g.*, HAROLD D. LASSWELL & ABRAHAM KAPLAN, POWER AND SOCIETY 97 (1952).

117 "Intent" is generally used synonymously with "purpose." However, the possibility of a broader definition—knowledge with substantial certainty—is not foreclosed. Bloche, *supra* note 76, at 247 n.58.

cognizable distinctions between sexes for the purposes of legal classification and exhibits no attempt to influence any individual decision. However, an implicit purpose of a system of incentives is to induce people to follow the encouraged course of action. By providing legal benefits and recognition upon the completion of some specified action—and denying such benefits when the action is not taken—the medical model evinces such an implied purpose. While there may be other motivations underlying the medical model, purpose may be inferred from the model itself. Such a finding is consistent with the purpose of the intent requirement—to eliminate the possibility of coercion being found when environmental factors, such as an illness, create the coercive situation.[118] When the coercive situation derives from external human activity done with conscious purpose, this concern is not implicated.

b. The Threat Is Credible and Irresistible

A coercive threat must be credible and irresistible.[119] A threat is credible when both parties know the person making the threat can carry it out.[120] The threat posed by the medical model is that the government will withhold the benefits of reclassification unless the individual completes specified medical procedures. The threat is obviously credible; clearly the government can and does refuse to provide the benefits of reclassification to those who do not complete the required medical intervention.[121] Credibility alone does not render a threat coercive; only irresistible threats implicate autonomous decision making severely enough to be considered coercive.[122] A powerful argument against a finding of irresistibility is the simple fact that many trans people do not undergo surgery.[123] However, it is impossible to separate the question of resistibility from other factors, such as cost and other medical conditions, which pose an absolute bar to surgery for many people. If obtaining surgery was financially and medically possible for more trans people, it is

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118 *See* FADEN & BEAUCHAMP, *supra* note 64, at 339. For an application of this model, see Bloche, *supra* note 76, at 249–57.

119 *See* FADEN & BEAUCHAMP, *supra* note 64, at 339.

120 *Id.*

121 There are rare exceptions where trans people are able to obtain some benefits of reclassification like amended identification by presenting the original sex designation as a mistake. *See* Spade, *Documenting Gender*, *supra* note 2, at 772–74. However, this is an atypical result that requires the system to fail in some manner.

122 *See* FADEN & BEAUCHAMP, *supra* note 64, at 341.

123 Spade, *Documenting Gender*, *supra* note 2, at 754.

entirely possible that the threat of non-recognition would be irresistible given the benefits associated with reclassification.

The question of irresistibility is also inextricably linked to the relative position of the trans community as a marginalized social group. Irresistibility necessarily requires a normative standard reflecting some sort of assumption about the "degree of external or psychological pressure that a person *ought* to resist, under the circumstances at issue."[124] Assuming that a trans person should be able to resist the same sorts of threats that a member of a non-marginalized group would be able to resist obscures this question. Requiring informed consent—but ignoring the problem of relativism—preserves a myth of free will rather than its actual expression.[125] Many trans people are not able to fully engage in society and the economy until reclassification has been achieved.[126] A trans person's rights may be decided entirely on the basis of what medical procedures he or she has undergone.[127] A non-trans person does not face the same threat if he or she does not consent to surgery. Understanding the relative position of the trans community makes it easier to re the medical model as posing an irresistible threat that could negate the voluntariness of consent.

2. Manipulation

The medical model may also manipulate a trans person into selecting a specific course of action, thereby rendering consent involuntary. Manipulation can occur when an influencing agent modifies the options available by changing the expected payoff of a course of action with the intent of modifying the decision.[128] A trans person seeking sex reassignment may

124 Bloche, *supra* note 76, at 251–52. The alternative to a normative judgment is a counterfactual one based on whether a person who succumbed to external influences might have withstood them. *Id.* However, determining what *might* have happened is an act of intuitive speculation, not one based on external facts. DOUGLAS R. HOFSTADTER, GÖDEL, ESCHER, BACH: AN ETERNAL GOLDEN BRAID 641 (1979).

125 *See* Jay Dyckman, *The Myth of Informed Consent: An Analysis of the Doctrine of Informed Consent and Its (Mis) Application in HIV Experiments on Pregnant Women in Developing Countries*, 9 COLUM. J. GENDER & L. 91, 102 (1999). Ignoring issues of relativism allows for consent to be manipulated to obtain a socially-desired result at the expense of the marginalized group. *Id.*

126 *See* GRANT ET AL., *supra* note 18; Spade, *Compliance Is Gendered*, *supra* note 21.

127 Spade, *Resisting Medicine*, *supra* note 14, at 17–18.

128 BEAUCHAMP & CHILDRESS, *supra* note 64, at 95. In the medical context, manipulation often occurs where the influencing agent deliberately manages information that alters a patient's understanding of the situation, thereby motivating the patient to choose the option the manipulator prefers. *Id.* A common example of informational manipulation occurs in the context of abortion if misleading disclosure is required by law. *See* Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical*

pursue numerous options, including "bilateral mastectomy, orchiectomy, phalloplasty, hysterectomy, vaginoplasty, hormone therapy treatment, brow reduction, facial implants, vaginal closure, voice surgery, metaodioplasty, augmentation mamaplasty, tracheal shave, liposuction, hormone therapy, group or individual counseling, [and/or] psychotherapy."[129] The medical model modifies these options by rewarding a specific course of action (typically genital surgery) with access to legal benefits and recognition.

The distinction between acceptable manipulation and prohibited coercion has been framed at times as the distinction between an "offer" and a "threat." One might construe the medical model as an offer (to provide benefits in exchange for surgery) or a threat (to deny benefits if one does not undergo surgery). The ease in which the medical model can be cast as either a threat or an offer illustrates the problem in relying on this as a principled distinction between forbidden and permissible conduct. Instead, the focus must remain on whether the medical model negates autonomy, regardless of whether it is described as an offer or a threat.[130] An offer may become sufficiently manipulative as to render autonomous choice impossible.[131]

The relevant distinction is therefore the one between permissible offers and offers that render consent involuntary. One manner of parsing this distinction is to classify offers as "welcome" and "unwelcome."[132] A welcome offer is one that the recipient wants to receive, even if it is not ultimately accepted; such an offer does not negate autonomy.[133] An unwelcome offer is one that the offeree will want to resist.[134] For trans people who desire surgery as an independent goal, the offer of legal recognition may be welcome. Electing

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Ethics, 19 MICH. J. GENDER & L. 1, 39–42 (2012).

129 *Birth Certificate Sex Designation*, *supra* note 59.

130 Some scholars have maintained that an accepted offer can never negate autonomy. *See, e.g.*, Bernard Gert, *Coercion and Freedom*, *in* COERCION 30, 36–37 (J. Roland Pennock & John W. Chapman, eds., 1972). However, this view has not been adopted in American jurisprudence. The foundation of the unconstitutional conditions doctrine holds that an accepted offer may not be constitutionally permissible if it is premised on the waiver of a constitutional right. See *infra* Part II.D for a detailed discussion of the unconstitutional conditions doctrine and its application to the medical model.

131 FADEN & BEAUCHAMP, *supra* note 64, at 340.

132 *Id.* at 357.

133 *Id.* One common example of a "welcome" offer is a job offer. Regardless of whether or not the individual accepts the position, the choice is autonomous.

134 *Id.*

to undergo surgery in that instance is not involuntary simply because it is accompanied by the offer of legal reclassification. However, for those who desire legal reclassification and its associated benefits, but not medical or surgical intervention, the offer is unwelcome; the person will naturally resist the pressure to undergo an unwanted, invasive medical procedure. A non-trans person (who does not face the same risks of discrimination and harassment) would likely reject such an offer immediately. For a trans person who is medically and financially capable of obtaining surgery, the offer may be impossible to refuse. In such a situation, the manipulating party—in this case, the government—is able to exercise not just influence, but control over the trans person's choice, rendering the decision non-autonomous.

A decision that is coerced or manipulated is not free from controlling influences, as it is controlled by the influencing agent.[135] Manipulation or coercion may be justified in some contexts. For example, a parent might coerce a child into following a particular course of action that is in the child's best interest. However, it is rarely justifiable in the medical context as informed consent represents a specialized type of consent that emphasizes individual autonomy over paternalism.[136] The medical model incentivizes treatment options in a manner that may render consent involuntary. Consent that is not voluntary does not fulfill the basic requirements of informed consent and is thus ineffective.

C. Informed Consent and the Relationship Between the Patient and the State

A finding that the medical model has the potential to coerce or manipulate consent does not end the inquiry. While there is little doubt that an individual physician would not be allowed to influence a patient's decision by promising some sort of benefit or reward should he or she elect to pursue a particular course of treatment over another, the medical model does not implicate the clinical relationship between a patient and physician. The medical model instead involves the relationship between the circumscribing legal framework regarding sex reclassification and an individual medical decision. What may be unethical or illegal in the individual context may be permitted as a policy matter where other concerns beyond individual interests must be considered. Distinguishing between permissible and forbidden influences at the policy level reflects normative commitments, particularly when a policy is intended to promote broad societal goals whose accomplishment requires collective action.[137] Thus, evaluating the permissibility of the medical model requires a balancing of

135 FADEN & BEAUCHAMP, *supra* note 64, at 337.

136 Miller & Wertheimer, *supra* note 109, at 80.

137 *See* Bloche, *supra* note 76, at 237.

the broad governmental interests with the effect of such a system on the individual.

1. Policy Justifications for the Medical Model

Courts have identified a number of governmental interests served by the medical model. Justifications for refusing to amend legal documents to reflect self-identified sex include: (1) the prevention of fraud;[138] (2) fear that allowing amendment will lead to illegal same-sex marriages;[139] (3) a belief that the legal system should not be used as a means to help "psychologically ill persons in their social adaptation";[140] and (4) a belief that birth certificates are a historical record that should accurately reflect facts that existed at the time of the birth.[141] In rejecting a proposal that would make reclassification in New York City easier,[142] the Department of Health also expressed concerns about housing in sex-segregated hospitals and prisons, and the fear that without a surgical requirement, some trans people may re-transition back to their original legal sex.[143] There is some debate as to the legitimacy of these concerns and whether these concerns could be alleviated with proper safeguards.[144] Nonetheless, insofar as these interests are advanced as justifications

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138 *See, e.g.*, Hartin v. Dir. of the Bureau of Records, 347 N.Y.S.2d 515, 518 (Sup. Ct. 1973) ("The desire of concealment of a change of sex by the transsexual is outweighed by the public interest for protection against fraud."); Anonymous v. Weiner, 270 N.Y.S.2d 319, 322 (Sup. Ct. 1966).

139 *See In re* Ladrach, 513 N.E.2d 828, 828 (Ohio Prob. Ct. 1987) (framing the question of whether a transwoman could marry a man as an issue of whether two individuals "biologically and legally of the same sex at birth" could legally marry).

140 *See Hartin*, 347 N.Y.S.2d at 517.

141 *See* K. v. Health Div., Dept. of Human Res., 560 P.2d 1070, 1072 (Or. 1977) (finding that a birth certificate is a "historical record of the facts as they existed at the time of birth," rather than a record of facts as they presently exist).

142 The proposal would have allowed the issuance of a birth certificate after an applicant provided evidence that he or she had completed their transition and intended to remain in their "new" gender permanently. The New York proposal did not require any specific surgical procedure. Kristin Wenstrom, Comment, *What the Birth Certificate Shows: An Argument to Remove Surgical Requirements from Birth Certificate Amendment Policies*, 17 LAW & SEXUALITY 131, 143 (2008). New York City currently requires "convertive surgery" which has been interpreted to mean genital surgery. *Id.* at 138.

143 *Id.* at 144; *see also* Greenberg, *Defining Male and Female*, *supra* note 2, at 316.

144 *See, e.g.*, Greenberg, *Defining Male and Female*, *supra* note 2, at 316–17 (rejecting policy concerns as justifying the use of sex indicated at birth as the official sex for all legal documents); Wenstrom, *supra* note 142, at 143–57 (rejecting these policy considerations as insufficient to justify discrimination of transgender people); *see also* LISA MOTTET & JOHN M. OHLE, TRANSITIONING OUR SHELTERS: A GUIDE TO MAKING HOMELESS SHELTERS SAFE FOR TRANSGENDER PEOPLE (2003), http://thetaskforce.org/downloads/reports/reports/

for stringent requirements for reclassification, they must be weighed against the interests of the individual.

2. Governmental Interests Do Not Justify the Violation of the Doctrine of Informed Consent in this Context

Governmental interests must be balanced against the interests of the individual. The individual interests at stake are not insignificant. While the doctrine of informed consent originally developed as a tort claim, it is fortified by constitutional concerns, namely the Due Process Clause and the right to privacy.[145] Indeed, as some scholars have noted, there is considerable overlap between the doctrine of informed consent and the constitutional right to privacy.[146] Both doctrines reflect concern for protecting individual autonomy against external interference.[147] This suggests that medical decision making is an area where government intrusion should be at a minimum, a principle that is generally borne out in practice. While the government may regulate matters related to health and safety to promote

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TransitioningOurShelters.pdf (discussing ways to house trans people in a manner that is sensitive to gender identity without creating a categorical rule).

Allowing more trans people to reclassify may actually serve to prevent fraud by enabling more individuals to carry identification. With proper safeguards, using gender reclassification to evade law enforcement is unlikely. Wenstrom, *supra* note 142, at 152. A person whose gender identity conforms to assigned sex is unlikely to disavow gender identity solely for the purpose of entering into a fraudulent marriage. Greenberg, *Defining Male and Female*, *supra* note 2, at 307–08. Birth certificates are amended with regularity upon the occurrence of certain events, like adoption. This belies the argument that birth certificates must be preserved as a historical record. Amending birth certificates results in greater, not less, accuracy. Wenstrom, *supra* note 142, at 155–56. Re-transitioning back to one's original legal sex is not likely to be a common occurrence. Moreover, re-transitioning is unlikely to pose any substantial threat to record keeping given that people are allowed to change a name multiple times. *Id.* at 156–57.

There is an additional concern for the safety and comfort of individuals in sex-segregated facilities. One common concern is that a transwoman possessing a penis could pose a danger to other women in a sex-segregated facility. However, shelters who house non-operative transwomen with other women have not reported any additional assaults. MOTTET & OHLE, TRANSITIONING OUR SHELTERS: A GUIDE TO MAKING HOMELESS SHELTERS SAFE FOR TRANSGENDER PEOPLE, *supra,* at 13. A non-operative transman may be placed in danger of physical and sexual assault in some sex-segregated environments, such as prisons. However, sensitive policies that allow for placement according to lived gender, preference, and/or safety can alleviate many of these concerns. *Id.* at 38. As it stands now, housing trans people according to legal sex serves only to emphasize their nonconforming gender identity in a manner that is harmful and dangerous. *Id.*

145 *See* Cruzan v. Dir., Mo. Dept. of Health, 497 U.S. 261, 269–78 (1990) (discussing the common law doctrine of informed consent and finding a substantive due process right to refuse medical treatment).

146 *See* Manian, *supra* note 65, at 262–63.

147 *Id.*

the public welfare, direct interference with individual decision making is relatively rare.

A common exception to this general rule illustrates this principle. In the context of abortion, a number of states have promulgated statutes that directly interfere with the individual decision to have an abortion by mandating waiting periods, ultrasounds, and biased disclosure.[148] However, such statutes are specialized "informed consent" statutes that contain specific requirements for consent to abortion. These statutes are commonly justified (among other things) as ensuring that women are provided with adequate information to make an educated decision about abortion.[149] Coercion or manipulation of a decision in this context can theoretically be justified is as a form of paternalism designed to benefit the individual.[150] One might argue that paternalism has no place in the medical context. However, even accepting that paternalism might be justified in these circumstances, the beneficiary of such paternalism must be the individual—not the government.[151] The individual woman seeking an abortion is thus the purported beneficiary of speicalized informed consent standards. By contrast, the medical model is typically justified as serving state interests rather than protecting individual interests.[152] Thus, the governmental interference with medical decision making in the context of sex reassignment cannot be defended as a form of justified paternalism.

Even if the medical model cannot be justified as a form of paternalism, it may still be valid from a policy perspective if the state interests outweigh the individual interest

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148 *See, e.g.*, Manian, *supra* note 65; Vandewalker, *supra* note 128.

149 *See, e.g.*, MINN. STAT. §§145.4242, 145.4243 (2012) (requiring a twenty-four hour waiting period and statutorily mandated disclosures about medical risks for informed consent for an abortion); MO. REV. STAT. §188.027 (1) (2012) (mandating that consent for abortion cannot be voluntary and informed unless the patient has been given by her physician, at least twenty-four hours in advance, a description of the procedure, medical and psychological risks, and alternative options); NEV. REV. STAT. §442.253 (2012) (listing the specific requirements for informed consent in the abortion context, including that the physician "[e]xplain the physical and emotional implications" of having an abortion). For a discussion of how these laws implicate the doctrine of informed consent, see Manian, *supra* note 65; Jennifer Y. Seo, *Raising the Standard of Abortion Informed Consent: Lessons to be Learned from the Ethical and Legal Requirements to Medical Experimentation*, 21 COLUM. J. GENDER & L. 357 (2011); Vandewalker, *supra* note 128.

150 *See generally* Douglas Husak, *Paternalism and Consent*, *in* THE ETHICS OF CONSENT, *supra* note 1, at 108. For an argument that extreme deference to patient autonomy does not satisfy patients' needs, see Dworkin, *supra* note 75, at 267–68.

151 Husak, *supra* note 1, at 110.

152 *See, e.g.*, Greenberg, *Defining Male and Female*, *supra* note 2, at 316; Wenstrom, *supra* note 142.

in refusing medical treatment. Thus, merely identifying the liberty interest[153] will not end the analysis. The relevant inquiry also requires balancing countervailing state interests against the individual interests.[154] If the state interests are great enough, interference with the liberty interest may be permitted. Greater intrusion into medical decision making is permitted in certain contexts, such as the right to die and abortion. In both settings, interference is justified on the grounds that the state has a profound interest in protecting and preserving human life, or the potential for life.[155] Beyond preserving life, other interests that have been identified as potentially outweighing an individual liberty interest include the protection of innocent third parties and the preservation of the ethical integrity of the medical profession.[156]

The interests at stake in the medical model are no doubt important. However, none of the governmental concerns are as profound as the interest in preserving life, protecting the public, or maintaining the ethical integrity of the medical profession.[157] Many of the justifications for the medical model are, at best, administrative; others implicate the need to prevent fraud. The intrusion into individual liberty significantly outweighs such concerns. Genital surgery is highly invasive and concerns itself with an inherently private choice intrinsically linked to identity.[158] On balance, the governmental interests are simply not

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153 Cruzan v. Dir., Mo. Dept. of Health, 497 U.S. 261, 289 (1990) ("Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment.").

154 *Id.* at 279 (balancing the liberty interest in refusing life-sustaining medical treatment against the relevant state interests).

155 *Id.* at 280 (finding that the interest in protecting human life justified heightened evidentiary standards when the refused medical treatment is necessary to preserve the life of the patient); Roe v. Wade, 410 U.S. 113, 162–63 (1973) (identifying two legitimate state interests in regulating abortion: the "interest in preserving and protecting the health of the pregnant woman" and the interest in "protecting the potentiality of human life."); *see also* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 878 (1992) (adopting the "undue burden" standard as a means of balancing the individual interest in abortion and the "profound" state interest in potential life).

156 *See* Runnels v. Rosendale, 499 F.2d 733, 735 (9th Cir. 1974) (suggesting that safety may represent a valid justification for forced treatment); *see also* Linda S. Demsky, *The Use of Depo-Provera in the Treatment of Sex Offenders*, 5 J. LEGAL MED. 295, 305–06 (1984) (identifying potential state interests as sufficient to outweigh the individual interest in refusing medical treatment as the preservation of life, the protection of innocent third parties' safety, the prevention of suicide, and maintenance of the ethical integrity of the medical profession).

157 Many of the concerns raised by state governments in defending high standards for reclassification can be alleviated or eliminated through practical safeguards. *See supra* note 144 and accompanying text.

158 *See* Anthony, *supra* note 96, at 185.

compelling enough to justify such an extreme invasion into the right to consent to or refuse medical treatment.

In general, states do not interfere directly with medical decision making. The rare exceptions occur when the state interest is exceptionally compelling, such as the interest in preserving life. By coercing or manipulating consent, the medical model interferes with the constitutionally protected decision to undergo or refuse medical treatment. The medical model cannot be regarded as a form of justified paternalism as it is designed primarily to protect governmental concerns rather that the needs of individuals, nor can it be justified as serving a highly compelling state interest. Given the individualized nature of consent in the medical context, the medical model should therefore be regarded as an unacceptable interference with medical decision making.

D. A Parallel Application: The Unconstitutional Conditions Doctrine

The application of the unconstitutional conditions doctrine closely parallels the inquiry into the voluntariness of consent and provides an alternate constitutional criticism of the medical model. At its core, the doctrine maintains that the government may not improperly induce a waiver of constitutional rights through the denial or provision of a discretionary benefit:

> In its canonical form, this doctrine holds that even if a state has absolute discretion to grant or deny a privilege or benefit, it cannot grant the privilege subject to conditions that improperly "coerce," "pressure," or "induce" the waiver of constitutional rights. Thus, in the context of individual rights, the doctrine provides that on at least some occasions receipt of a benefit to which someone has no constitutional entitlement does not justify making that person abandon some right guaranteed under the Constitution.[159]

The difficulty courts have faced when applying the doctrine is creating a principled method to distinguish between constitutionally permissible and forbidden influences.[160] Influences determined to be impermissible are often described as coercive.[161] However,

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159 Richard A. Epstein, *Foreword: Unconstitutional Conditions, State Power, and the Limits of Consent*, 102 HARV. L. REV. 4, 6–7 (1988) (citing Van Alstyne, *The Demise of the Right-Privilege Distinction in Constitutional Law*, 81 HARV. L. REV. 1439, 1445–49 (1968)).

160 Kathleen M. Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1413, 1419 (1989).

161 *Id.* at 1419–20.

"[c]oercion is a judgment, not a state of being" and the label of "coercion" does not reflect an objective analysis.[162] The analysis of the voluntariness requirement of informed consent provides a means for evaluating the coercive nature of the medical model.[163] If one finds the medical model sufficiently coercive or manipulative, the medical model may be conceptualized as fitting within the paradigm of the unconstitutional conditions doctrine by coercing the waiver of a constitutionally protected right (the right to refuse medical treatment) through the offer of discretionary government benefits and privileges (legal sex reclassification and associated benefits).

To be subject to unconstitutional conditions analysis, a benefit may not be directly barred by independent constitutional grounds, nor can it be one that the government is required to provide.[164] The benefit may be an exemption from regulation, taxation, or another constitutionally permissible burden. It may also be a subsidy or other form of government largess.[165] Government largess, as defined by Charles Reich in *The New Property*, includes government jobs, contracts, facilities, services, and resources.[166] Unconstitutional conditions analysis has also been applied in connection with the exercise of state police power.[167] With this understanding, legal reclassification may be viewed as such a benefit. A number of government-funded facilities and resources (such as homeless shelters and domestic violence shelters) refuse to house transgender persons whose legal sex is inconsistent with expressed gender.[168] Marriage, a government institution that provides numerous tax benefits, may only be accessible to trans people after reclassification in states that do not permit same-sex marriage.[169] Gender reclassification itself can be regarded as a discretionary benefit—like a zoning variance—distributed through the police power.[170]

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162 *Id.* at 1450.

163 *See supra* Part II.B.

164 Sullivan, *supra* note 160, at 1423–24.

165 *Id.*

166 Charles A. Reich, *The New Property*, 73 YALE L.J. 733, 734–37 (1964).

167 *See* Epstein, *supra* note 159, at 58; *see also* Nollan v. Cal. Coastal Comm'n, 483 U.S. 825 (1987) (describing a zoning variance as a discretionary benefit).

168 Spade, *Compliance Is Gendered*, *supra* note 21, at 219.

169 *See supra* note 36 and accompanying text.

170 *Nollan*, 483 U.S. 825 (1987).

The unconstitutional conditions framework also requires the waiver of a constitutional right. The infringed upon right must involve some sort of autonomous choice, such as the right to privacy.[171] Some international courts have held that gender identity itself falls under the right to privacy.[172] However, regardless of whether the right to privacy includes the right to define one's own gender identity, the medical model directly implicates the right to refuse medical treatment. The right to refuse medical treatment is encompassed within the right to privacy, and has been characterized as a liberty right.[173] Such a right is an autonomous choice that is normally within the constitutionally protected discretion of an individual. Thus, the right to decide what medical treatments are required to express gender, and the right to refuse treatments unwanted by a patient, is a constitutionally protected right.

The medical model may therefore be viewed as imposing an unconstitutional condition on the exercise of a constitutionally protected right. This indirect burden on the constitutional right imposed by the medical model should be analyzed as if it were a direct burden on that right, and is consequently subject to strict scrutiny analysis.[174] The medical model would likely fail such an analysis. A rigid system that compels highly invasive and permanent body alteration is unlikely to be considered "narrowly tailored" or the least restrictive method of protecting whatever governmental interest is at stake. Indeed, as discussed *supra* in Part II.C, no governmental interest promoted by the medical model is as compelling as the interest in life, public safety, or the ethical integrity of the medical profession. A desire to prevent fraud or same-sex marriages may be a valid governmental interest; however, it is highly implausible that the only way to protect against such concerns is to require permanent, body-altering surgeries that are inextricably bound up in individual identity. There are numerous other ways to accomplish such goals without overly burdening the right to make medical decisions.[175]

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171 Sullivan, *supra* note 160, at 1426.

172 *See* Van Kuck v. Germany, 2003-VII Eur. Ct. H.R. 1, 12 (holding that the right to private life includes the "freedom to define herself [or himself] as a female [or male] person").

173 *See, e.g.*, Cruzan v. Dir., Mo. Dept. of Health, 497 U.S. 261, 289 (1990) ("Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment . . . ."); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965); *see also* Manian, *supra* note 65, at 262–63.

174 Sullivan, *supra* note 160, at 1419.

175 *See infra* Part III for potential alternatives to the medical model. For further discussion on unconstitutional conditions, see Vicki Been, *"Exit" as a Constraint on Land Use Exactions: Rethinking the Unconstitutional Conditions Doctrine*, 91 COLUM. L. REV. 473 (1991); Epstein, *supra* note 159; Daniel A. Farber, *Another View*

III. Evaluating Alternatives to the Medical Model: Advocating a System of Self-Identification Based on Lived Gender

The medical model is not an acceptable method for classifying legal sex and distributing benefits associated with conformity to legal sex. In addition to making sex reclassification inaccessible to many trans people, the medical model coerces and manipulates consent in violation of the doctrine of informed consent. This Part will examine alternatives for sex reclassification that do not suffer the same deficiencies while also accounting for the valid governmental interests at stake. Alternative solutions include reducing the importance of sex categorization, changing the medical requirements for reclassification, and adopting a system for reclassification based on lived gender rather than medical treatment. This Part will discuss each alternative in turn.

A. Reducing the Importance of Sex Categorization Does Not Eliminate the Need for Sex Categorization

As the wide inconsistencies in policies for determining legal sex illustrate, sex determination is not obvious or unambiguous. Legal standards and policies are based on an assumption that sex categorizations are stable and methodological; this is not borne out in practice, even when reinforced through medical treatment.[176] While eliminating legal sex categorization altogether would eliminate the need to establish a principled way to distinguish between the sexes, such a possibility is unlikely given the prevalence of categorization in all aspects of life and the illegality of same-sex marriage in a majority of states.[177] As an alternative to eliminating sex categorization entirely, one might alleviate some of the problems with the medical model by reducing the importance of sex categorization in daily life.

The importance of sex categorization could be reduced through a number of possible methods. One could apply an "opt-in" system where legal sex is determined only when

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of the Quagmire: Unconstitutional Conditions and Contract Theory, 33 FLA. ST. U. L. REV. 913 (2006); Seth F. Kreimer, *Allocational Sanctions: The Problem of Negative Rights in a Positive State*, 132 U. PA. L. REV. 1293 (1984); Sullivan, *supra* note 160; Charles R. Bogle, Note, *"Unconscionable" Conditions: A Contractual Analysis of Conditions on Public Assistance Benefits*, 94 COLUM. L. REV. 193 (1994).

176 *See* Spade, *Documenting Gender*, *supra* note 2, at 802.

177 *Where State Laws Stand*, FREEDOM TO MARRY (Dec. 20, 2013), http://www.freedomtomarry.org/pages/where-state-laws-stand. Same-sex marriage is also permitted in the District of Columbia. *Id.*

it becomes necessary, such as when the individual seeks a marriage license.[178] One could also assign sex at a set point in life later than birth, such as when an individual turns eighteen.[179] The importance of sex classifications could also be minimized by removing sex from identification documents, like passports and driver's licenses, where the designation does not provide much assistance in identifying the individual.[180] While there may be some benefit to tracking the apparent birth sex of infants, it does not necessarily follow that sex must be recorded on individual birth certificates.[181] Some states already provide short-form birth certificates that do not include sex; it is reasonable to assume that, for most purposes for which the birth certificate is used, sex is irrelevant.[182] Gender nonconformity becomes less obvious under such policies, and some of the discrimination against the trans community may be eliminated. Such a system would also benefit those whose gender identity does not neatly conform to "male" or "female." However, unless virtually all sex categorizations are eliminated for all purposes, there must be some manner of distinguishing between the sexes.

B. Changing the Medical Requirements for Reclassification Does Not Eliminate the Possibility of Coercing or Manipulating Consent

If sex categorization cannot be eliminated, one might instead try to change the requirements for reclassification to avoid the problems posed by the medical model. For example, the New York Department of Health considered a proposal that would allow birth certificate amendment when the applicant was able to present medical evidence that his or her gender transition was complete and that he or she intended to live permanently in the "new" gender.[183] The new proposal, unlike current law, did not require evidence of a specific surgery.[184] This sort of solution, while attractive as an incremental step to reducing barriers to reclassification, nonetheless continues to implicate the voluntariness requirement of informed consent. Practically speaking, such a proposal would expand the number of possible medical procedures sufficient for reclassification and thereby increase

178 *See* Newlin, *supra* note 17, at 486.

179 *See id.* at 485–86.

180 *See* Greenberg, *Defining Male and Female*, *supra* note 2, at 317.

181 *See* Spade, *Documenting Gender*, *supra* note 2, at 807.

182 *Id.*

183 Wenstrom, *supra* note 142, at 143.

184 *Id.*

the number of ways in which a trans person may obtain the legal benefits of reclassification. However, this proposal still requires medical intervention and thus still may coerce or manipulate consent.

Changing medical requirements for reclassification does not materially change the balance between state and individual interests. Any medical treatment required for reclassification has the potential to coerce or manipulate consent to the specified procedure. Even a minor treatment may not be medically advisable, desired, or in the best interests of the patient. On balance, when the treatment imposes a less severe burden and yields the same benefits, consent is more likely to be coerced or manipulated and less likely to be autonomous. The liberty interest and governmental interests are unchanged. While the actual physical intrusion into autonomy may be less severe, the balance between individual and state interests is not altered. Without an interest as profound as protecting life or public safety, the right to refuse treatment cannot be superseded.[185] Thus, changing the medical requirements for reclassification does not present a remedy consistent with bioethical principles and norms.

C. The Bioethical and Practical Advantages of Adopting a System of Categorization Based on Lived Gender

If changing the medical requirements for reclassification does not provide a viable solution to the bioethical problems inherent in the medical model, reclassification must be based on something other than medical treatment. A system that allows for categorization based on lived gender—the gender that an individual expresses in day-to-day life—would provide such a solution. Reclassification based on lived gender would enable sex reclassification without requiring a medical procedure or diagnosis. Provided that adequate safeguards are in place, the governmental policy concerns justifying the medical model will not be implicated. Adopting a model of self-identification does not mean that legal sex should be able to be changed on a whim or for fraudulent purposes; rather, it allows greater access to reclassification without running into the ethical concerns implicated when medical treatment is required.

The United Kingdom's Gender Recognition Act (GRA), passed in 2004, provides some guidance in adopting a system without a medical procedure.[186] The GRA allowed legal sex to be changed upon application to a panel consisting of at least one medical and one

185 *See supra* notes 154–56 and accompanying text.

186 Gender Recognition Act, 2004, c. 7 (U.K.).

legal expert.[187] Gender must be changed upon a showing that the applicant: (1) has gender identity disorder; (2) has lived two years in the acquired gender; and (3) intends to live in that gender until death.[188] This system sets up a panel of experts as a gatekeeper. Adopting a similar gatekeeper system would address the governmental concerns underlying the medical model as the gatekeeper would be able to screen out those seeking reclassification for fraudulent purposes. A significant waiting period would also reduce the possibility that an individual would seek sex reclassification for illicit purposes.

While the GRA is notable in that it explicitly does not require applicants to undergo medical treatment before reclassification,[189] it still conceptualizes gender in terms of the gender dysphoria medical narrative. There are advantages, such as reducing fraud, in having an established gatekeeper apply a medical framework to people applying for a change in legal sex. However, inherent in such a system is the belief that gender identity can *only* be understood through a medical framework. Ultimately, this framework does not track the actual experiences of trans people.[190] Trans people whose experiences do not conform to a standard narrative of gender dysphoria will still find themselves excluded from the protections offered through reclassification. Perhaps most problematically, such a system does not completely eliminate the major flaw of the American medical model as it still requires people to submit to medical testing that may be unneeded and unwanted. Even obtaining a diagnosis will be financially impossible for some people in the United States. A system that allows for gender reclassification based solely on lived identity would alleviate many of these concerns. Such a system would allow an individual to seek gender-confirming healthcare, but would not require any sort of medical procedure, even psychiatric evaluation, to diagnose gender dysphoria. Reasonable barriers to reclassification, like waiting periods, may be imposed to address governmental concerns. For example, the state might require an individual to live in his or her expressed gender for a period of at least a year before legal sex can be changed. This would deter those who seek to change gender to escape creditors or law enforcement. Such a waiting period would also deter those seeking reclassification solely to enter into an illegal same-sex union. The possibility of someone whose gender

187 *Id.* § 1(4).

188 *Id.* § 2(1). The GRA also provided for recognition based on a change of legal sex in a country with similar or stricter standards. *Id.* § 2(2).

189 The lack of medical requirement reflects a concern about the ability of some trans people to access medical treatment, due to medical concerns or a lack of insurance coverage. JOINT COMMITTEE ON HUMAN RIGHTS, NINETEENTH REPORT OF SESSION 2002–03 (DRAFT GENDER RECOGNITION BILL), 2002–03, H.L. 188-I, H.C. 1276-I, at 13, *available at* http://www.publications.parliament.uk/pa/jt200203/jtselect/jtrights/188/188.pdf.

190 *See supra* Part I.D.

identity conforms to assigned sex living in the opposite gender on a permanent basis solely to enter into a same-sex marriage is remote.[191]

A system of self-identification also comports with the principles proposed by ICATH, a recognized medical standard of care that promotes overall health and autonomy for transgender people.[192] ICATH adopts a model that departs from a system that relies on gender dysphoria as a means for accessing gender-confirming healthcare by not requiring trans people to attend therapy prior to receiving treatment.[193] Trans people—not therapists—are thus empowered to decide what procedures are best for themselves and their bodies. A requirement that an individual "live" in his or her expressed gender is an achievable standard for most trans people and enables reclassification without forcing trans people to pathologize gender identity as a "condition" to be cured. A waiting period is not a cure-all for every governmental concern. However, placing reasonable, non-medically based barriers to legal transition provides a solution that is narrowly tailored and does not violate bioethical norms or constitutional concerns.

A system based on self-identification still excludes those whose gender identity does not conform to "male" or "female." In maintaining gender classifications, even a model of self-identification reinforces the gender binary by forcing an individual to choose "male" or "female" and live in that identity on a permanent basis. However, there is no obvious solution to this problem without eliminating gender classifications altogether. Given the prevalence of gender designations in legislation and the refusal to allow same-sex marriage in a majority of states, the elimination of sex categorization altogether is unrealistic. Adopting a system that permits reclassification based on self-identification expressed through lived gender would avoid many of the problems identified in Parts I and II while giving weight to governmental concerns. Thus, while requiring an individual to express gender in a recognized manner limits the choices available to trans people, it does so in a manner that will not coerce or manipulate trans people into obtaining unneeded and unwanted medical treatment.

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191 *See* Greenberg, *Defining Male and Female*, *supra* note 2, at 307–08.

192 ICATH, http://www.icath.org/ (last visited Apr. 16, 2014).

193 *Id.*

CONCLUSION

The medical model should be abandoned as an violation of bioethical principles and the doctrine of informed consent. As the numerous variations of requirements for reclassification suggest, there is no one way to determine legal sex. Requiring medical intervention to alter legal sex has done nothing to address this problem and has instead privileged those wealthy enough to obtain a diagnosis of gender dysphoria and afford surgical intervention. Linking legal benefits to medical intervention only exacerabates this problem, and emphasizes the inequality inherent in the medical model. Moreover, in requiring specific medical procedures, the medical model acts in direct violation of bioethical norms by failing to respect the autonomy of trans people to choose what medical intervention, if any, is needed to express gender identity and by requiring medical procedures that may not be in the best interests of a patient.

Linking legal rights and benefits to surgery has the potential to coerce and manipulate trans people into consenting to a medical treatment that is unneeded and unwanted. The medical model does not serve any state interest sufficiently compelling to justify such extreme interference with the individual right to consent to or refuse medical treatment. In light of these serious ethical and constitutional concerns, the medical model should be discarded as the tool for establishing when legal sex has been changed. Alternative proposals, such as changing the medical requirements for reclassification or reducing the prevalence of gender categorization in day-to-day life, would help many trans people, but do not address the bioethical concerns inherent in a system that provides benefits on the basis of surgery. Though not perfect, a system that permits reclassification based on self-identification and lived gender should be adopted, as it does not implicate the bioethical concerns raised by the medical model.