



Preventing transition “regret”: An institutional ethnography of gender-affirming medical care assessment practices in Canada[☆]

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ABSTRACT

When a person openly “regrets” their gender transition or “detransitions” this bolsters within the medical community an impression that transgender and non-binary (trans) people require close scrutiny when seeking hormonal and surgical interventions. Despite the low prevalence of “regretful” patient experiences, and scant empirical research on “detransition”, these rare transition outcomes profoundly organize the gender-affirming medical care enterprise. Informed by the tenets of institutional ethnography, we examined routine gender-affirming care clinical assessment practices in Canada. Between 2017 and 2018, we interviewed 11 clinicians, 2 administrators, and 9 trans patients (total n = 22), and reviewed 14 healthcare documents pertinent to gender-affirming care in Canada. Through our analysis, we uncovered pervasive regret prevention techniques, including requirements that trans patients undergo extensive psychosocial evaluations prior to transitioning. Clinicians leveraged psychiatric diagnoses as a proxy to predict transition regret, and in some cases delayed or denied medical treatments. We identified cases of patient dissatisfaction with surgical results, and a person who detransitioned. These accounts decouple transition regret and detransition, and no participants endorsed stricter clinical assessments. We traced the clinical work of preventing regret to cisnormativity and transnormativity in medicine which together construct regret as “life-ending”, and in turn drives clinicians to apply strategies to mitigate the perceived risk of malpractice legal action when treating trans people, specifically. Yet, attempts to prevent these outcomes contrast with the material healthcare needs of trans people. We conclude that regret and detransitioning are unpredictable and unavoidable clinical phenomena, rarely appearing in “life-ending” forms. Critical research into the experiences of people who detransition is necessary to bolster comprehensive gender-affirming care that recognizes dynamic transition trajectories, and which can address clinicians’ fears of legal action—cisgender anxieties projected onto trans patients who are seeking medical care.

1. Introduction

Gender transitions involve taking steps to affirm and express a transgender or non-binary (trans) gender identity, often following unique paths. Transitioning may include social (e.g., new name or

pronouns), legal (e.g., identification documentation), and/or medical processes (gender-affirming hormones and surgeries). Biomedical transition technologies, also referred to as gender-affirming care, include a spectrum of medical interventions intended to mitigate the distress that some trans people experience in response to an incongruence between

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their birth-assigned sex and gender identity. Medical transition often requires support from qualified clinicians who can diagnose or assess “gender dysphoria” and initiate hormonal and/or surgical care. Still, when a person openly “regrets” their medical transition outcomes, discontinues transitioning, or reverse-transitions, this bolsters within the medical community and the public an impression that trans people require close scrutiny when seeking hormones and surgeries (MacKinnon et al., 2020a). Detransitioning refers to a process whereby, after initiating gender transition, an individual discontinues, reverses, or re-directs the course of their transition (Exposito-Campos, 2021). Clinicians fear these outcomes when providing trans people with gender-affirming care for myriad reasons, but some concerns evoke questions of professional liability and the ethics of causing harm to patients (Coleman et al., 2012; Deutsch, 2013; Dewey, 2013; Olsson and Moller, 2006; shuster, 2021).

Cisnormativity and transnormativity are significant critical social theories relevant to scholarly discussions on gender-affirming care, transition regret, and detransition. Cisnormativity refers to a discursive two-gender system which privileges and normalizes cisgender (non-trans) people’s bodies, identities, and experiences (Boe et al., 2020). Transnormativity is a sibling concept of cisnormativity and it specifically relates to how medicalized standards, such as gender dysphoria diagnostic criteria, regulate trans people’s identities and their interactions with healthcare and legal institutions (Johnson, 2016; Riggs et al., 2019). For instance, in some jurisdictions trans people are required to undergo a medicalized gender transition to change legal sex designation (Scheim et al., 2020). Like cisnormativity, transnormative ideas about trans people hinge upon essentialist, binary notions of gender such as trans people being “trapped” in the “wrong body”, and that trans bodies can be corrected by gender-affirming medical interventions (Johnson, 2016; Riggs et al., 2019). Contrasting with gender non-conforming trans people (e.g., non-binary), trans people who conform to binary gender expectations and whose life experiences closely align with gender dysphoria diagnostic criteria are rendered more intelligible and “authentically” trans (MacKinnon et al., 2020a; Vipond, 2015). Trans people are held deeply accountable to transnormative discourses. Those who express transition regrets or who detransition are seen as inauthentic for transgressing the implied uni-directionality of gender transition. Said differently, according to cisnormative and transnormative discourses and understandings of gender, these individuals were never truly trans.

In this article, we explore clinicians’ everyday clinical assessment and referral practices in the area of gender-affirming care, which we argue are in large part organized to prevent transition regret and detransition. Grounded in the material practices of a sample of eleven clinicians, two healthcare administrators, and nine trans people in Canada (total n = 22), we document clinical regret prevention strategies. Our analysis explicates how clinical activities reflect pervasive cisnormativity and transnormativity in biomedicine and contrast with the actual healthcare needs of trans persons. Our analysis brings forth questions surrounding the tensions and consequences of clinicians’ regret prevention work and we suggest future avenues of research on transition regret and detransition. While we note the usage of “regret” has been critiqued for negatively describing and evaluating medical transition outcomes, often by researchers or clinicians (Hildebrand-Chupp, 2020), this discourse serves a powerful coordinating function in clinical settings. We thus engage with this term critically and to mirror language used by our study participants. In so doing, we provide a critical, empirical Canadian study of what Hildebrand-Chupp (2020) identifies as a prominent discursive theme of “preventing regret” in gender-affirming care policy, practice, and medical research.

1.1. A tenuous on-going history of the biomedical treatment of trans people

The medical community’s cisnormative and transnormative

understanding of gender as binary, and of medical transition as uni-directional, strongly shaped physicians’ early practices in gender-affirming care. Trans patients who did not fit physicians’ binary notions of gender and related social roles were often denied medical care (Sledge, 2019). Theoretical analyses of biomedicalization provide insights into how, in the 1950s–1960s, sex and gender identity incongruences were transformed into treatable medical conditions in Western societies (Conrad, 2007; Johnson, 2015; MacKinnon, 2018). *The Transsexual Phenomenon*, authored by endocrinologist Dr. Harry Benjamin (1966), outlined some of the historical legal and ethical practice challenges with respect to replacing psychoanalytic talk therapies with hormonal and surgical care of (adult) trans people in the United States (US). The early clinical work of physicians, like Benjamin, involved assessing the extent to which trans patients fit binary gender, ostensibly to prevent regretful malpractice lawsuits (Meyerowitz, 2002; shuster, 2021). Benjamin wrote about American surgeons who refused to perform gender-affirming surgeries on trans patients on ethical grounds, and of hospital boards that forbid surgeons to perform these surgeries out of a fear of legal repercussions, and he also wrote about a case of detransition (Benjamin, 1966; Exposito-Campos, 2021).

This transformation can be traced to the last half century of developing a transnormative model for the medical care of trans people, which has largely entailed standardizing the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria for gender dysphoria (American Psychiatric Association, 2013), and innovating hormonal and surgical care (Riggs et al., 2019; shuster, 2021). The Harry Benjamin International Gender Dysphoria Association—now the World Professional Association of Transgender Health (WPATH)—was instrumental in this work. The organization publishes internationally-recognized standards of care (WPATH-SOC) which are composed of clinical guidance and standardized eligibility assessment criteria used by clinicians to assess and refer trans people for hormones and surgeries. Hastings et al. (2021) note that the WPATH-SOC criteria reflect binary gender expectations and contribute to some patients being refused care for being determined “not trans enough” (e386).

The WPATH-SOC provides guidance on the medical management of gender dysphoria. For adolescent trans and gender questioning people under the age of 16, hormone suppression medications are used to pause or delay puberty to provide more decision-making time (Bonifacio et al., 2019). Gender dysphoric persons aged 16 and older have capacity to consent to gender-affirming hormone therapies such as testosterone, estrogen, progesterone, and antiandrogens (Hembree et al., 2017). However, the *Endocrine Society Clinical Practice Guidelines* suggest these hormonal treatments could be considered at age 13.5–14 (Hembree et al., 2017). Surgical interventions are generally only offered to those aged 18 and older and these procedures include breast augmentation, chest masculinization surgeries, facial feminization/masculinization surgeries, and genital surgery (e.g., orchiectomy, vaginoplasty, hysterectomy, bilateral saplingo-oophorectomy, metoidioplasty, and phalloplasty). Though, on a case-by-case basis and with parental/guardian consent, chest masculinization surgery (e.g., mastectomy with masculine chest contouring) is considered prior to age 18 following a minimum of one year of testosterone treatment (Coleman et al., 2012).

Hormones and surgical care are significant to trans people’s gender transitions and these treatments are consistently linked with improvements in mental health and quality of life (Almazan and Keuroghlian, 2021; Bauer et al., 2015; Costa and Colizzi, 2016; Tomita et al., 2018; Turban et al., 2020). There are currently no widely accepted clinical guidelines to address transition regret or detransition (Exposito-Campos, 2021; Turban and Keuroghlian, 2018). Though, the eighth edition of the WPATH-SOC is anticipated to include a chapter on detransitioning (Butler and Hutchinson, 2020).

1.2. Preventing regretful transitions and detransitioning: clinical practice, research, and policy

Despite no clinical guidance on regret or detransitioning, and scant evidence that detransitioning is a negative phenomenon, practices of preventing these outcomes define the gender-affirming care enterprise. To avoid regret, adherence to clinical assessments is recommended (e.g., the DSM and the WPATH-SOC) (Coleman et al., 2012; Olsson and Möller, 2006). When trans people seek medical transition, the WPATH-SOC guides clinicians to determine whether the patient meets DSM criteria for gender dysphoria, and to identify whether the patient's mental health is "controlled" because mental distress may "complicate" the gender exploration and transition assessment process (Coleman et al., 2012, p. 25). These concepts are nebulous and practices ill-defined, but are thought to mitigate the risk of regret or detransitioning caused by a psychiatric misdiagnosis (e.g., another psychiatric condition caused gender identity issues) (Byne et al., 2018). The WPATH-SOC itself proclaims that: "Since the *Standards of Care* [SOC] have been in place, there has been a steady decrease in dissatisfaction with the outcome of [gender-affirming] surgery ... Even patients who develop severe surgical complications seldom regret having undergone surgery (Coleman et al., 2012, p. 107, emphasis in original). WPATH supports this claim by contrasting the results of one study conducted prior to establishment of the SOC with two studies conducted following the introduction of the SOC, while indicating a majority of patients had "improved social and emotional adjustment" after treatment (p. 107). None of these discrete studies cited by WPATH employed methodologies (e.g., randomized-controlled trial or another experimental methodology) which enable robust comparisons between trans patients who received gender-affirming care outlined by the WPATH-SOC versus another model of care.

The possibilities of regret and detransitioning are also used as rationale to heavily restrict gender-affirming care for young trans people (Ashley, 2020). Typically this approach includes in-depth mental health screenings and exploring alternative explanations for the onset of gender dysphoria (e.g., trauma; eating disorders; internalized misogyny), and potentially, a different course of treatment (Marchiano, 2017). Some writers have gone so far as to argue that clinicians evade—or even collude with—patients' psychological distress by affirming trans identities and offering gender-affirming medical treatments, putting young trans people at risk of regret (see Withers, 2020). Still, a consequence of strict mental health assessments is that trans people who are seeking gender-affirming care may strategically downplay mental distress to avoid being diagnosed with a "complex" mental illness and denied hormones or surgeries on this basis, thereby having to choose between accessing medical transition, or mental health supports (MacKinnon et al., 2020a).

Yet different conclusions about detransition have been drawn. For example, regret and detransition are not synonymous. Some young people who detransition are not regretful and they report overall positive experiences of gender-affirming care, such as being provided an opportunity to clarify their gender identity (Turban and Keuroghlian, 2018). Predicting or preventing detransition may be impossible given how dynamic gender identity can be, and instead, clinicians must be prepared to provide compassionate supports irrespective of transition pathways and outcomes (Exposito-Campos, 2021; Turban and Keuroghlian, 2018). Furthermore, attempts to prevent detransition—vis-à-vis the transnormative WPATH "gatekeeping model" of strict assessment practices designed to identify only those who "truly" meet eligibility criteria—may create unethical, paternalistic, and dehumanizing practice conditions (Ashley, 2018; ; Riggs et al., 2019 Toivonen and Dobson, 2017).

Some medical sciences literature focuses on estimating prevalence of transition regret (Dhejne et al., 2014; Hess et al., 2014; Olsson and Moller, 2006; Bustos et al., 2021). Discrete studies conducted in Germany, the US, Sweden, and the Netherlands show that between 0.3%

and 15% of trans people are dissatisfied to some degree with medical transition outcomes (Deutsch, 2013; Dhejne et al., 2014; Johansson et al., 2010; Zavlin et al., 2018). In relation to surgeries specifically, a systematic review and meta-analysis of 27 studies pooling 7928 trans patients found a ~1% "prevalence of regret" after gender-affirming surgery (Bustos et al., 2021). Overall, transition regret and detransition are presented within this literature as an "outcome to be avoided" (Hildebrand-Chupp, 2020, p. 805).

Etiology of regret or detransition is not well-described by the medical or social science literatures, and the direct experiences of clinicians or of "regretful" trans or detransitioning persons themselves are scantily studied. Yet, there are myriad external contextual factors which could explain detransition, and medical failures appear to be a relatively minor one. One survey of 46 US and Europe-based surgeons who performed gender-affirming surgeries on ~22,725 trans patients, identified 59 patients (0.26%) who sought surgical detransition (Danker et al., 2018, p. 189). Reasons reported were: societal or relationship pressures, a change in gender identity, or post-surgical pain. A US sample of 17,151 trans participants found that 13.1% of survey respondents reported a history of detransition (Turban et al., 2021, p. 276). Reasons given included: experiencing external pressure such as from a parent, partner, or from community/social stigma, which in turn may lead to doubting one's gender identity (p. 277). A survey of 237 people who identify as detransitioners largely living in the US and Europe found respondents endorsed the following explanations for detransitioning: gender dysphoria was related to other issues; health concerns; unhappy with social changes; change in political views; and financial concerns, among others (Vandenbussche, 2021, p. 6). Although Vandenbussche's (2021) survey is among the only known, published empirical studies examining the experiences of individuals who self-identify as detransitioners, 92% of the sample were assigned female at birth—only 8% of respondents were assigned male at birth (p. 4). Thus, there may be unique factors impacting detransition pathways for those assigned male at birth which are not identified nor discussed in this study.

Despite their low prevalence, concerns over regret and detransition may explain growing gender-affirming care legal challenges happening in Western countries. In 2020, the United Kingdom (UK) High Court decision in *Bell v. Tavistock* (2020) found that youth under 16 are unlikely to have capacity to consent to puberty suppression medication. The lawsuit was initiated by detransitioner, Keira Bell. In the wake of the decision, Sweden's Karolinska University Hospital restricted gender-affirming care for trans young people, with medical interventions made available to 16–17-year-olds only in the context of clinical research (Nainggolan, 2021). In 2021, the UK Court of Appeal overturned the *Bell v. Tavistock* judgment, concluding that doctors, not the courts, are to decide young patients' capacity to consent (Siddique, 2021). In the US, the legal context of gender-affirming care for trans young people is increasingly tenuous, with several states introducing bills which seek to prohibit gender-affirming care for patients under the age of 21 (Robinson, 2021). These legal developments contradict the WPATH-SOC and have been strongly opposed (Turban et al., 2021; De Vries et al., 2021). This new legal landscape is anticipated to bring about cascading negative consequences, such as compounding the already high rates mental health issues experienced by this population (Ashley and Dominguez, 2020). It is important to point out that the provision of gender-affirming care—particularly for those below the age of majority—varies from place to place and clinical practices are sensitive to political, economic, legal, and social contexts.

1.3. Gender-affirming care in Canada: tracing the landscape of a fragmented federalist system

In Canada, gender-affirming care services are fragmented regionally because healthcare falls under provincial or territorial jurisdiction. While the *Canada Health Act* establishes national healthcare norms forming Canada's universal healthcare system, ultimate regulatory

authority remains within the provincial and territorial governments. Through the *Act*, residents of Canada can access publicly-funded, “medically-necessary” physician and hospital services through a health insurance plan provided by their provincial/territorial government. Physician and hospital services determined not “medically necessary” by government decision-makers are rendered uninsured and patients may be charged a fee (Government of Canada, 2011). Thus, there are inconsistencies across the country in terms of public coverage for gender-affirming care.

Across Canada, trans people’s access to hormones and surgeries is fraught with structural barriers. Given the absence of a national Pharmacare plan, trans people largely purchase hormone therapy out-of-pocket or, for some, prescription medications may be covered by post-secondary or employer-provided extended health insurance (Ziegler et al., 2020). In the absence of Canadian gender-affirming care standards, clinicians use the WPATH-SOC to assess and refer trans people for hormones/surgeries. Referrals for publicly-funded surgeries must conform to the WPATH-SOC as part of the prior government approval process (Ziegler et al., 2020). Yet surgical care is further complicated by the fact that for the duration gender-affirming surgeries have been available in Canada, procedures have been performed in privately-owned clinics, which rarely publish surgical outcomes data (MacKinnon et al., 2020b). One such clinic is the Centre Métropolitain de Chirurgie in Montréal—which was the only site in Canada performing genital surgeries until 2019, when the first public gender-affirming surgical clinics were established in Vancouver and Toronto (MacKinnon et al., 2020b).

Contrasting with the US where only those aged 18 and older can make independent medical decisions, in Canada there is no standard legal age for medical decision-making. Each province/territory has in place different legislative Acts which regulate medical consent. In most regions, youth 16 and older are capable of “giving and refusing consent in connection with their own care” (Coughlin, 2018, p. 140). Below 16, the “mature minor” doctrine applies and capacity to consent must be assessed on a case-by-case basis. Youth able to exercise “mature, independent judgment”, and whose wishes “reflect true, stable and independent choices” are capable of consenting on their own (*AC v Manitoba*, 2009 SCC 30). The views of those below that threshold must be afforded an importance that is proportionate to their maturity, in line with article 12 of the *Convention on the Rights of the Child*. In the context of gender-affirming care, the British Columbia Court of Appeal ruled that a 14-year-old was mature enough to consent to initiating hormonal testosterone therapy (*AB v. CD*, 2020 BCCA 11). In the province of Quebec, capacity to consent begins at age 14 and there is no “mature minor” exception below that age.

While the possibilities of regret and detransition lead some clinicians to fear lawsuits, it is worth emphasizing that such outcomes do not by themselves open professionals to liability. Under Canadian law, professionals’ actions must demonstrate a reasonable level of knowledge, competence, and skill expected of ordinary professionals in their field (*ter Neuzen v. Korn*, [1995] 3 SCR 674). Clinicians following a recognized standard practice of the profession will typically not be found negligent, even in cases of regret and/or detransition results for the particular patient. The standard bearing upon clinicians is not one of result, but of diligence.

Gender-affirming care is predicated on cisnormative binary gender expectations together with transnormative standardized clinical assessments used to distinguish between “legitimate” trans persons from those who clinicians perceive to be more likely to regret transition (e.g., trans people with mental illness). Despite the enterprise of medical transition being built on this assessment work—and no evidence that regret or detransition are necessarily negative outcomes caused by medical failures—there have been significant legal efforts in multiple Western countries to criminalize hormonal and surgical procedures for young trans people. Drawing from interviews and textual analysis conducted in Canada, this study examines the material effects of regret/

detransition discourses and explicates how clinicians engage in regret prevention work with trans people.

2. Methodology

Our study was informed by institutional ethnography. Institutional ethnography is an empirical, materialist research strategy developed by sociologist Dorothy E. Smith (1987, 2001, 2005). Institutional ethnographers explicate the ruling relations discursively organizing and regulating a particular system. The ruling relations are defined as specialized, technical discourses and power structures which coordinate knowledge, and by consequence, people’s social relations (Campbell and Manicom, 1995). Institutional ethnographers examine people’s concerted work practices to reveal how these are mediated by discursive ruling relations, enabling the explication of a system under study. Work is defined broadly to include any actions that require time, effort, and intent, independent of paid employment (Smith, 2005). For instance, the time and efforts required for trans people to be assessed and referred for hormones and surgeries constitute patient work.

To make visible the ruling relations, institutional ethnographers study how people work with, and activate, institutional texts (e.g., the WPATH-SOC). Texts include standardized documents that can be reproduced and read by multiple people in locations beyond their original writing, and they mediate people’s local work within a system (Smith, 2001). Examined together, texts and people’s coordinated work practices enable institutional ethnographers to identify the ruling relations determining what people do. Although people’s material practices and texts are analyzed in institutional ethnographies, it is important to note that the ruling relations are the object of analysis. In other words, institutional ethnographies are an analysis of a coordinated, discursive macro-level system.

This project received research ethics board approval and data were collected between June 2017 and January 2018. First author (KMK) interviewed twenty-two participants including trans people (n = 9), clinicians (n = 11), and healthcare administrators (n = 2). Clinicians specialized in the areas of family and emergency medicine, psychiatry, psychology, and social work, and their practice experiences largely occurred in Canada (one clinician previously worked in the US). Trans participants ages 18 and over were recruited through social media in the Greater Toronto Area, Ontario. Some trans people discussed accessing gender-affirming care outside of Ontario, of being clinically treated for gender dysphoria in childhood, and of seeking hormones or surgeries prior to turning 18. Interviews were conducted in-person and ranged between twenty to 90 minutes. All interviews were transcribed verbatim, and transcripts were sent to each participant for verification.

Following text-talk-text institutional ethnographic methods (Grace, 2013), data collection and analysis were iterative and dynamic to fill in gaps in understanding of how gender-affirming care is delivered in Canada. Participants discussed their roles related to assessments and referrals, and they identified clinical and health policy texts pertinent to their work. Interviews with trans people focused on the work of preparing to be assessed by clinicians, and clinician-participants were asked how they conduct assessments for hormones and surgeries, and prepare referrals for publicly-funded surgeries. Clinicians were explicitly asked whether they used, or had familiarity with, specific standardized assessments, and how these were applied (e.g., the DSM or the WPATH-SOC). A total of 14 texts were reviewed for this analysis, including the DSM-5, the WPATH-SOC-7, and 12 provincial/territorial surgery funding policies. One Canadian territory (Nunavut) does not have a gender-affirming surgery policy so this jurisdiction was excluded from analysis.

The current study extends previous, related analyses from this dataset showing how the WPATH-SOC mediates the clinical learning and teaching of gender-affirming care in Canada (MacKinnon et al., 2019) and the textual mechanisms through which the WPATH-SOC and the DSM construct barriers to hormones and surgeries for trans people

with “complex” mental health issues (MacKinnon et al., 2020a). Below we present clinicians’ and trans patients’ accounts of gender-affirming care assessment and referral practices in Canada, which we trace directly to the logics of attempting to prevent transition regret and detransition.

3. Findings

3.1. Gender-affirming care: assessing, referring, delaying, or denying trans people

Clinicians described in detail the systematic work practices of assessing rigorously trans people’s eligibility for hormones, and in particular, surgeries. To determine eligibility for these medical interventions, clinicians used the DSM to ensure that trans patients met diagnostic criteria for gender dysphoria and fulfilled the WPATH-SOC “readiness components”. For example, a social worker explained the assessment and referral preparation process for genital surgery:

If they [patient] have been diagnosed with gender dysphoria, that’s something that you end up commenting on; this person has the diagnosis that they need; this person has the gender role experience; and this person has been on hormones for at least a year. In terms of the [transition] readiness components, you are talking about the fact that this person is currently living here, has been doing so for the last two years with their partner, their mental health is stable, when they do experience any challenges this is how they cope. And then other readiness is ... what they know about the procedure. And that’s how we’re able to gain an informed consent that this has been thought out.

–Social worker, participant #10

This social worker’s assessment of “readiness” for surgery mirrors the WPATH-SOC eligibility criteria which include assessing the extent to which any mental health challenges are “well-controlled”, that the 12-month gender role experience has been completed, and the patient understands the procedure and can provide informed consent (Coleman et al., 2012). This participant also described assessing and documenting further details required by surgeons who receive the referral, such as the patient’s domestic and housing context, and psychosocial coping mechanisms with respect to life challenges. These items extend beyond the WPATH-SOC eligibility criteria but these additional criteria are often required by surgical clinics.

For surgeries involving trans people’s reproductive organs, assessments/referrals are accompanied by a second clinician’s independent assessment in order to fulfil the WPATH-SOC’s requirement of two assessments. A physician participant explained:

Our centre in Canada that does most of the surgeries—bottom [reproductive organ] surgeries—strictly adhere to the WPATH criteria. And it creates another barrier to care for transgender people ... So they’ll [surgical centre] accept our [assessment] letter, one letter from us [physicians] because we know the patient. But they do require a second letter and it has to be from a mental health professional ... What drives somebody like myself crazy when I think about this, is that for no other surgery do I have to do that. You’re telling a transgender person you are some sort of different type of person that isn’t capable of knowing who they are, and knowing that they need this surgery. For example, if I refer [a patient] for hip surgery because of a bad hip, nobody says “well you’ve got to see two psychiatrists before they’ll do your hip.”

–Physician, participant #22

As explained by this participant, the WPATH-SOC requires patients have two clinical eligibility assessments, one of which must be conducted by a mental health provider. This in turn adds an additional layer

of scrutiny on trans patients seeking surgery, producing a unique patient category for trans people who comprise a “different type of person that isn’t capable”. Drawing a comparison with hip surgery, this physician notes that the WPATH-SOC policies and procedures add extra steps to the surgical referral process. Consequentially, more work and barriers are present for trans people because they must visit two different clinicians before the surgical centre will consider accepting them, and they often pay out-of-pocket for assessments given that mental health care is largely private.

After receiving surgical referrals, some surgeons may double-check with the referring clinician that the patient is mentally “stable” enough for gender-affirming surgery. Or surgeons may request from psychiatrists an additional psychiatric capacity assessment. A psychiatrist participant provided details on this:

Surgeons sometimes refer to me to say: “well, is this person OK for me to operate on?” And it’s like, well, what’s your concern?.. More often than not it’s that the surgeon might wonder: they have a history of “this” or “that” in terms of their mental health, so are they “stable” enough to go through with a surgery? And, it’s like, you’re a surgeon, you work with people all of the time regarding informed consent ... Why can’t you do it with a trans person the same way you would with a non-trans person?

Interviewer: So what do you think is happening with that surgeon? I mean it’s hard to think that it’s not transphobia, right?

–Psychiatrist, participant #12

Like the previous participant, this psychiatrist suggested that the surgical assessment, informed consent, and referral processes differ between cisgender and trans patients. Some surgeons rely on psychiatric assessments to assuage their hesitations in operating on trans patients. Significantly, trans people with a history of mental illness triggered requests for psychiatric capacity assessments prior to gender-affirming surgery.

Participants also reported encountering clinicians who delayed, or denied, gender-affirming care. In a majority of these cases, the patient’s mental health was provided as the main factor limiting access to hormones or surgeries. In the context of hormonal assessments, a social worker participant shared:

I had a client who went [for an assessment]. A young trans man. Actually, he was 26 so he wasn’t even a youth anymore ... Anyway, the doctor said that ... he was not mentally “stable” enough to have hormones. I’ve had a couple of clients refused to have hormone therapy due to not being mentally “stable”.

– Social worker, participant #17

Within an assessment for hormones, if a trans patient’s mental “stability” is called into question, they could be denied medication. One of the WPATH-SOC eligibility criterion for hormone therapy directs clinicians to assess whether any mental health concerns are “controlled” (Coleman et al., 2012, p. 34). Trans participants also discussed clinicians who completed surgical assessments and then delayed submitting a referral to the surgeon due to concerns that mental distress would impact surgical satisfaction. In one example, a trans participant explained that:

There was maybe three years in between from the point I started at [youth gender identity clinic] to when I went to the [adult] gender clinic. And there they established that I had body dysmorphia because I was also getting plastic surgeries on my face. I wasn’t happy with [the results] and it was causing me distress ... Because I wasn’t passing [as a cisgender woman] and it was really difficult ... They didn’t want to provide me with [genital] surgery, because of how upset I was with the results of my [facial feminization] surgeries

that I wouldn't be able to handle SRS [genital surgery]. But I tried to explain to them that it's not the same thing as my face and they did not understand.

-Trans person, participant #19

From this account, it is evident that in disclosing dissatisfaction with previous facial feminization surgeries, clinicians "established" the patient was suffering from "body dysmorphia"—a different DSM diagnosis than gender dysphoria. Despite attempting to explain to clinicians that the source of her distress and surgical dissatisfaction was linked with her unmet desire to be read socially as a cisgender woman ("passing"), her clinicians "did not understand". Instead, she was diagnosed with body dysmorphia disorder and she disagreed with clinicians' interpretation of her facial surgery dissatisfaction. Of note, she did not "regret" having these surgeries, but rather was unhappy with the gendered features of the surgical outcomes. Still, her past surgical dissatisfaction was leveraged as a proxy to predict future regret, and to delay providing a referral for surgery for approximately three years.

3.2. Risk mitigation work in the clinic: preventing transition "regret" and avoiding lawsuits

In discussing gender-affirming care, clinicians raised concerns surrounding transition regret. While clinicians explained that assessment and referral practices are largely in place to ensure that trans people understand all anticipated risks and benefits of hormones and surgeries, salient to clinicians was the potential risk of malpractice lawsuits in cases of regret. One physician explained:

[Clinicians have] some concerns about liability. You know, usually the bad stories are more heard, as opposed to positive stories. They may have heard of some other providers who had concerns about that type of issue [of transition regret lawsuits].

Interviewer: Yeah what do you think would be the worst fear for a liability concern?

I don't think this is founded, first of all. But people are afraid of parents, or family, who may not be supportive of the person's transitioning with hormones or surgery. And you know, they may be afraid of getting complaints or getting lawsuits even. Although I haven't really heard of that many cases in actuality ... I guess there's a fear that there will be "regret". Quote unquote "regret". But again, I haven't heard of any cases in actuality.

-Family physician, participant #20

This participant notes that "stories" of regret receive disproportionate negative attention, which may then amplify clinicians' fears of complaints or lawsuits from regretful patients or from patients' unsupportive parents. Further, these fears may be more acute when working with younger trans people whose legal guardians are more directly involved in youth medical decision-making. While this participant recognized clinicians' fears and the potential risks and consequences of legal action, at the same time, he questioned the extent to which these fears are justified given rarely encountering any actual cases of transition regret.

One trans participant who began medically transitioning at age 16 shared some observations of the work clinicians do to mitigate the risk of future regret with younger trans people. In order to access hormone therapy, he first needed to obtain a referral to a clinic specializing in gender-affirming care and was then required to attend several meetings between himself, his parents, a social worker, a psychologist, and a physician. Some of these meetings involved eligibility assessments, as well as additional mental health evaluations. Clinicians also discussed fertility preservation. He stated that:

I went around and I visited a bunch of psychologists and psychiatrists ... I ended up getting referred to [clinic] ... They [clinicians] had a whole list of the side effects for both hormone blockers and testosterone. There was also a separate mental health evaluation sheet, and your opinions on reproductive health. Like whether you would have kids, or whether you would want to perform procedures to like save, store your eggs somewhere ... I think my parents might have received some pamphlets on supporting trans children.

-Trans person, participant #7

Given the participant's age of 16, he could legally provide informed consent for hormonal treatments without parental consent. Yet, based on this account, clinicians met with the parents and provided them "pamphlets on supporting trans children". Clinicians additionally explored this participant's "reproductive health" needs prior to initiating hormone therapy in order to determine whether fertility preservation services were required. The involvement of parents in spite of his being of legal age to make independent medical decisions, together with fertility preservation assessment activities, show clinicians' regret prevention work.

Although clinicians and trans patients discussed eligibility assessments including rigorous informed consent processes, regret and/or detransitioning was unpredictable. For example, a psychologist provided an example of a client who sought surgical detransition:

I've had a person come in who regretted their top [mastectomy] surgery ... I'll say "she". She was certainly not a client that I would have felt in any way concerned about in terms of their [transition] journey. I met with the parents. I had taken the time, because she was like: "I want to explore, I want to think about this." It [transition] was led by her. And she came back to me because she wanted to get breast implants. And I asked her—because really, there are other clients who I go: "hmm not sure where that's going to end up"—but, her, I wouldn't have been at all concerned. So I said "is there anything that I should have done differently?" And her answer to me was really important, she said: "the best thing you did for me was give me entirely the decision."

-Psychologist, participant #21.

Based on this psychologist's own account, the client had previously medically transitioned and accessed chest masculinization surgery through an explorative, comprehensive assessment and referral process. This participant described meeting with the client's parents, conducting the required eligibility assessments, and was not "at all concerned" about recommending surgery. Despite all of this, the client later returned seeking a psychological assessment for breast implants in order to surgically detransition. The client did not recommend to the psychologist any stricter assessments prior to making "the decision" to medically transition in the first place, nor initiate any lawsuits related to "regret" or detransition.

Trans participants offered different interpretations of the logics built into the prevailing model of gender-affirming care. Some participants suggested assessments were often too strict and disconnected from the experiences of trans people seeking medical transition. As one example, a trans participant critiqued clinicians' attempts to prevent regret:

I think that [genital surgery eligibility criteria] it's fucked up because our society is so obsessed with genitals, and they think that if someone gets [genital surgery] and they regret it, it's life-ending. I think their perception of it seems so silly to me because I think it's just based on the fact that as a society we're obsessed with genitals and "oh my god you did this to your genitals?" Like my family, or someone will be like: "I can't believe you went through that". But, not really, because when you're trans—if you don't understand what it's like to be trans—then you don't get how actually, it's a big deal for me to have it—but it's also not going to make me. You know what

I mean? It's not that life changing! It's just my genitals are different ... But they [clinicians] don't want to be liable for anything that you might do after. Or any regrets that you might have.

–Trans person, participant #19

In this rendering of transition regret, even if this occurs it may not be the “life ending” event that seems to preoccupy clinicians’ fears and a society “obsessed with genitals”. Strict clinical assessment practices may instead reflect a projection of cisgender people’s priorities and anxieties, rather than the concerns of trans people, as noted by the participant above.

4. Discussion

Extending from clinicians’ and trans patients’ work practices, our research examined routine clinical activities happening in gender-affirming care in Canada. We uncovered that clinical work involves applying standard transition “readiness” assessments (e.g., the DSM; the WPATH-SOC) together with additional psychosocial evaluations (e.g., housing status; mental health coping strategies) which are deployed as proxy measures to predict future transition satisfaction/regret. When young trans people seek gender-affirming care—particularly those ages 16–18—clinicians may also meet with parents/guardians, even though across Canada most people ages 16 and older are legally determined to possess the capacity to make independent medical decisions (Coughlin, 2018). When a potential differential diagnosis (e.g., body dysmorphia; schizophrenia; borderline personality disorder) is identified, this confounds the assessment process and psychiatrists are consulted for additional, specialized capacity assessments. In such cases, patients’ requests for hormones or surgeries may be denied. Our analysis explicates how cisnormative discourses of regret coordinate assessment practices and may materialize from some clinicians’ (or clinics’) fears of being held legally responsible for trans patient decision-making. Assessment practices, and the overall discursive project of “preventing regret” in trans people, are deeply reflective of how cisnormativity and transnormativity rule biomedicine—including gender-affirming care. We discuss and contextualize these findings below.

As described by both clinician and trans participants in this study, “bad stories” of transition regret as “life ending” draw disproportionate attention. Such cisnormative discourses animate clinicians’ rigid gender-affirming care assessment practices (e.g., multiple assessments; capacity assessments; delaying surgery; parental involvement where it may not be legally required), and at the same time “bad stories” may amplify clinicians’ liability fears when trans people seek gender-affirming care. These results extend a study of mainstream media coverage in the US and the UK where between 2015 and 2018 the topic of detransitioning was featured over 50 times, contributing to a moral panic amongst the public in turn (Slothouber, 2020, p. 90). By contrast, Danker et al.’s (2018) survey of surgeons in the US and Europe who had surgically treated ~22,725 trans patients reported 59 patients who detransitioned (p.189). Importantly, 67% of these surgeons recalled a practice timeline of greater than ten years which suggests media coverage of detransition is decontextualized. Likewise, the American investigative journalism television series, *60 Minutes*, presents the stories of four regretful detransitioners who claimed that the gender-affirming medical care they themselves received did not meet clinical standards, however their medical providers were not interviewed to verify this claim (Stahl, 2021). Taken together with our study findings, we underscore that media coverage on detransition may compound clinicians’ fears of patient regret, detransition, and liability concerns with trans patients in particular, in effect, discursively coordinating rigid assessment practices. Farley and Kennedy (2020) argue that given ongoing anti-trans scientific and social environments, and when clinicians’ own anxieties about trans people remain uncontested, these could be used to justify withholding standard treatments such as

hormones and surgeries. Even more, the total absence of clinical guidance on detransitioning within the WPATH-SOC may aggravate clinicians’ fears, resulting in stricter assessments.

Our institutional ethnography reveals that transition assessment practices are coordinated by cisnormative and transnormative ruling relations. Thus, trans patients are treated as a “different type of person that isn’t capable” of medical decision-making, as one physician participant noted, and any disclosures of dissatisfaction with surgical outcomes are interpreted through a cisnormative lens of “regret” as evidenced by a trans participant’s account. Transnormativity further constructs transition regret or detransition as “life-ending” and trans identity ending, which can be traced to biomedical research categorizing these events as a “negative outcome” or a medical “failure” (Hildebrand-Chupp, 2020). Ashley and Dominguez (2020) point out that scientific medical knowledge production integral to trans healthcare has historically excluded trans people, which in turn reifies mistaken cisnormative/transnormative assumptions made by clinicians and researchers. Yet, as discussed by participants and corroborated by existing literature, regret is an “exceedingly rare” outcome (Danker et al., 2018, p. 189) even more rarely appearing in a “life ending” form accompanied by malpractice lawsuits expected by some clinicians (Deutsch, 2013; Exposito-Campos, 2021; Korpaisarn and Modzelewski, 2019). Further challenging transnormativity, evidence suggests that many people who detransition do so only temporarily and their trans identities often persist even whilst discontinuing gender transition (or their gender identities may shift dynamically) (Turban et al., 2021; Turban and Keuroghlian, 2018).

This is not to suggest that clinicians’ worries of regret or detransition are invalid. To be clear, our sample included nine trans people, eleven clinicians, and two administrators. Of those, one psychologist explicitly discussed a patient who—in the clinician’s words—“regretted” surgery and detransitioned. Although no other cases of detransition were discussed in our study, it is possible clinicians we interviewed elected not to disclose these cases, or were not fully aware of each of their patients’ long-term transition outcomes. It has been asserted that when people detransition, they avoid returning to the same clinician, and by default are counted as a “successful” transition, which contributes to under-reporting (Hildebrand-Chupp, 2020; Marchiano, 2020). However, our analysis contradicts this claim, given that a detransitioning person returned to the same clinician for an assessment/referral to obtain breast augmentation surgery and it also counters the dominant narrative that detransitioning occurs due to insufficient therapeutic exploration. It must also be stated that our analysis contrasts with dominant detransition narratives amplified by the mainstream media which explicitly endorse stricter psychosocial “readiness” assessments to prevent regretful detransitions, such as those portrayed by the *60 Minutes* segment discussed above.

Prudent to point out, no trans study participants discussed “regrets” with medical transition, nor a desire to detransition. Nor did clinicians disclose experiences of malpractice lawsuits launched by regretful trans or detransitioned patients. Rather, a physician noted the salience of such fears but that these concerns may not be “founded”. This is consistent with a US survey of 12 gender-affirming care clinics that provided hormonal therapy without a mental health assessment to 1944 patients; Deutsch (2013) found a regret rate prevalence of 0.8%, with 0.1% of regret cases leading to detransition, and no claims or judgments of medical malpractice (p. 141). However, we note that in providing recommendations toward the development of clinical guidelines on detransitioning, Exposito-Campos (2021) lists legal supports for detransitioned patients to explore the possibility of “medical malpractice” claims (p. 6). Vandenbussche’s (2021) survey of 237 detransitioners also identified that 13% endorse a need for advice to explore medical malpractice legal action. Though, 31% of this sample reported transitioning “only socially” (p. 4), so it is worth noting that some people who identify as “detransitioners” never received gender-affirming medical treatments and would therefore have no legal basis to pursue

malpractice.

Regret and/or detransition are unpredictable outcomes which strict clinical assessments may not be able to reliably prevent. The one example of detransition identified within our study suggests that even in a straight-forward case whereby “no concerns” emerge from comprehensive assessments, detransition is possible. This is consistent with the messaging of a training seminar provided to clinicians at the Advancing Excellence for Transgender Health conference where [Graham \(2017\)](#) stated that “a good decision at the time can still be later regretted” (n.p.). Similarly, [Exposito-Campos \(2021\)](#) explained that some people will detransition despite rigorous assessments and gender exploration. Our analysis suggests that clinicians do engage in extensive work to prevent regret within individuals, but rather than promising all trans people satisfying outcomes, these practices instead can create new risks.

When clinicians delay or deny patients gender-affirming care, rather than preventing regret or detransitioning, this may present clinicians with a different set of ethical and legal considerations. Even more, this could cause serious health consequences. In a survey of trans people in Ontario, Canada, [Rotondi et al. \(2013\)](#) identified that a quarter of respondents who reported current hormone use had a history of obtaining hormones or herbal supplements from non-medical sources such as from a friend, the street, or the internet; they also found five cases of self-performed surgical procedures. We stress that strict clinical assessments, in concert with the criminalization of hormone and surgery provision in some jurisdictions, could amplify non-medically supervised transitions and could even create unanticipated legal risks to clinicians (e.g., legal action related to denying recommended medical treatments).

We would like to acknowledge our study limitations. First, a majority of our interviews occurred in a large urban centre in Canada where people ages 16 and older are legally capable of independent medical decision-making. Our findings may therefore lack transferability to other geopolitical contexts, such as the US. As the landscape of gender-affirming healthcare varies significantly across contexts, often a function of cross-jurisdiction differences in the availability of legal protections for trans persons ([Kcomt, 2019](#)), this limitation is important to consider in future studies addressing gender-affirming care and detransition. Additionally, while a strength of institutional ethnography involves triangulating interview data with multiple actors and studying their application of texts in multiple locations ([Smith, 2005](#)), we acknowledge that there may have been other data sources we could have incorporated to strengthen this analysis. For example, our study may have been enhanced with direct field observation of the clinical encounters between trans patients and clinicians.

We conclude that the logic organizing clinicians’ assessment work reflects cisnormativity and transnormativity in biomedicine. Assessment eligibility criteria are designed to prevent regret, and in particular, avoid legal action from trans patients (or their legal guardians), but clinical procedures contrast with trans people’s material healthcare needs. To remedy this, our recommendations for building critical, trans-inclusive knowledge are two-fold. First, involve trans and detransitioning/ed people in identifying objectives of transition outcomes data collection and analysis because their priorities and language may diverge significantly from those of cisgender researchers and clinicians. Relatedly, and as highlighted by our findings, dissatisfaction with surgical results, transition regret, and detransition are all conceptually and materially discrete outcomes. Separate, scholarly attention to each of these outcomes that does not take for granted these are categorically negative medical failures in need of prevention, is warranted. Second, more research into the diverse experiences of people who detransition is necessary to respond to the widely held, cisnormative misconception of this as “life-ending”, and to assuage clinicians’ fears. This knowledge could also bolster comprehensive gender-affirming care—inclusive of detransitioners’ medical and social support needs—affirming all expansive and non-linear gender transition trajectories.

Author contribution

Kinnon MacKinnon: Conceptualization, Methodology, Data collection and analysis, Writing – Original draft preparation. Florence Ashley: Conceptualization, Writing- Original draft preparation, reviewing and editing. Hannah Kia: Writing – Reviewing and editing. June Lam: Writing- Reviewing and editing. Yonah Krakowsky: Writing – Reviewing and editing. Lori Ross: Supervision, Conceptualization, Writing – Reviewing and Editing.

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