

Clarifying Our Stance on BMI and Accessibility in Gender-Affirming Surgery: A Commitment to Inclusive Care and Dialogue – A Reply to Castle & Klein (2024)

Luke R. Allen^{1,2}, Noah Adams³, Cody Dodd⁴, Diane Ehrensaft⁵, Lin Fraser^{1,2}, Maurice Garcia^{1,6}, Simona Giordano^{1,7}, Jamison Green^{1,8}, Thomas Johnson⁹, Justin Penny^{1,10}, Katherine Rachlin², and Jaimie Veale¹¹

¹ World Professional Association for Transgender Health Ethics Committee

² Independent Practice

³ Ontario Institute for Studies in Education, University of Toronto; Center for Applied Transgender Studies, Chicago, IL, USA; Transgender Professional Association for Transgender Health

⁴ Department of Psychiatry and Behavioral Sciences, University of Texas Medical Branch at Galveston

⁵ Department of Pediatrics, University of California San Francisco

⁶ Department of Urology, Cedars-Sinai Medical Center

⁷ Centre for Social Ethics and Policy (CSEP), School of Social Sciences, The University of Manchester


⁸ Independent Legal Scholar

⁹ Department of Anthropology (Emeritus), California State University, Chico

¹⁰ Department of Family Medicine and Community Health, University of Minnesota; Center for Bioethics, University of Minnesota


¹¹ School of Psychology, University of Waikato


Author Note

Luke R. Allen  <https://orcid.org/0000-0001-5420-2992>

Noah Adams  <https://orcid.org/0000-0002-8354-0293>

Cody Dodd  <https://orcid.org/0000-0002-3620-0069>

Simona Giordano  <https://orcid.org/0000-0002-3608-0263>

Jaimie Veale  <https://orcid.org/0000-0002-9151-7413>

Conflict of Interest: The authors declare that they have no conflict of interest.

This article does not contain any studies with human participants or animals performed by any of the authors.

Correspondence concerning this article should be addressed to Luke R. Allen, PhD (www.LukeAllenPhD.com). Email: LukeAllen@Lrallen.com

This is an Accepted Manuscript of an article published by Taylor & Francis in The International Journal of Transgender Health on February 29, 2024, available at: <https://doi.org/10.1080/26895269.2024.2321036>.

Clarifying Our Stance on BMI and Accessibility in Gender-Affirming Surgery: A Commitment to Inclusive Care and Dialogue – A Reply to Castle & Klein (2024)

We want to take this opportunity to thank Castle and Klein for their comments regarding our article, *Principlism and Contemporary Ethical Considerations for Providers of Transgender Health Care*. We agree that the use of Body Mass Index (BMI) requirements in transgender healthcare is highly problematic. We acknowledge the importance of thoughtful and sensitive discourse regarding BMI in transgender healthcare and welcome the opportunity to ensure our language more accurately reflects our commitment to challenging harmful stereotypes, rather than perpetuating them.

In our article we assert that “*some* patients with very high BMI *may* be physically unable to dilate due to limited reach” (italics added). We wish to point out that our intent here is not to generalize or assert that all, or even most, individuals with higher BMI cannot reach their genitals for dilation purposes, but rather that this may be a concern for *some*. Further, we did not intend readers to interpret this as meaning that these considerations are insurmountable barriers to gender-affirming care. Castle & Klein (2024) would seem to agree in pointing out that while there do not appear to be adaptive tools to use dilators in the case of physical mobility issues, suitable alternatives could be envisioned. We regret, however, that we did not better provide this context, as Castle & Klein are correct to infer the possibility that some readers might make anti-fat inferences in its absence.

In response to Castle & Klein's interpretation of our discussion on weight requirements—where they claim we insinuate “fat patients who cannot dilate due to physical limitations are not unfairly disadvantaged” (p. 3)—we must highlight: pointing out the existence of unfair disadvantages due to weight requirements does not logically imply nor insinuate the nonexistence of such unfair disadvantages, contrary to Castle & Klein's assertion. Our discussion is meant to illuminate the reality of these unfair disadvantages, not to deny them.

Our critique that “[weight requirements] can act as an insurmountable barrier to care, especially if they are used, as is common, in candidacy assessments for GAC” (Allen et al., 2024, p. 13) was directed at the systemic barriers. They act as insurmountable barriers to care **only if** poorly justified BMI requirements remain a requirement prior to accessing surgery. We advocate for a more inclusive approach that considers each patient's unique circumstances and needs. Our point was to highlight that such requirements can become unjust obstacles when not critically assessed or justified. We argue against the blanket application of BMI thresholds that do not consider individual health contexts and advocate for a nuanced approach to surgical candidacy. Ultimately, our critique of BMI is directed at poorly justified BMI thresholds that obstruct surgery access, not the individuals affected by these requirements. We stand against such barriers and commit to advocating for policies that prioritize patient health, autonomy, non-maleficence, and justice.

In response to the assertion that shared decision-making contradicts the principle of respect for autonomy, we maintain that our definition of shared decision-making upholds patient autonomy. We state “By shared decision-making, we mean a process where the client is the main decision-maker, fully informed by the clinician(s), with the healthcare provider acting as a technical expert, supporting the client's autonomy and understanding of treatment choices (Gerritse et al 2021; see also Coleman et al., 2022)” (Allen et al., 2024, p. 5). This collaborative model does not diminish patient autonomy; rather, it enhances it by

ensuring that patients are well-informed and supported in their decision-making. Thus, there is no contradiction in our statements — both respect for autonomy and shared decision-making are integral to informed consent and providing all necessary information to empower patients in making healthcare decisions that best align with their values and preferences.

We would, however, like to push back on an assertion by Castle & Klein. They ask us to consider a person who is physically disabled (instead of fat) from the assumption that “the disabled individual would not be expected to become able-bodied to have surgery.” In fact, ableism is experienced as a pervasive barrier to trans-affirming healthcare that affects a variety of disabled individuals, be they autistic (Bruce, Munday, & Kapp, 2023), D/deaf (Álvarez, 2019; Transgender Europe, 2018), or physically disabled (Baril, Sansfaçon, & Gelly, 2020). Let us be clear. It is unequivocally discriminatory to deny or prolong any individual's access to healthcare based solely on their disability or physical differences. In service of an individual's healthcare, each person's specific healthcare needs and the relevant factors pertaining to the proposed medical intervention must be considered independently.

Moving forward, we will strive for clearer and more empathetic communication, ensuring our advocacy efforts reflect our commitment to inclusivity and equity in healthcare. We agree that assuming limitations based solely on weight can unjustifiably reinforce negative stereotypes and overlook the diversity of individual capabilities and needs. We aim to highlight the existence of these challenges, not endorse them. We advocate for thoughtful consideration of additional means and measures to ensure equitable healthcare access.

References

- Allen, L. R., Adams, N., Ashley, F., Dodd, C., Ehrensaft, D., Fraser, L., Garcia, M., Giordano, S., Green, J., Johnson, T., Penny, J., Rachlin, K., & Veale, J. (2024). Principlism and contemporary ethical considerations for providers of transgender health care. *International Journal of Transgender Health, 1–19*.
<https://doi.org/10.1080/26895269.2024.2303462>
- Álvarez, L.M. (2019, September). Guidelines to human rights-based trans-specific healthcare. *Transgender Europe*. <https://tgeu.org/wp-content/uploads/2019/12/TGEU-Guidelines-to-Human-Rights-Based-Trans-specific-Healthcare-EN.pdf>
- Baril, W. Sansfaçon, A.P., & Gelly, M.A. (2020). Digging beneath the surface: When disability meets gender identity. *Canadian Journal of Disability Studies, 9(4)*.
<https://doi.org/10.15353/cjds.v9i4.666>
- Bruce, H., Munday, K., Kapp, S.K. (2023, Jun 13). Exploring the experiences of autistic transgender and non-binary adults in seeking gender identity health care. *Autism in Adulthood, 5(2)*. <https://doi.org/10.1089/aut.2023.0003>
- Castle, E. R., & Klein, A. (2024). Pointing out anti-fat bias in BMI restrictions discourse: Response to Allen et al. (2024), “Principlism and contemporary ethical considerations for providers of transgender health care.” *International Journal of Transgender Health*.
- Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. L. C., Deutsch, M. B., ... & Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health, 23(sup1)*, S1–S259.
<https://doi.org/10.1080/26895269.2022.2100644>
- Gerritse, K., Hartman, L. A., Bremmer, M. A., Kreukels, B. P. C., & Molewijk, B. C. (2021). Decision-making approaches in transgender healthcare: Conceptual analysis and ethical implications. *Medicine, Health Care, and Philosophy, 24(4)*, 687–699.
<https://doi.org/10.1007/s11019-021-10023-6>
- Transgender Europe. (2018, January 30). Key policy principles from “oppression squared: D/deaf and disabled trans experiences in Europe.” Transgender Europe.
<https://tgeu.org/key-policy-principles-from-oppression-squared-d-deaf-and-disabled-trans-experiences-in-europe/>