“The law is not going to tell us how to care for the patient.” – Health Professionals and the Argentine *Gender Identity Act*

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Introduction[1]

In May 2012, the Argentinian Congress approved Law 26.743 on Gender Identity. This legislation allows any person of legal age to change their name and gender on their identity documents by carrying out a personalized procedure before the civil registry offices, without requiring judicial, medical or administrative authorization. Article 11 of the law, entitled “Right to free personal development”, stipulates that any person of legal age who so wishes may access free medical treatments to “adapt their body, including their genitalia, to their self-perceived gender identity,” with the sole requirement being a signature confirming informed consent. Based on the concept of comprehensive health, the legislation incorporates these benefits into a Compulsory Medical Plan, which covers Argentina’s three health subsystems (public, private and social services). Before its approval in this legislation, genital surgery to align the body with gender identity could only be performed with judicial authorization, under the provisions of Law 17.132 on the Exercise of Medicine. Similarly, per Law 18.248, persons requesting the correction of registration of name and sex on their identification documents needed judicial authorization. This authorization required an extensive range of medical and psychological professionals to indicate that the person suffered from “Transsexualism” or “Gender Identity Disorder”.

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The content of the Gender Identity Act was developed entirely by trans organizations in Argentina, who demanded the elimination of diagnostic and judicial requirements previously in force to access these rights.

This paper deals with the reception of the *Gender Identity Law* by health professionals in the Metropolitan Area of Buenos Aires, Argentina. It investigates the criteria that were adopted by health professionals after the approval of the Law to evaluate the admission and results of surgical interventions and hormonal treatments requested by the trans population. Between 2014 and 2019, during my doctoral and later my postdoctoral research, I conducted a total of fifteen interviews with health professionals working in the Buenos Aires Metropolitan Area with experience in gender affirming treatments requested by the trans population. They included professionals from the specialties of mental health, endocrinology, plastic surgery, urological surgery, gynecology, phono audiology and medical clinics. In the interviews, participants were asked about their professional careers, how the Law on Gender Identity had changed the organization of care, and their perceptions of the depathologizing paradigm embodied in the Law. Each interview lasted approximately forty-five minutes and was conducted after the signing of an informed consent form. Interviews were recorded, loaded into software for the analysis of qualitative data and encoded based on the analysis dimensions indicated. In this paper, I analyze the interviews of four professionals of the specialty of endocrinology, two of mental health, two of urological surgery and two of plastic surgery.

Below, I explain the start and development of the diagnoses of Transsexualism and Gender Identity Disorder, and their incorporation into widely circulated and dominant diagnostic manuals in the local and global medical community. Then, I describe three shifts identified in the discourses of the Argentine medical field following the approval of the Law on Gender Identity: from diagnosis to counseling, from protocol to personalization-customization, and from minimization of risk to cost-benefit calculation. In the conclusions, I summarize the research and reiterate the main findings.

From the Doctor's Office to the Street: The Birth and Transformation of a Diagnosis

The birth of transsexuality as a medical and identity category associated with various medicalized interventions can be understood as a result of the advancement of endocrine knowledge and improvement of surgical techniques (see Hausman 1995). The term "psychic transsexualism" was coined in 1923 by the German physician Magnus Hirschfeld, who developed the two-tier-theory (*Zwischenstufentheorie*). The term was taken up in 1949 by the American physician David Cauldwell, who described it as an inherited organic predisposition that, combined with a dysfunctional upbringing, could produce a variety of psychological effects among which would be the belief of belonging to the "other sex". He understood it as a condition that could improve or even be cured through psychological treatment (Cauldwell 2006).

In the late 1960s, Harry Benjamin, a German endocrinologist based in the United States, established the basis for diagnosing what he called true transsexualism. In contrast to previous approaches, from his perspective, surgical and hormonal interventions could constitute an indicated therapy for such diagnostic pictures. These developments were embodied in a series of protocols applied in the mid-1960s in the Gender Identity Clinics created in the United States and later replicated in various parts of the world.

In 1979, Benjamin edited the Standards of Care for Gender Identity Disorders (SOC), in which he established a standardized method for the diagnosis and treatment of transsexualism. Initially, the diagnostic process involved ruling out psychosis and schizophrenia, then identifying three criteria: the feeling of belonging to the opposite sex, the early and persistent use of clothing of the opposite sex without an erotic sense, and contempt for homosexual sexual behavior. After the diagnostic process, treatment consisted of three progressive and inseparable stages: psychological, hormonal, and finally, surgical. In the 1980s, first Transsexualism and then Gender Identity Disorder were included in the world's most widely circulated classification manuals of mental illnesses and disorders: The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association and the International Classification of Diseases (ICD) of the World Health Organization.[2] After Benjamin died in 1986, the SOCs – which, like the aforemen-

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[2] The first version of the International Classification of Diseases dates back to 1893. In its 6th version of 1948, it included a chapter on mental disorders and in its 8th version of 1965 it included a section on Sexual Deviations, incorporating the categories of Transvestism and Homosexuality. ICD 9 of 1978 eliminated the Homosexuality category but included the diagnosis of Transsexualism within the Sexual Deviations section. In 1992, ICD 10 was published. There, Transsexualism, along with non-fetishistic transvestism and gender identity disorder in Childhood, were placed within the umbrella category of gender identity disorder (GID) (located in the chapter on Mental

tioned diagnostic manuals, are periodically revised – came under review by the World Professional Association for Transgender Health (WPATH). In its 7th edition, published in 2011, the SOC introduced concepts that recognized multiple identities and bodily possibilities, in a way of depathologizing trans identities that reflected longstanding demands from trans activists around the world (Coll-Planas 2010; Suess Schwend 2010). This document states that gender variability (or gender nonconformity) and gender dysphoria are not necessarily linked phenomena. With the terms gender nonconformity or gender variability, the document refers to those forms of gender identification or expression that differ from established cultural norms. Gender dysphoria is the term used to refer to "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (WPATH 2012:2). In line with these transformations, the DSM-5 (published in 2013) devoted a specific chapter to Gender Dysphoria, which is split from sexual dysfunctions and paraphilias. The Gender Dysphoria chapter mentions gender nonconformity, specifying that it does not necessarily involve an experience of psychic suffering.

Until 2012 in Argentina, requests for a change in official records and identification documents, as well as access to gender affirmation surgeries, required juridical authorization as established in the Penal Code, Law 17.132 on the Exercise of Medicine and Law 18.248 which regulates the right to the name one is allowed to use. Until the end of 2010, these legal proceedings required a psychiatric diagnosis of Gender Identity Disorder (Cabral 2003; 2007; Farji Neer 2013; 2016). Argentina's trans organizations, formed in the mid-1990s, denounced these procedures as violating the human rights of trans people. Additionally, reports prepared by these organizations demonstrated that before the *Gender Identity Law* came into effect, trans people often avoided health consultations due to experiences of mockery and mistreatment by professionals and administrative staff (Berkins and Fernandez 2005 Berkins 2007; Frieder and Romero 2014). This was addition to the bureaucratic barriers

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and Behavioral Disorders). The 1980 DSM III also eliminated the category Homosexuality and created a new category: Sexual Identity Disorder. It incorporated the diagnosis of Transsexualism. In the 1994 version, it replaced it with gender identity disorder, which, together with Paraphilias and Sexual Dysfunctions, formed the Sexual and Gender Identity Disorders section (Di Sengi 2013).

caused by a lack of access to documentation accurately reflecteing the gender identity of a patient. These barriers discouraged and hindered access to healthcare, leading to widespread use of risky practices such as the injection of silicone oil, clandestine cosmetic surgeries and the consumption of hormones without medical supervision (Berkins and Fernandez 2005; Berkins 2007; Frieder and Romero 2014).

The *Gender Identity Act* created social and legal conditions that permitted expert discourses of medicine to be challenged by the demands of trans people. As a result, on an organized and individual scale, trans people have demanded greater participation in decision-making regarding their treatments and intervened in the instituted forms of medical authority and doctor/patient relationship.

In order to address changes and continuities in medical criteria after the introduction of the *Gender Identity Law*, I describe the approaches of health professionals who performed or evaluated the admission to hormonal and surgical gender affirmation treatments in the Buenos Aires Metropolitan Area. I analyze how the criteria for admission, the indication for treatment and the evaluation of the results were defined after the approval of the Law. At the same time, based on the interviews conducted, I identify a set of discursive changes with respect to the criteria of care present in the diagnostic manuals and international healthcare guidelines for the trans population in force prior to the 2010s.

From Diagnosis to Accompaniment

Between 2014 and 2019, most of the professionals interviewed provided interdisciplinary care in public and private clinics as well as in social security clinics. Some of the teams preexisted the *Gender Identity Law* and others were formed after its enactment, either on the initiative of individual professionals within these teams, or that of institutional medical directors. The teams were coordinated centrally by a professional who belonged to the specialty of psychiatry, urological surgery, plastic surgery or endocrinology. This was the person in charge of organizing work across these different specialties. In some instances, the teams conducted admission interviews, evaluation and referral of patients. It is worth noting that neither the Law nor its regulations, nor the National Ministry of Health through ordinances or other regulatory instruments, established a care model. Each team developed their own care guides based on local and international guidelines, accumulated clinical experience and the conceptions and criteria of their members.

One of the main guidelines for structuring care was the comprehensive evaluation (physical and psychological) of patients, to determine the extent to which they were prepared to initiate the requested treatments, especially surgical ones. The criteria that were previously intended to certify the diagnosis of Transsexualism or Gender Identity Disorder were put to the service of a more holistic process of assessment. Professionals considered that a comprehensive evaluation was necessary to understand the physical, emotional, and psychological conditions of potential patients.

The evaluation of patients had several objectives. The principal objective was to understand or help build the applicant's understanding of their identity and, from there, offer the various options available for body reconstruction, reporting the potential benefits and risks. Interviews were aimed at determining whether the person was *emotionally fit* to undergo the treatments. As the psychiatrist coordinating one of the teams stated:

> "What we do is assess the need of each person and based on their particular need, we assist them. But first we clarify their present life circumstances, that the person is clear who they are and what they need and based on that, we provide whatever type of treatments – hormonal, surgical, total, partial – it's different in every particular case" (John, psychiatrist).

In order to make these assessments, the team constructed contextually elaborated indicators of stability or instability in decision-making throughout life. An endocrinologist described the method developed as follows:

> "Talking to him and asking him for his story first, his family support, his social support, his involvement with paid work, his level of acceptance within his environment, seeing what he looks like, whether he looks like a man or a woman, how he dresses and asking him about his expectations, if he has had any other treatment in the past and trying to assess… certain patterns can tell you about the person. For example, a people who says to you 'I started law school and I quit, I started architecture and I quit, I started medical school and quit, I like the theatre but I haven't done it consistently, then you can infer that they will not be constant in their treatment" (Miguel, endocrinologist).

The evaluation was based on professional perceptions of the life trajectory of those seeking treatment. After the first interview, psychotherapeutic consultation could be mandatory or optional, depending on the criteria used by the team or the professional. In some teams, psychotherapeutic consultation was mandatory as some type of surgical intervention were required. If the person was already in therapy, the practitioners did not request that they see a different therapist, but rather requested to contact their current therapist and carry out a joint evaluation.

Despite the demands of local and international activism for the depathologization of trans identities (see Coll-Planas 2010; Suess Schwend 2010), between 2014 and 2019 in various services of the Metropolitan Area of Buenos Aires the requirement to have an endorsement by a mental health professional remained mandatory for access to genital surgery. Health practitioners maintained the need for such an endorsement by appealing to the irreversibility of interventions, speaking in a tone that seems halfway between care and guardianship:

> "There is something that simply I won´t change: the fundamental role of psychology and psychiatry. Because some people tell me now 'I don't need [psychological assessment], according to the Law.' And I say 'How do we go back from a surgery like this one? Impossible. So, we have to make sure you're okay with the surgery. If we make you a woman, how do we go back? Impossible […] If you've already been in treatment somewhere else two or three years back, well, [we ask] for a certificate from the other psychologist or psychiatrist to say that you are fit to operate" (Raul, plastic surgeon).

If hormone treatments were requested, the indication of psychotherapeutic consultation depended on the health practitioner's criteria, depending on each case. Interview with a mental health professional was not intended to corroborate a diagnosis or to rule out psychosis or schizophrenia as in the first protocols developed by Benjamin but to assist the patient with their decision-making process regarding treatments. It also served to provide health practitioners with reassurance regarding the emotional stability of the applicants and their degree of certainty about requested treatments. Following the passage of the *Gender Identity Law*, the interview process was no longer about discharging the health professional's legal responsibility or complying with protocols, but rather a matter of professional moral responsibility, grounded in the notion of care and holistic medicine. A surgical urologist said:

> "As a doctor, it's not pleasant to operate on someone and instead of helping them, you complicate their life. Most of the messages we receive are like

> 'Doctor, thank you, you changed my life', it's not very nice to receive 'Doctor, my brother killed himself because of what you did to him'. So it's no longer a legal issue, it's a medical issue. We want to do things to improve people's lives, and it wouldn't be very nice to know that you operated on someone, that it's irreversible, and that the person regrets it" (Gerardo, surgical urologist).

Those who did not request psychotherapeutic consultation used evaluation mechanisms developed based on subjective criteria and, if they identified evidence of doubt or instability, implemented various forms of deterrence intended to delay intervention. Referring to the process pre-surgical consultation, a plastic surgeon said:

> "I don't make them [go to therapy]; I don't ask them. What's more, I'm not a psychologist obviously, but in the conversation, I look at the profile of the patient, and for example, some patients come and I see them as very unstable and I don't say 'No!', but I say 'Look, it would be good to take time with such an important decision, why don't you come… let's take a few months and speak again.' So, I try to draw out the process when I see that the person is very unstable" (Alejandra, plastic surgeon).

The request for consultation with a mental health professional when patients do not consider it necessary constitutes a mentoring practice. The fact that mental health professionals, specifically psychiatrists, occupy a decision-making place in access to genital surgery through pathologizing practices and discourses has been called "gatekeeping" (see Lane 2018). In some respects, the arguments put forward by the health practitioners interviewed seem to express typical "gatekeeping" attitudes. However, they have other characteristics that differentiate them. The practitioners do not speak in terms of diagnosis but consider consultation with a mental health professional – not necessarily a psychiatrist – as a guarantee to safeguard the health of patients from irreversible surgical interventions. On the other hand, it is worth noting that the requirement for consultation with a mental health professional seems to be usually motivated by the doubts and uncertainties that the destabilization of gender binarism produces among health practitioners, rather than the actual health needs of trans patients.

The main challenge in avoiding power dynamics between practitioner and patient is to carry out a process of dialogue that constructs informed consent. It requires the implementation of modalities of care in which professionals recognize trans users as fully autonomous and not as subjects who must be cared for differently from any other patient who presents for medical consultation.

From Protocol to Personalization – Customization

Another of the displacements identified was the change from a model of protocolized care composed of three linear and successive stages (psychotherapy – concurrence – genital surgery) to a model of personalization or customization of treatments according to the needs of trans patients. For the medical professionals interviewed, this modality maximized the likelihood of "successful" interventions, not only in organic-functional but also in symbolic terms. Symbolic, here, refers to bodily self-representation and sexual pleasure. As explained by one of the surgical urologists interviewed:

> "It's not just surgery. Surgeons are used to thinking about surgery and nothing else, but if you start to say that this is to remove the testicles, remove the penis, make a vagina… It has a lot of symbolism. We need to talk to the patients first. Not all patients want the same type of surgery. There is a strong theme of customization and individualization here" (Mariano, surgical urologist).

Professionals assumed that to be successful they needed to develop a sensitivity that exceeded mere technical capabilities: it required attentive and committed listening to the needs and expectations of trans people. There was no protocol that could supplement the sensitivity necessary to carry out the task, since it implicated identity and sexuality, practices that were essential for the subjective constitution of each person. In this regard, when referring to mastectomies, a surgeon who was interviewed referred to the following:

> "Every patient is different, and every patient has been an apprenticeship. That learning is not easy because there are unique conditions that set the direction with each patient: the characteristics of the skin, if they are using hormone therapy, if they have used a binder or sash anything before, are all questions… the size of the breast… the patient's desire, because the patient sometimes wants a particular technique and you have to adapt it to the extent that you can […] there are patients who come and tell me 'I don't want anything, I don't want any memory of my previous life, I don't want an areola,

> I don't want a nipple, I do not want anything.' Other patients, due to the size of the breast you have to do a particular technique and then you have to do a reconstruction to create an areola and a nipple [...] It's a combination of so many factors. You have to negotiate all the time and come to an agreement" (Alejandra, plastic surgeon).

From Risk Minimization to Cost-Benefit Calculation

In WPATH protocols in force until 2011, the main risk to be weighed was that of regret, which in extreme cases could lead to suicide (Pragier 2011). But between 2014 and 2019 care was provided taking into account a wide range of possible risks, not just the risk of repentance. A multiplicity of possible consequences was weighed, including the consequences of non-intervention. Professionals began to scoff at the idea that there could be an ideal situation where there was no risk. From this perspective, they considered that both intervention and non-intervention had some kind of cost or risk to consider, whether physical or subjective. This is explained by an interviewee:

> "There is a lot of commotion among medical professionals saying 'if you are going to give someone estrogen you are predisposing them to thrombosis, if you are going to give them progesterone you are predisposing them to breast cancer and osteoporosis [...]. So, they're usually thinking of the ideal, that is, of *their* ideal... 'Better if I don't give them anything and I exempt them from risk.' But they forget that if you leave someone in their present condition you have another risk. Therefore, realistically you have to take risks because if you have a person who is not happy with their sex, you have to choose between the risk of deterioration of their mental health and the risk of thrombosis, there is no option of no risk" (Miguel, endocrinologist).

In the same vein, another professional stated:

> "Among people on whom I have operated, no one has expressed regret... among cases I have seen presented at conferences, there is a small percentage of people who express some small regrets [...]. I believe that with time and with the times we are living in, we're going to encounter regret sometimes. I think so. It's logical, because insofar as they go, they come, they do, they undo... well, it's going to happen. It's what I think, it's a thought of mine" (Alejandra, plastic surgeon).

For this professional, regret was an inescapable consequence given the complex experiences of trans people, who were conceived as people in constant search, fluctuation and experimentation with body and identity. For the professional interviewed, regret should be seen as one possible consequence within the multiple possibilities created by the availability of gender-affirming medical treatments for trans people.

Important questions emerge from the discursive shifts identified above. One is, who weighs up the risks of treatment options and who has the final say about which course of action to follow? The Gender Identity Act legalized gender affirming medical treatments for trans people and thus eliminated the potential for treating professionals to be accused of violating the Medical Exercise Act (*Ley de Ejercicio de la Medicina*). Nonetheless, based on the idea that there is no ideal situation and that there are always risks to consider, many medical professionals continued to exercise authority over the definition of the course of treatments, appealing to their responsibility for ethical-professional care and irreplaceable clinical experience and knowledge.

In this sense, the professionals interviewed were critical of the content of the *Law on Gender Identity* and of any legislation that aimed to intervene in the exercise of their profession. They criticized a formulation of the concept of patient autonomy that understood the patient as an individual consumer of biotech goods and services, where clinical criteria were deemed unnecessary:

> "The law will not tell us how to care for the patient, nor say when is the appropriate time to give what assessment, nor when it is time to give approval to operate, nor when treatment is not appropriate. Everything you have, everything your doctor does, has indications, counter-indications, side effects, etc. […] There are a lot of issues that contraindicate, and while there is the Law, there are medical questions too […] people believe that if it says in the law that doctors have to give X and Y, then suddenly the doctor is a kiosk operator who is planted there and the patient comes and says: 'Give me this, give me that' […] well then it's like you as a doctor *do not exist* and you do not have any role" (Luis, endocrinologist).

Promises for the future: the Return to Biology

In a manner that traverses the three discursive shifts identified above, some of the medical professionals interviewed displayed a persistent interest in the scientific revelation of the supposed biological underpinnings of the existence of trans people. According to some of the professionals interviewed, although they had not yet been revealed by genetic research, a set of organic determinants – presumably genetic – would eventually be found to explain trans experiences. This is how one endocrinologist put it:

> "There must be something that makes a three-year-old boy say, 'I feel like a girl'. There's gotta be something discovered to explain that, within in fifty years, I reckon. Everything has to have a reason. Like, of premature ejaculation it's known that, some studies say that, it has a genetic basis: there are genes that have to do with the speed of the ejaculation reflex, as well as serotonin levels. Everything is regulated by genes, so something must have generated this issue. Afterwards, there's what it has to do with society" (Luis, endocrinologist).

In the same vein, another interviewed endocrinologist stated:

> "I think there is a strong biological determinant in this trans [...] it's a subject that interests me a lot: the determinant. Because understanding it would help to clarify this issue for the general population. It's not a whim. Whoever wants to be trans does not choose it, this I want to say [...] I believe that the literature in general accepts and has some evidence for the biological, for the biological determinants" (Julian, endocrinologist).

According to the interviewees, scientific confirmation of the existence of biological determinants of trans experience would provide the necessary arguments against those who understand the gender affirming treatment needs of the trans population as a "whim". At the same time, such an explanation would allow progress in social acceptance and fulfillment of the rights of trans people, since socially the argument of biological roots would bear more weight than those made in terms of inclusion and human rights.

These arguments about the scientific basis of medical practice were articulated with a feeling of hope linked to the belief that we may know, in a not-too-distant future, the organic causes that would explain the multiplicity of trans experiences. Faith in the scientific narrative operated among some health professionals as a guarantee of certainty that minimized the uncertainty and moral conflict presented to them when responding to requests for access gender affirming care. In this sense, for the professionals interviewed, the promise of the future of a still nonexistent scientific truth prevailed above the voices of the real subjects about their present vital needs.

Final Reflections

This paper discussed the reception of the *Gender Identity Law* by health professionals in the Metropolitan Area of Buenos Aires who specialized in gender affirming hormone and surgical treatments. Several discursive mutations were identified in the criteria for the entry and evaluation of the results of these treatments compared to those previously in force. These discursive mutations reflect a process of local reappropriation of diagnostic manuals and care guidelines in global circulation.

The first section addressed the birth and development of diagnoses of Transsexualism and Gender Identity Disorder, and their incorporation and transformation into the main widely circulated diagnostic manuals in the local and global medical communities. This section also set out the criteria for admission and care in force in the medical protocols that since the end of 1970 systematized standards and criteria for gender affirming medical treatment.

The subsequent three sections analyzed the main discursive mutations identified among the health professionals interviewed: from diagnosis to accompaniment, from protocol to personalization-customization, and from risk minimization to cost-benefit calculation. These mutations developed within the framework of the Argentine *Gender Identity Law*, which dejudicialized and de-pathologized access to gender affirming treatments. However, other explanatory factors were also identified, including changes in diagnostic manuals in global circulation, advancement in the acquisition of rights by LGBT people, and increasing visibility of the demands of trans groups in local public space.

In a manner that traverses the three discursive shifts identified, there was a persistent interest from the professionals interviewed in the scientific unveiling of the alleged organic basis for the existence of trans people. The expectation that these scientific certainties will be found in the not-too-distant future minimized uncertainty and moral conflict among health professionals when responding to requests for access to gender affirming-care by trans people.

Based on the analysis carried out, it can be said that the demands made of the medical community by local and global trans activists have, in some cases, managed to destabilize the certainties of health professionals and prompted a review of their practices. In other cases, medical professionals have responded with the reaffirmation of their authority in a defensive sense. Two dimensions are worth noting in this regard. On the one hand, professionals demand to be recognized as experts in their professions, and not as mere "vendors" of hormones and surgeries. On the other hand, the request for consultation with mental health professionals is the manner they have found to deal with the doubts and uncertainties that the destabilization of gender binarism causes them. This requirement to have authorization by a mental health professional to be able to access gender affirming care reproduces a 'gatekeeping' logic that restricts the autonomy of trans patients, the very autonomy that the Law on Gender Identity was intended to promote.

Taking into account these tensions, it can be said that in order to promote non-gatekeeping practices in health services, medical professionals must reflect deeply on the fears and uncertainties that gender affirming treatments provoke in them. They must implement dialogic processes of building informed consent, in which by suspending their authority, they recognize trans people as fully autonomous and not as subjects who should be subjected to differential care.

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