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Medicalized versus Humanized: The Human Rights Concerns of Medical and Legal Transition in the United States

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Transgender individuals currently face significant discrimination in the United States' healthcare system. Despite the known benefits of medical transition, numerous access barriers to transition-related care remain prevalent, including policy barriers, financial barriers, physical barriers, and psychological barriers. Additionally, differing models of care for providing transition-related treatment contribute to the systemic discrimination of transgender individuals. As the legal transition process in the United States is widely dependent on access to transition-related medical care, access barriers to care thus negatively impact many other areas of transgender individuals' lives, contributing to discrimination in sectors such as employment and housing. The high rates of discrimination against transgender people in these sectors and the inaccessibility of heath care for them in the United States warrants examination of whether U.S. is upholding the right to health, right to work, and right to housing for its transgender population. Ultimately, the current medical and legal transition processes and the intersection of these processes present clear violations of all three rights. It is urgent that these violations are addressed to protect the health and well-being of transgender individuals in the United States.

Transgender individuals – people whose internal sense of gender differs from their gender assigned at birth, including both binary and non-binary gender identities – have historically faced discrimination and violence due to their transgender status. While acceptance and knowledge of transgender identities and experiences has increased in recent years, transgender individuals continue to face significant discrimination, including systemic discrimination. One of the most prominent examples of this is the healthcare system in the United States.

Transition-related health care first began emerging in the U.S. around the 1950s. During this time, most physicians who worked with transgender individuals viewed transgender identities as psychiatric conditions which needed to be cured. One primary physician during this time that helped shape the current approach to transition-related care in the U.S. was David O. Cauldwell, who argued

that transgender individuals "were mentally ill and considered surgery…to be mutilation and a criminal action" (Beemyn, 2014, p. 12). While some physicians – most notably Harry Benjamin, who believed psychotherapy treatments to change transgender individuals' gender identities were "a useless undertaking" (Benjamin, 1966, p. 53) – opposed Cauldwell's view, the vast majority did not. Remnants of Cauldwell's beliefs regarding transgender identities and how physicians should approach transition-related care are still seen today, both through societal opinions of transgender identities and experiences and through structures and policies regarding transition-related care.

Although transition-related care and the American healthcare system as a whole has unequivocally progressed since the 1950s, several significant concerns related to transgender individuals remain. First, there are a plethora of barriers impacting transgender people's ability to access health care, both for transition-related care and general care. While these access barriers are detrimental to transgender individuals on their own, their impacts are further complicated by the connection between the medical and legal transition processes in the U.S. Throughout most of the U.S., some degree of medical proof of receiving transition-related care remains a requirement for changing one's gender marker on identification documents. Therefore, access barriers to medical transition likewise function as access barriers to legal transition. Next, existing requirements for transgender people to first receive mental health care and/or a diagnosis of gender dysphoria to receive transition-related physical health treatments, such as but not limited to hormone replacement therapy (HRT) and gender-affirming surgeries, reinforce Cauldwell's belief that transgender identities are mental health conditions. The continued prevalence of this belief reinforces many justifications for gender-identity-based discrimination. Lastly, the immense increase in proposed anti-trans legislation throughout the country – targeting transgender people's access to transition-related healthcare, especially prominent against transgender youths, access to use of public or school restrooms, excluding transgender individuals from athletics, restricting their ability to change identification documents, and more (Freedom for All Americans, n.d.) – recontextualizes these issues and makes their immediate address imperative.

This paper seeks to provide a rights-based approach to understanding and addressing the challenges faced by transgender individuals in the U.S. within the medical and legal transition processes and the intersection of these processes. Throughout, medical transition refers to the process in which a transgender individual seeks medical care (such as but not limited to HRT and gender affirmation surgeries) to bring about physical changes to their primary and/or secondary sex characteristics to further align these characteristics with their gender identity. Legal transition refers solely to the process of legally changing one's gender marker on identification documents. An overview of the human rights

framework will first be discussed with a focus on the right to health and its significance in understanding the current medical transition process in the U.S. Then the medical transition process, including barriers transgender individuals face in accessing healthcare and the differing models of transition-related care, will be examined, followed by the legal transition process and the intersection of these processes. In examining both processes individually and through their intersection, several rights concerns arise: the U.S. is in violation of the right to health, the right to work, and the right to housing for its transgender population. The urgent and complete address of these violations is critical for the health and well-being of transgender individuals in the U.S.

Human Rights Framework

The significance of healthcare being inaccessible to transgender individuals and the intersection of the medical and legal transition processes in the U.S. can best be understood through a human rights framework. However, rights-based approaches for addressing these issues are lacking in the current literature. Medical care and access to health insurance is widely viewed as an individual responsibility in the U.S., and much of the research done on these issues adheres to this individual approach, focusing solutions on the actions of individual healthcare providers or institutions. The human rights perspective, conversely, serves as a much-needed reminder that the State is the guarantor of all human rights. Thus the U.S. government, not individuals living within the U.S., holds responsibility for upholding and maintaining the right to health through ensuring healthcare is accessible to all U.S. citizens.

The right to health was originally established in 1948 by the United Nations in the Universal Declaration of Human Rights (UDHR). Article 25.1 of the UDHR reads "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services" (UN General Assembly, 1948). Though the UDHR is not a legally binding agreement, several other documents expand upon and establish this principle in international human rights law. The most notable is Article 12.1 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN General Assembly, 1966). The phrase "highest attainable standard" is significant here as it distinguishes the right to health from the ideal for all people to be healthy, and takes into account various economic, political, or other factors that contribute to disparities between the standards of health across countries. This phrase is likewise significant for the conversation of transgender healthcare in the U.S. Even if one were to argue that the highest standard of health for transgender individuals was being provided somewhere within

the U.S., which in itself would be a difficult argument to make, the multitudes of disparities between healthcare quality and accessibility for transgender individuals throughout the U.S. shows that the government as a whole, as the guarantor of human rights, is not upholding the highest attainable standard of health for its transgender populations.

To further break down the “highest attainable standard,” the UN Committee on Economic, Social, and Cultural Rights (2000) explains in General Comment 14, section 12, that “the right to health in all its forms and at all levels contains the following interrelated and essential elements,” which are availability, accessibility, acceptability, and quality. None of these elements are currently met in full for transgender individuals seeking medical care in the U.S., most significantly in terms of transition-related care but for general care as well. Starting with availability, section 12a of General Comment 14 explains that “functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party” (UN Committee on Economic, Social, and Cultural Rights, 2000). While the U.S. does not majorly lack in general healthcare facilities, there is a lack of healthcare facilities, programs, and providers that are informed of transgender individuals’ distinct healthcare needs and that provide transition-related care.

Next, healthcare services must be “accessible to everyone without discrimination” (UN Committee on Economic, Social, and Cultural Rights, 2000, par. 12b). Accessibility is further broken down by the following components: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility. The current approach to transgender healthcare in the U.S. fails at accessibility in nearly all of these ways.

The third element, acceptability, explains that “all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, [and] sensitive to gender and life-cycle requirements” (UN Committee on Economic, Social, and Cultural Rights, 2000, par. 12c). While transgender people do not have a unified culture, they are unequivocally a targeted minority group. Furthermore, many transgender individuals, including transgender individuals whose gender identity aligns with the gender binary, conceptualize their gender as distinct from cisnormative male and female genders. Therefore, it is necessary that transgender identities be included in the “sensitive to gender” requirement for healthcare acceptability.

The final element, quality, requires “skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation” (UN Committee on Economic, Social, and Cultural Rights, 2000, par. 12d). This relates to the issue of

transgender care within the U.S. in its requirement of "skilled medical personnel," as many healthcare providers are uninformed, and therefore lacking skill, in transition-related care. Furthermore, discrimination against transgender individuals, including healthcare providers refusing services to transgender patients, creates a discrepancy in healthcare providers who are otherwise capable and skilled in providing care being unwilling to provide such care to transgender individuals.

Nearly all of the concerns relating to the violation of the right to health for transgender individuals and subsequent human rights concerns stemming from the intersection of the medical and legal transition processes, such as concerns relating to the right to work and the right to housing, can be further understood as violations of the principle of non-discrimination. The principle of non-discrimination has been well-established in international human rights law. It first appears in Article 2 of the UDHR, which states "everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (UN General Assembly, 1948). Article 2 of the ICESCR mirrors this language nearly exactly, stating that "the rights enunciated in the present Covenant will be exercised without discrimination of any kind" with the same following list (UN General Assembly, 1966). Although interpretations of US non-discrimination laws – such as Title VII of the 1964 Civil Rights Act, which prohibits employment discrimination on the basis of sex, and Title IX of the Education Amendments of 1972, which prohibits education discrimination on the basis of sex – have yet to come to a final consensus on if transgender individuals are protected by the basis of sex (American Civil Liberties Union, 2022), the phrasing of these articles ensures no doubt of transgender people's inclusion. The phrases "such as," "other status," and "of any kind," all work to ensure that transgender people are included as a protected group, regardless of if one believes transgender people are included in non-discrimination laws on the basis of sex. Therefore, the human rights perspective unequivocally calls for the protection of transgender people against discrimination.

The principle of non-discrimination is thus essential for understanding and addressing both the healthcare and legal transition barriers transgender individuals currently face and the human rights violations against transgender people present in the United States' healthcare and legal systems.

Medical Transition in the U.S.

Before addressing the many concerns of the current system of medical transition in the U.S., it is important to acknowledge that the current literature overwhelmingly supports that transitioning, through social, medical, and legal means, improves the overall well-being of transgender individuals'

lives. In particular, the process of medical transition has been proved to be a medically beneficial practice. A literature review conducted by Cornell University found that transgender individuals who transitioned and received transition-related medical care experienced “improved quality of life, greater relationship satisfaction, higher self-esteem and confidence, and reductions in anxiety, depression, suicidality, and substance use” (What We Know Project, 2018). These findings can thus be broken down into two groups: mental health benefits and social health benefits.

Many trans-rights activists and transgender individuals themselves are already acutely aware of the alarming statistics regarding transgender suicide rates. Findings such as the statistics that over a third of transgender high school students attempt suicide in a year (Johns et al., 2019) and the “rate of suicidal thoughts and attempts [among transgender youths] was at least three times higher than that of the general youth population” (Harvard Law Review, 2021, p. 2168) are prevalent in the literature. However, it is critical to not view these statistics as intrinsic aspects of the transgender experience. With social support and medical intervention, these statistics change dramatically. For instance, a study looking the psychological function of transgender adolescents before and after receiving transition-related medical care found comparable psychological functioning to cisgender peers after receiving treatment (de Vries et al., 2014). Additionally, The Trevor Project (2021), in their most recent National Survey on LGBTQ Youth Mental Health, reported that “transgender and nonbinary youth who reported having pronouns respected by all of the people they lived with attempted suicide at half the rate of those who did not have their pronouns respected by anyone with whom they lived.” These finding thus stress the importance of support and access to transition-related health care for transgender individuals.

Additionally, medically transitioning has been shown to improve transgender individuals’ social health. While part of this improvement (such as increased self-image or self-confidence) intersects with improved mental health, there are likewise distinct social health benefits to medically transitioning. For example, one article notes that medical transition aids in “reducing the hardships of navigating…social relationships while presenting as a gender with which [one does] not identify,” and concludes that this leads transgender individuals with access to transition-related health care to be more “socially well-adjusted than their nontransitioned peers” (Harvard Law Review, 2021, p. 2170). Therefore, access to transition-related health care is medically beneficial for transgender individuals’ mental and social health. It is also significant to note that regret around medically transitioning is extremely rare. Studies have found regret rates range from as low as 0.3% up to only 3.8% (What We Know Project, 2018). The primary reasons for regret include lack of social support and poor surgical outcomes (What We Know

Project, 2018). Considering this, concerns of future regret are not substantial reasons to bar access to transition-related health care, especially when paired with the immense benefits medical transition can bring to transgender individuals.

Current Barriers to Healthcare Access

Despite the benefits of medical transition, a multitude of accessibility barriers continue to exist for transgender individuals seeking medical care in the United States. While these barriers impact access to both transition-related care and general medical care, this paper will focus primarily on access barriers to transition-related care. These barriers can be divided into four main categories: inconsistencies in policy and legislation; financial barriers, including inconsistencies in insurance coverage; physical barriers, including distance and time; and psychological barriers, including a lack of trust in healthcare providers and fear of discrimination. Each of these barriers contributes to the violation of the right to health against transgender individuals in the U.S.

Currently, a national policy regarding transition-related health care does not exist. This means that access to specific procedures is greatly dependent on one's location, both at a state and regional level. Additionally, as healthcare in the U.S. is widely privatized, it is difficult to find accurate information on all policies that may be negatively impacting transgender people's ability to access transition-related care.

One federal program that can be looked to as an indicator of transition-related care accessibility is Medicaid, which provides insurance coverage to individuals whose income falls below state-dependent thresholds. While Medicaid is both federally and state-funded, the specific elements of transition-related care covered by Medicaid vary between states. Thus, Medicaid works both as an indicator of overall transition-related care accessibility and as an indicator of inconsistencies in accessibility. Kempf et al. (2021) analyzed the coverage of transition-related care treatments across 15 selected states. Of the treatments they examined, they found that "coverage for hormone medications and surgeries, regardless of type, varied the most" whereas a "near universal access to primary care, preventative care, and mental health services" was present (p. 98-99). This shows a clear disparity in one's ability to access transition-related care throughout the U.S., as the cost of care for those without health insurance coverage "could total between $15,000 for transgender men and $26,000 for transgender women who receive [gender-affirming surgeries]" (Koch et al., 2020, p. 111). Most working-class Americans, including those who would be eligible for Medicaid, would not be able to afford these procedures out-of-pocket. Thus, the inconsistencies between state policies, due to a lack of federal

policy regarding minimum required access to transition-related health care, creates many further barriers to healthcare access for transgender individuals.

These disparities in coverage for transition-related care in one of the few government-funded healthcare programs in the U.S. raises concerns regarding the element of availability for the right to health. Although Medicaid itself may be sufficiently available to all who meet its income requirements, transition-specific care is unequivocally not sufficiently available through this program, and no other government-funded programs currently exist to fill that gap. The disparities in coverage for transition-related care specifically likewise presents as a form of discrimination against transgender individuals. Throughout the U.S., there is greater availability and coverage of services for cisgender individuals and/or those seeking non-transition-related care. The lack of a national policy establishing a minimum coverage for transition-related care services in Medicaid allows this discrimination against transgender individuals to continue and contributes to the violation of the right to health.

As noted, the cost of gender-affirming surgeries without insurance coverage is significantly higher than most could afford. As the U.S. does not currently have a universal healthcare system, the cost of transition-related care and inconsistencies in insurance coverage, or a lack of insurance coverage altogether, creates significant financial barriers for transgender individuals seeking medical transition. De Santis et al. (2020) found that even when participants had health insurance, transition-related care was not consistently covered. One of their study participants noted "I couldn't find a therapist that specialized in transition (care) that took Medicare or Medicaid, and I had no money to pay for anyone on a regular basis…I could maybe get in one visit" (quoted in De Santis et al., 2020, p. 933). Another participant explained that "the access to care is, is extremely difficult, but [gaps in health insurance coverage] is another thing" (quoted De Santis et al., 2020, p. 932). Pratt-Chapman et al. likewise found that "out of pocket costs were a deterrent to healthcare seeking" for transgender patients (2021, p. 5). Therefore, costs of transition-related care and inconsistencies in insurance coverage create major accessibility barriers to transition-related health care.

These financial barriers directly violate the element of accessibility, specifically economic accessibility, for the right to health. The element of economic accessibility calls for governments to ensure that health care services "are affordable for all, including socially disadvantaged groups" (UN Committee on Economic, Social, and Cultural Rights, 2000, par. 12b). The U.S. is not ensuring affordable health care services for transgender people; transgender individuals not only lack access to health insurance, but those with insurance or who receive health care coverage through Medicaid still lack coverage for transition-related care. This leads many transgender individuals with health insurance

paying out-of-pocket costs for transition-related care or foregoing care altogether. Additionally, the element of accessibility for the right to health explains that care “must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination” (UN Committee on Economic, Social, and Cultural Rights, 2000, para. 12b). Transgender people, a historically marginalized and discriminated against group, neither receive accessible health care in the U.S. in law or fact, which serves only as further discrimination.

Next, several physical barriers to healthcare access were noted in the literature. De Santis et al. (2020) describe these types of barriers as “fragmented healthcare services,” explaining that “fragmentation of healthcare services required participants to receive primary care with one provider, gender-affirming medical interventions with another provider, and mental health-related services with a different provider” (p. 933). These fragmented services increase one’s time commitment to receiving health care services and can also impact the physical distance one must travel to obtain accessible services. De Santis et al. (2020) note that one participant, whose health insurance did not cover mental health services, “had to travel to another county where free services could be obtained” (p. 933). These physical barriers raise additional concerns relating to the element of accessibility for the right to health as the element of accessibility states that “health facilities, goods and services must be within safe physical reach for all sections of the population” (UN Committee on Economic, Social, and Cultural Rights, 2000, par. 12b). While there may more generally be health facilities or services within a transgender individual’s physical reach, many transgender individuals, much like the individual in De Santis et al.’s (2020) study, find that transition-related care services or physicians knowledgeable and willing to treat transgender individuals are not within the physical distance they would otherwise travel to receive care.

Additional time barriers occur through both the time needed to wait to receive transition-related care and in the time needed to recover from care. Koch et al. (2020) note that “some surgeons will require six months of psychotherapy services prior to surgery, especially if the patient is not taking HRT” (p. 112). Furthermore, the recommended recovery time for many gender-affirming surgeries is around six weeks (Bandoim, 2021). During this time, the person recovering will be extremely limited in their ability to work, and most likely will not be working at all; additionally, one or more supporting persons will need to aid the person recovering, which may then limit their ability to work. These time commitments then intersect with financial concerns for seeking transition-related care, further adding to the concerns of accessibility for the right to health.

Last, a multitude of psychological barriers to healthcare access were identified in the literature. These barriers impact both general healthcare access and transition-related care access. One major psychological barrier is a lack of trust in healthcare providers. A participant in Pratt-Chapman et al.'s (2021) study, a 45-year-old transgender man, stated that "[healthcare providers] have to know what a trans person is…basically every trans person becomes their own expert because more often than not…we have to do a lot of front end explaining" (p. 6). Here, the participant shows a lack of trust that healthcare providers will be informed about transgender patients and explains the difficulties of self-advocacy when providers are not competent in caring for transgender patients. A participant from De Santis et al.'s (2020) study reinforces this idea, saying that "you need to trust them because this is basically your life, your transition. If you don't trust them, you really don't have much of a choice because there are not many more [competent providers] that you can go to" (p. 931). Adding to the importance of provider trust is transgender individuals' fear of discrimination when seeking medical care. One participant recounted their experiences facing healthcare discrimination due to their transgender identity, saying:

> They [healthcare providers] just said that they don't deal with transgenders. If you try and pin them down, they'll tell you that they're not qualified, they don't have the knowledge. They don't have the training. Um, but, you know, from the tone of their voice, you, you can't help but feel that, you know, that that they just…don't want to get involved…I don't think they want to provide the care… They go out of their way not to be helpful in any way, shape or [form] (quoted in De Santis et al., 2020, p. 933).

Experience such as this reinforce a lack of trust in healthcare providers, restrict transgender individuals' access to care, and create a healthcare environment in which transgender individuals are hesitant or unwilling to seek out care, even if it is accessible to them.

As the benefits of medical transition have been well-established, reducing the multitude of barriers to healthcare access for transgender individuals is critical for the overall health and well-being of transgender people. Furthermore, given the immense fear of discrimination in healthcare settings among transgender individuals, the highly personal nature of a transgender individual seeking transition-related care, and the historical and current discrimination against transgender individuals still present in the U.S. healthcare system, it is imperative that the US government address these rights concerns and violations regarding the right to health for transgender individuals. In doing so, the principle of non-discrimination must be upheld to the fullest extent.

Models of Care

Further concerns arise in the current models of transition-related care. Two primary models for providing transition-related care are present: the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) model and the informed consent model. Much of the literature supports the WPATH SOC; however, a critical examination of each model is warranted as transition-related care is one of the extreme few types of care that deviates from the informed consent model in the US (Lipshie-Williams, 2020, p. 394). This deviation in care models for transition-related care thus has several negative implications.

The most notable distinction between these two models is that the SOC model upholds the requirement for transgender individuals to have documented mental health evaluations prior to receiving transition-related care (Lipshie-Williams, 2020, p. 395). This requirement is partially treatment-dependent, as "one form of documentation…is required for chest surgeries and two forms for genital surgeries," while documentation for HRT is "recommended," but not required (Lipshie-Williams, 2020, p. 395). However, a recommendation of mental health assessments prior to transition-related care to any degree is problematic. First, this recommendation reinforces the harmful belief that one's transgender identity is a mental illness. This belief has historically been used to ostracize and discriminate against transgender people. When considered with the discrimination transgender individuals currently face when seeking healthcare, and that fear of discrimination is a major barrier to transgender individuals' willingness to seek care, the SOC model should be rejected. Additionally, mental health assessment requirements and recommendations continue to enforce the diagnosis of gender dysphoria, which both continues the stigmatization of transgender identities and reinforces a narrative of the trans experience focused solely on the negative. Transgender individuals instead are increasingly creating narratives of the trans experience focused on gender euphoria – the positive and affirming feelings one has when living as and being seen as their true gender identity (Beischel et al., 2021). Therefore, the upholding of the WPATH SOC must be reconsidered.

The informed consent model, however, moves away from harmful perceptions of the trans experience and instead recognizes transgender individuals' capability and autonomy in making their own informed medical decisions. Lipshie-Williams (2020) explains that the informed consent model "tasks physicians with appropriately explaining risks and benefits of care to their patients in order to enable patients to make the best possible decisions for themselves." In this model, a transgender patient does not first need to receive care from a mental health provider before receiving transition-related care. This not only destigmatizes transgender identities, but also works to reduce financial and

physical barriers to care access. Additionally, an adoption of the informed consent model for transition-related care can work to normalize both the trans experience and transition-related care for physicians, as this model of care is nearly universally used in the US for adults "who are able to consent to all other aspects of their own care" (Lipshie-Williams, 2020, p. 394). As physicians then already use the informed consent model with transgender adults seeking non-transition-related care, the deviation of the informed consent model solely for transition-related care is unwarranted.

Considering again the principle of non-discrimination and the significance in upholding this principle for transgender individuals, the right-based approach thus supports the informed consent model for transition-related care, despite the overwhelming support of the WPATH SOC model in the current literature.

Legal Transition in the U.S.

Next, it is critical to understand the legal transition process in the United States. Many primary identification documents, such as drivers' licenses and birth certificates, are issued at the state-level, and thus the process for changing information on these documents is state-dependent. However, a common requirement for changing one's gender marker on these documents is proof of undergoing medical transition (Harvard Law Review, 2021; National Center for Transgender Equality, 2022). Table 1 breaks down the various requirements to legally change one's gender marker on state-issued IDs in all 50 states and the District of Columbia (D.C.), focusing specifically on the relationship between the medical and legal transition processes. Table 2 does the same for birth certificates. Note that all information for both Table 1 and Table 2 was sourced from the National Center for Transgender Equality (2022).

Table 1

Requirements for Changing One's Gender Marker on State Issued IDs by State

A Letter or Designation Form Signed by a Licensed Healthcare Provider	Proof of Gender-affirming Surgery	No Medical Requirements	A Court Order, which may or may not contain a medical requirement	Unclear Requirements
Alaska	Georgia	Arkansas	South Carolina	Alabama
Arizona	Oklahoma	California	Texas	
Colorado (minors)		Colorado (adults)	Utah	
Delaware		Connecticut		
Florida		D.C.		
Hawai'i		Illinois		
Idaho		Maine		
Indiana		Maryland		
Iowa		Massachusetts		
Kansas		Michigan		
Kentucky		Minnesota		
Louisiana		Nevada		
Mississippi		New Jersey		
Missouri		New Mexico		
Montana		Oregon		
Nebraska		Pennsylvania		
New Hampshire		Rhode Island		
New York		Vermont		
North Carolina		Virginia		
North Dakota		Washington		
Ohio				
South Dakota				
Tennessee				

A Letter or Designation Form Signed by a Licensed Healthcare Provider	Proof of Gender-affirming Surgery	No Medical Requirements	A Court Order, which may or may not contain a medical requirement	Unclear Requirements
West Virginia Wisconsin Wyoming				

Table 2

Requirements for Changing One's Gender Marker on Birth Certificates by State

A Letter or Designation Form Signed by a Licensed Healthcare Provider	Proof of Gender-affirming Surgery	No Medical Requirements	A Court Order, which may or may not contain a medical requirement	Gender Marker Changes Prohibited
Alaska Arizona Colorado (minors) Connecticut Delaware D.C. Florida Hawai'i Illinois Iowa Kansas	Alabama Arkansas Georgia Louisiana Mississippi Missouri Nebraska New Hampshire North Carolina Wisconsin Wyoming	California Colorado (adults) Idaho Michigan Montana Nevada New Jersey New Mexico New York Oregon Washington	Indiana Ohio Oklahoma South Carolina South Dakota Texas Utah Virginia West Virginia	Tennessee

A Letter or Designation Form Signed by a Licensed Healthcare Provider	Proof of Gender-affirming Surgery	No Medical Requirements	A Court Order, which may or may not contain a medical requirement	Gender Marker Changes Prohibited
Kentucky Maine Maryland Massachusetts Minnesota North Dakota Pennsylvania Rhode Island Vermont				

In analyzing each state's requirements for both document types, several notable findings emerge. First, only eight states (15.69%) explicitly do not require proof of medical transition to change the gender marker on both an individual's state ID and birth certificate. This means that the legal transition process in the remaining 42 states and DC (84.31%) is in some way dependent on a transgender individual first obtaining transition-related medical care. Next, nine states (17.65%), excluding minors in Colorado, require either a letter or Gender Designation Change Request Form (called Sex Designation forms in some states) signed by a licensed physician or social worker to change the gender marker on both state IDs and birth certificates. Only one state (1.96%), Georgia, requires proof of gender-affirming surgery for one to change their gender marker on both their state ID and birth certificate.

Another interesting finding is that, overall, there are greater medical requirements to change a gender marker on birth certificates than on state IDs. Eight of the states that require proof of gender-affirming surgery to change the gender marker on a birth certificate only require a letter or form signed by a physician to make the same change on state IDs, and 10 of the states that require a letter or form

signed by a physician to change a birth certificate have no medical requirements for changing one's gender marker on state IDs.

Additionally, when comparing these findings to the findings of Kempf et al.'s (2021) study, a correlation between the level of access to transition-related care and the degree of medical requirements needed to legally transition emerges. Of the five states in Kempf et al.'s (2021) group that explicitly *exclude* coverage for gender-affirming surgeries in their state Medicaid program (Alaska, Missouri, Ohio, Tennessee, Wyoming), all five require either a letter or physician's signature to change the gender marker on state IDs. Two states, Missouri and Wyoming, require proof of surgery to change the gender marker on birth certificates, whereas Alaska requires a letter or physician's signature, Ohio requires a court order, in which the court may or may not require proof of medical transition, and Tennessee prohibits the changing of a gender marker on birth certificates for any reason. Conversely, of the five states in Kempf et al.'s (2021) explicitly *including* group (California, Illinois, Michigan, New York, Pennsylvania), two states, California and Michigan, have no medical requirements to change either document type, whereas New York requires only a letter or physician's signature to change the gender marker on state IDs and Illinois and Pennsylvania require a letter or physician's signature to change the gender marker on birth certificates. As cost of transition-related care is a major access barrier, and as lower-income transgender individuals are those greatest effected by a lack of coverage for transition-related care in their state's Medicaid program, this correlation is concerning. A low-income transgender individual living in Wyoming, for example, will not only face more barriers to accessing transition-related medical care than a low-income transgender individual living in California, but will be completely unable to legally transition until they have accessed this care, whereas the transgender individual living in California can access legal means of transition completely apart from their medical transition.

Furthermore, the vast use of requiring at least one form of proof that a person has received transition-related medical care in order to change the gender marker on at least one type of identification document reinforces several harmful perceptions of transgender individuals. First, it reinforces the belief that being transgender is a medical or mental health condition. Next, it reinforces a belief that all transgender individuals desire a medical transition, or that an individual's transgender identity is not valid unless they have received or desire to receive transition-related medical care. Lastly, in centering medical proof as the primary criteria of one's transgender identity, gender dysphoria, or in a broader sense the negative aspects of the transgender experience, likewise becomes the primary perception of transgender identities and experiences, which, as previously discussed, is both problematic and inaccurately represents transgender lives. Thus, as proof of undergoing medical

transition to legally transition directly harms transgender individuals, it likewise creates many indirect means of harm through reinforcing negative and inaccurate perceptions of transgender individuals.

While the correlation between the medical and legal transition processes in the U.S. is unequivocally harmful to transgender individuals, perhaps the most significant finding is that there is no inherent reason for these medical requirements to exist within the legal transition process. Again, eight states (15.69%) have no medical requirements for changing one's gender marker on either document type, yet all of these states still have a functioning legal process for making this change. Furthermore, no medical requirements are currently in place to change a gender marker on a U.S. passport, a document that is issued at the federal level by the U.S. Department of State (U.S. Department of State, 2022). These established systems of legal transition without medical requirements then highlight that the use of medical requirements have no necessary legal function and are instead only in place to reinforce societal transphobia.

Access to legal transition, however, is imperative for transgender individuals. Inconsistent gender markers – whether inconsistent between identification documents, consistent between documents but inconsistent with one's gender identity or presentation, or gender markers that appear incongruent with one's legal name – all increase the probability of discrimination due to transgender status (Elias, 2019). Furthermore, one or more identification documents are needed to apply for and receive both employment and housing in the U.S. As the legal transition process in the U.S. is highly dependent on access to transition-related healthcare, accessibility barriers to healthcare then directly correlate with employment and housing discrimination faced by transgender individuals. This intersection of the medical and legal transition processes thus presents several subsequent human rights concerns in addition to the right to health: the right to work and the right to housing.

The right to work is most notably established in Article 6 of the ICESCR, which recognizes "the right to work," including "the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts," and explains that States "will take appropriate steps to safeguard this right" (UN General Assembly, 1966). However, transgender people in the U.S. face significant discrimination in employment. One study found that the unemployment rates for trans men and women are 15.5% and 15.6%, respectively; these rates differ strikingly from the unemployment rate for the general population, which at the time of the study was approximately 5% (Leppel, 2021). This significant difference in the unemployment rate for transgender individuals versus the general population suggests not only that transgender people are discriminated against in employment, but that transgender people are not able to fully choose their work "freely," as they are limited to employers willing to hire transgender

individuals. Additionally, the same study "did not find evidence that state-level employment non-discrimination laws are associated with improved employment outcomes for trans individuals" (Leppel, 2021). This suggests that the US has not taken the "appropriate steps to safeguard" the right to work for transgender individuals. Therefore, through allowing significant discrimination in employment against transgender individuals, the U.S. is violating the right to work for its transgender population.

While discrimination against transgender individuals in employment is significant in its own right, employment discrimination further impacts the inaccessibility of healthcare for transgender individuals. One of the primary means of accessing health insurance in the U.S. is through employment. Therefore, the higher unemployment rates of transgender individuals correlates with their high uninsured rates. While lack of access to transition-related care thus corresponds to a lack of access to legal transition which correlates with employment discrimination, employment discrimination likewise corresponds with access barriers to healthcare. Because all of these systems are so deeply intertwined in the U.S., it is incredibly difficult for transgender individuals to escape this cyclical discrimination.

This discrimination further impacts transgender individuals' right to housing. Article 11 of the ICESCR establishes the right to housing, stating that everyone has a right "to an adequate standard of living…including adequate food, clothing and housing, and to the continuous improvement of living conditions" (UN General Assembly, 1966). The UN Office of the High Commissioner for Human Rights (OHCHR) (2022) further explains that the right to housing contains the entitlement to "equal and non-discriminatory access" to housing. However, Kattari et al. (2016) write that 19% of transgender individuals were denied access to housing for which they had applied and an additional 11% of their study participants had been evicted from existing housing because of their gender identity. Furthermore, the Fair Housing Act notably does not include protection for sexual orientation and gender identity (Kattari et al., 2016). This leads transgender inclusion in housing non-discrimination laws to be state-dependent, which, as other state-level laws and policies regarding transgender people have proved, is problematic. Therefore, the U.S. is not ensuring that its transgender population has adequate "non-discriminatory access" to housing and is thus violating the right to housing for transgender individuals in addition to the rights to health and work.

Recommendations

Actions need to be taken to address the human rights violations associated both with the barriers transgender people face in accessing healthcare and with the intersection of the medical and legal transition processes in the U.S. Several recommendations have been identified. The

recommendations seek to first address healthcare access barriers and the violation of the right to health. Further recommendations then address the intersection of the medical and legal transition processes and subsequent rights violations stemming from that intersection.

The first recommendation calls for the complete removal of transgender identities and/or "gender dysphoria" from mental health diagnoses. The primary resource on mental health disorders used in the U.S. is the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), which currently defines "gender dysphoria" as "a marked incongruence between one's experienced/expressed gender and their assigned gender" (American Psychiatric Association, 2021). Although many transgender individuals experience gender dysphoria, gender dysphoria in itself is neither necessary for one to be transgender, nor is the defining characteristic of transgender identities and experiences. Additionally, there is international precedent for removing "gender dysphoria" or other diagnoses relating to transgender identities as mental health diagnoses within the US healthcare system. In May of 2019, the International Statistical Classification of Diseases and Related Health Problems (ICD) updated their diagnostic codes relating to transgender identities, removing "all trans-related diagnostic codes…from the chapter 'Mental and Behavioural Disorders'" while adding "gender incongruence" to the chapter "Conditions Related to Sexual Health" (Schwend, 2020). Furthermore, diagnosing "gender dysphoria" as a mental health condition contributes to the pathologization of transgender people and to the over-medicalization of transgender experiences (Schwend, 2020; Beischel et al., 2021). Schwend (2020) explains that there is a relationship "between the conceptualization and diagnostic classification of gender transition as a mental disorder and the situation of discrimination, stigmatization, social exclusion, and transphobic violence…including both forms of physical and institutional violence." The removal of this or similar diagnoses would thus work to recontextualize transgender experiences in a more positive, affirming, and respectful way. It would likewise reduce access barriers such as fragmentation of services and other physical barriers, and could possibly reduce financial barriers, since transgender individuals would no longer be required to pursue a mental health diagnosis or mental health treatment before pursuing physical transition-related health care. Lastly, the removal of transgender identities and/or "gender dysphoria" from mental health diagnoses could function as precedent for the removal of some or all medical requirements in the legal transition process.

The next recommendation calls for the U.S. to adopt a national informed consent model for transition-related care. As the other primary model for transition-related care in the U.S., the WPATH SOC model, requires a mental health diagnosis and/or proof of mental health treatment before one can pursue physical transition treatment(s), implementation of the previous recommendation would thus

support the adoption of the informed-consent model. Furthermore, as the informed consent model is already widely used in U.S. healthcare, there is significant precedent for the adoption of this model regarding transition-related care (Lipshie-Williams, 2020). The adoption of this model would reduce access barriers and address the violations of the right to health for transgender individuals in several ways. First, as with the previous recommendation, it would reduce the fragmentation of healthcare services and other physical and financial barriers as the overall number of healthcare providers a transgender individual would need to see would be reduced. Second, it would increase systematic, and possibly provider, respect for transgender individuals by recognizing their ability to make informed medical decisions for themselves. Third, it could work to demystify the transgender experience, especially for healthcare providers less familiar with transgender experiences, by using a model of care that healthcare providers are already familiar with, thus establishing transgender individuals as "regular clients," as one participant of De Santis et al.'s study called for (2020, p. 931). Lastly, the adoption of a national informed-consent model of care for transition-related healthcare can thus work to reduce the overall discrimination faced by transgender people in the U.S. healthcare system. Reducing this discrimination is a major component of addressing the violation of the right to health for transgender individuals in the U.S.

The third recommendation calls for the U.S. to adopt a national government-funded healthcare system, commonly referred to as universal healthcare. Although there has been much debate about the implementation of universal healthcare in the U.S., specifically around the costs involved to do so, universal healthcare "would significantly reduce the resources devoted to unusual ways of paying for healthcare" (Nersisyan & Wray, 2019, p. 26). Furthermore, to address concerns of switching from private- to public-funded healthcare, "there is nothing about government spending that necessarily makes it more inflationary than private spending – all else equal" (Nersisyan & Wray, 2019, p. 27). While challenges in implementing universal healthcare in the U.S. would unequivocally remain, the financial challenges that many use to oppose universal healthcare may not be as immense as they initially appear. Likewise, universal healthcare has several significant benefits from a rights-based approach. Universal healthcare would address violations of the right to health not only for transgender people, but for any Americans who face access barriers, especially financial barriers, to healthcare. Universal healthcare would additionally provide an avenue to establish national-level policies regarding transgender care, which would amend the discrimination caused through varying levels of transgender-inclusion in state healthcare programs, such as Medicaid. On this note, however, it is impertinent that a national healthcare system, if adopted, actively promotes and ensures non-discrimination, and includes

coverage of all transition-related treatments. Adoption of universal healthcare, if combined with the adoption of a national informed consent model of care for transgender care, would reduce a significant amount of transgender people's current access barriers to healthcare and would work to significantly address the United States' violation of the right to health for its transgender population.

The fourth recommendation, to address the intersection of the medical and legal transition processes and the subsequent violations of the rights to employment and housing which stem in part from this intersection, is to remove all medical requirements from the legal transition process. The complete separation of these two processes would reduce many barriers transgender people currently face in accessing legal means of transition. As Scheim et al.'s (2020) study found that only 10.7% of participants had both their preferred name and gender marker on all identification documents, increased access to legal transition is widely needed. This change would likewise combat the pathologization of transgender people and their experiences, which would thus aid in reducing gender-identity-based discrimination (Schwend, 2020). As with other recommendations, actions taken outside of the U.S. can be examined as precedents for this change in the U.S. Previous examples of countries implementing legal transition processes separate from medical transition processes include the 2012 Argentinian Gender Identity Law and laws passed in 2014 in Denmark, 2015 in Mexico City, Colombia, Ireland, and Malta, 2016 in Bolivia, France and Norway, and 2018 in Portugal, Costa Rica, Chile, and Uruguay (Schwend, 2020). This shows significant international support and precedents for the separation of these transition processes.

While the complete separation of the legal and medical transition processes would reduce access barriers to the legal transition process and reduce discrimination resulting from an incongruence with one's gender identity and gender marker on legal identification documents, the legal classification of gender overall leaves room for discrimination based on transgender identity. This possibility is especially pertinent in sectors such as employment and housing, as legal identification documents are required to obtain access to both. Even if an individual accesses legal transition so that the gender marker on their identification documents matches their gender identity, they could still be discriminated against if one were to think their gender marker was 'incorrect.' Although gender identity and presentation-based discrimination cannot be completely prevented through the legal transition process, the U.S. can and should still implement policy which works to reduce this discrimination as much as possible. This leads to the final recommendation: the complete removal of gender markers from all identification documents in the U.S.

The complete removal of gender markers from U.S. identification documents would resolve nearly all issues associated with one's gender marker being inconsistent with one's gender identity and/or presentation, with one's gender marker being inconsistent with the expected gender association of one's legal name, and with one's gender marker being inconsistent between identification documents. Additionally, the removal of gender markers from identification documents is the most gender-inclusive solution to addressing these issues. While the "X" gender marker has been proposed as a gender-inclusive option, and has been implemented on some identification documents, such as U.S. passports, there are negative effects to this option. Mainly, the "X" gender marker immediately raises questions of one's gender identity and transgender status, thus outing transgender individuals and putting them at risk for discrimination and potential violence. The removal of all gender markers, however, would ensure that no one would have a legally marked gender incongruent with their gender identity, and those with a gender identity outside of the gender binary would not be at additional risks of discrimination due to their legal identification documents. Furthermore, Scheim et al. (2020) identified that two major reasons transgender individuals had not changed their gender marker on identification documents were that the gender options did not fit one's gender identity (40.3%) and of fear of being "outed" (21.1%). The removal of gender markers would resolve both of these concerns. Other benefits include a decrease in financial, time, and emotional burdens that come from navigating the process of changing one's legal identification documents.

The implementation of each recommendation individually can significantly address many access barriers transgender people currently face to both medically and legally transition in the U.S.; however, an implementation of most to all recommendations is needed to adequately address the human rights concerns and violations related to access barriers to medical and legal transition and the intersection of the medical and legal transition processes in the U.S.

Conclusion

Transgender individuals in the U.S. currently face numerous barriers in accessing healthcare, both for general and transition-related care. Although medical transition has been well-documented as a medically beneficial practice for transgender people, policy, financial, physical, and psychological barriers continue to significantly bar transgender people's access to transition-related care.

The current primary model of care for providing transition-related care, the WPATH SOC model, enforces institutional barriers and medical discrimination of transgender individuals.

Given the immense intersection of the medical and legal transition processes in the U.S., transgender individuals likewise face significant barriers in accessing legal means of transition. Access to legal transition is imperative for transgender individuals, as incongruent gender markers on legal identification documents contributes to the discrimination of transgender individuals, most notably in the sectors of employment and housing.

While much of the current research on these issues has recommended solutions focused on the actions of individual healthcare institutions and providers, a human rights perspective most effectively addresses these issues. The human rights perspective first serves as a reminder that the State is the guarantor of human rights, thus meaning the U.S. government holds responsibility for addressing these issues, not transgender individuals, healthcare institutions, or healthcare providers. Furthermore, the human rights perspective makes clear that these issues constitute as violations of the right to health, the right to work, and the right to housing, as the principle of non-discrimination is not being upheld within these sectors for transgender Americans.

Several recommendations to address these human rights violations have been identified in this paper. However, further research of these issues from a human rights perspective is warranted. Notably, research of these issues in countries other than the U.S. is needed. Transgender people face discrimination and healthcare access barriers globally. Additionally, many other countries likewise have a significant intersection in their medical and legal transition processes. In Japan, for example, transgender individuals seeking legal transition must undergo sterilization surgery, along with other requirements (see Koch et al., 2020, p. 107). This raises significant human rights concerns. Further research of the medical and legal transition processes and their intersection globally is needed to fully understand and address these issues.

In light of current debates and proposed legislation within the U.S. that would increase discrimination against transgender people and the barriers transgender people face in accessing transition-related health care, the U.S. must take action now to address these issues and ensure transgender people's human rights are upheld.

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