

**Barriers, Boundaries, and Borders: An Investigation into Transgender Experiences  
within Medical Institutions**

by

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As a population that has been often dismissed, neglected, discriminated against, and abused by medical institutions, the relationship between the transgender community and medicine has remained shrouded in silence until recent history. As a result of being forced to contend with transphobia, violence, and erasure, the transgender community in the United States suffers from tangible health disparities when compared to the health outcomes of the national adult population. This thesis addresses issues of boundary enforcement, gatekeeping, and Western ethnocentrism, which are problems that transgender people often experience in their interactions with healthcare. Each chapter addresses a different aspect concerning transgender experiences in healthcare in the United States by reviewing scholarship on these experiences, considering available evidence of health disparities in medicine, and exploring medical perspectives on the lives of trans individuals. This project contributes to trans studies via an investigation of some of the nuanced experiences trans individuals face in medical settings. Through this work I argue that scholars and activists must work to deconstruct harmful barriers, boundaries, and borders in medicine to improve the quality of and access to healthcare for transgender populations. The first chapter discusses the theory in transgender studies on transgender healthcare. The second chapter centers the experiences of trans individuals within healthcare institutions and discusses the health disparities that exist for transgender communities when compared to their cisgender counterparts. The third chapter looks at these topics from the perspective of medical practitioners and engages with

methods of communication that can help to bridge the chasms in the health disparities that exist between transgender and cisgender populations. This project works toward a future in which trans people are able to access compassionate, gender-affirming, quality healthcare within medical institutions that do not engage in harming transgender patients.

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## Preface

I would like to thank my thesis advisor, Dr. Lester Olson, for his time spent helping me make my project the best it can be. As a scholar in communication, Lester's perspective on my work has been invaluable. I would also like to thank the additional members of my defense committee, Dr. Julie Beaulieu, Dr. Lisa Brush, and Dr. Natalie Kouri-Towe, for their time generously spent helping me refine my work. Their expertise and mentorship have been absolutely crucial to this project, and I will forever be grateful for their efforts. Through the courses that I have been fortunate enough to take with each of these professors, they have all played a role in my development both as a scholar and as someone with a lifelong love of learning. Thank you all for your patient guidance throughout this process and for believing in me, especially during those moments in which I struggled to believe in my own capabilities. Julie, you are one of the kindest, most supportive, and empathetic people I have ever met. I consider myself ridiculously lucky to have been able to spend the last two years in classes with you. You manage to teach students far more than what is listed on your course syllabi, and for that I am so grateful. I am continually impressed by your remarkable passion for pedagogy and activism in the classroom, and hope to one day be able to pay forward even a fraction of the gifts you've given me by doing the same for the next generation of students and scholars. I have the utmost admiration and respect for who you are and everything that you do. Natalie and Lisa, you are both such amazing mentors and role models. I greatly appreciate all the time, effort, and attention you have generously put into my project. Thank you for always being so supportive of my passions and ambitions, and for always challenging me to improve my work. You are both incredibly inspiring to me, and I am so glad that I have had the chance to get to know you throughout my experience as an undergraduate.

Special acknowledgment goes to my dear friend Leo Bake, who not only put in countless hours helping me discuss my ideas and direction for this project, but also always knew when I was unsure of myself. I am so appreciative that Leo chose to make himself a source of endless love and encouragement. Thank you for gently reminding me when I needed to rest and come back to this project with a better perspective, and also for helping me succeed in the face of self-doubt. I am endlessly appreciative of your continued input on my scholarly endeavors and for being one of my biggest supporters both throughout this process and in life generally. Additional thanks go to my editors, Kate Shindle, Kieran Craft, Kelsey Kerr, and Cody Hoellerman, who read chapters of my work in various stages of completion and graciously offered me their insight and feedback. You are all champions for making it through the entirety of my first draft. Further thanks go to my Gamma Sigma Sigma family, especially Lauren Frank, Vanessa Pappal, and Faith Sutton, for always encouraging me to be the best I can possibly be. To Brooke McEvoy and Mariah Reinard, my first two Pitt friends, look at how far we have come. Thank you for supporting me as I continued to add majors and projects to my college plan. I greatly appreciate your support and cannot wait to see what life looks like for us beyond graduation. Jane and Chandler Scull, thank you for giving me the space to be myself and for always trying to understand who I am and will become. I am endlessly grateful to have your love and support as my mother and sister. To my friends, peers, and family, thank you for loving and supporting me the way I am. I wish I could list all of your names individually, but you know who you are. I could not have done this without you. And finally, thanks to my feline companions, Tuxedo, Edward, Rory, and Emerson, who have been avid in supporting this project by always sitting on the exact papers I need and for stepping on the keyboard to add their insightful commentary to my manuscript.



This work is dedicated to every member of the transgender community. Thank you to everyone who is brave enough to share their truth with the world. I wish you nothing but acceptance, love, success, and happiness. May the interactions between your life and medical institutions continually improve. To the transgender children living in the United States: We see you. We support you. We love you. Let us always remember and honor the vibrant lives that the transgender community has lost through acts of senseless violence.

## 1.0 Introduction

You must be so much happier now that you can be you!” I look at the practice nurse taking my blood for my routine quarterly hormone level analysis. Haven’t I always been me? ... I tell her nothing of the verbal abuse and physical and sexual assaults that I routinely experience. I tell her nothing of the poverty and unemployment that is my unchanging life.

There’s no point. (O’Shea 43)

In a *New York Times* article published on October 21, 2018, Green et al. discuss the Trump Administration’s memo arguing for the adoption of a legally-binding biologically essentialist definition of gender that conflates assigned sex at birth and gender identity at the federal level. Such a policy would effectively render invisible the experiences of the approximately 1.4 million American citizens who identify with a gender other than that assigned at their birth (Green et al.). Catherine E. Lhamon, having led the Education Department’s Office for Civil Rights under President Obama, states that “This [move] takes a position that what the medical community understands about their patients— what these people understand about themselves— is irrelevant because the government disagrees” (Green et al.). But how well does the medical community understand its patients? This work investigates the nature of interactions between those who identify as transgender and medical institutions as a whole to answer this question.

In the developing field of transgender studies, an engaging theme that emerges is how trans individuals frequently find themselves pushed up against borders and barriers in varying capacities. From the offices of clinicians to completing intake paperwork, trans people are presented with categories and barriers that restrict their rights and ability to self-identify

considerably. When those who identify as transgender do not conform to the expectations placed upon them, there are significant consequences such as being denied healthcare and experiencing discrimination. The fact that trans people encounter such a substantial amount of resistance in the forms of both negligence and refusal when seeking care is a critical concept in trans studies because cisgender individuals seeking plastic surgery or other similar bodily modifications have not historically been treated in the same manner. The differential treatment between cisgender and transgender patients illustrates how medical discourses continue to affirm healthcare for cis bodies while denying that same healthcare for trans bodies. Further, it also highlights how both cisgender and transgender bodies are already constructed rather than being constructed through various encounters with the medical establishment. Boundaries and gatekeeping play a significant role in trans experiences. Many such boundaries exist to generate narratives that create specific ways of existing for trans individuals. Those who find themselves excluded from these recognized ways of existing as transgender can struggle to convince health professionals and others in their day to day lives that they are “really” trans, which produces a discourse and hierarchy of what “trans enough” looks like. Such discourses ultimately further marginalize transgender individuals by reinforcing false cultural narratives surrounding the existence of trans populations. In this thesis, I will address issues of boundary enforcement and Western ethnocentrism by taking a historical approach while also advocating for deconstructing the borders and constricting categories facing transgender individuals today. I organize this thesis into three chapters: Trans Scholarship on Medicine, Health Disparities and Experiences in Transgender Medicine, and Medical Perspectives on Transgender Patients. Chapter one engages most directly with trans theory written by scholars working in the field of transgender studies. Chapter two discusses the experiences of transgender patients seeking healthcare today and the health disparities that exist between the trans community and the general

population. Chapter three approaches these issues from the provider perspective and discusses ways in which the relationships between transgender patients and their healthcare providers can be improved through the use of communication. Ultimately, this project contributes to trans studies via an exploration of some of the more nuanced experiences trans individuals face in medical settings. Furthermore, this work strives toward a goal of deconstructing boundaries, specifically those that exist within the medical field, in an effort to improve the quality of and access to healthcare for transgender populations.

Deconstructing and analyzing the barriers, boundaries, and borders that transgender individuals face within medicine is an urgent project not just for trans populations, but for everyone who interacts with the medical system during their lifetime. Examining how transgender people experience discrimination within medicine can illuminate the ways in which those from other marginalized identity groups may experience similar harmful interactions with their healthcare providers. The knowledge gained from the positionality of queer and transgender people as marginalized subjects within medical spaces both allows for and necessitates the ability to see medical shortcomings in a particular way. This knowledge can thereby lead those belonging to other marginalized identity categories to ultimately realize that the care they are receiving may be biased or discriminatory in some capacity. Thus, the implications of investigating the erasure and harm of transgender individuals within medicine is a hugely important project that has the potential to significantly improve the holistic healthcare of all people living in the United States.

This piece of scholarship is one that acknowledges, respects, and makes an active effort to use the correct pronouns and terminology of transgender, nonbinary, and cisgender individuals at all times. As such, readers may find unfamiliar pronouns throughout the text including but not limited to they/them/theirs and ze/hir/hirs, which some transgender or nonbinary people use in

order to have their gender identity adequately recognized. I make every effort to avoid stigmatizing and derogatory language but chose to reprint quotations as they originally appear without censorship of sensitive terminology. In instances where a quotation uses “outdated” terminology, terms that are no longer accepted by the field of transgender studies, or a slur to refer to transgender subjects or sex workers, I reprint it as it appears with [sic] following the word in question.<sup>1</sup> As a final note, I make every effort to include the narratives of transgender people whenever possible. As a community whose voices have been erased for so long, hearing the first-person stories of a marginalized population serves to humanize those who are struggling with the unquantifiable effects of prejudice and discrimination.

## 1.1 Key Terms

We will begin our engagement with borders by defining some key terms necessary to comprehend the existing scholarship in transgender studies. Since the accepted rhetoric used to discuss marginalized populations and experiences changes significantly over time and as knowledge production continues, it is essential to note that the terminology that I use in this work will likely become “outdated” in a matter of years, or even perhaps months. I do not believe that the changing rhetoric of transgender studies through time and across cultures is a negative phenomenon, however. The evolution of language is something that scholars in trans studies should embrace and encourage as more individuals find terminology that speaks to their embodied

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<sup>1</sup> What terminology is accepted and used within academia compared with terms that scholars conceptualize as outdated is a highly political question. The answers certainly change depending on the identity categories that individuals inhabit, which can include race, gender, class, sexuality, and more. With these considerations in mind, this project is one that seeks to use the academic terminology of transgender studies in 2019.

experiences of the world. The following sections discuss the terminology of transgender studies at this point in history. I engage with these key terms in three separate categories: identities, practices, and theoretical approaches. These conceptual categories create space for a broader discussion of each term and allow for elaboration on how the terms relate to one another.

### 1.1.1 Identities

Identities are tools that one uses to explain or illustrate their own experiences of the world. They indicate that the person who identifies in a particular way understands and recognizes themselves within parts of the narratives of others who use the same identity. I use **queer** as an umbrella term to refer to all individuals who do not identify with a heterosexual sexual identity (Planned Parenthood). Examples of queer identities are gay, lesbian, bisexual, pansexual, asexual, demisexual, and more. **Gender identity** refers to someone's innate sense of who they are as a gendered subject (Human Rights Campaign). While related to gender identity, **gender expression** includes the physical indicators and manifestations of one's gender (Human Rights Campaign). Examples of gender expression include the clothing and accessory choices, makeup and hairstyle decisions, name and nicknames used, pronouns, and any other physical characteristics of a person that can be viewed and understood in gendered ways. Gender expression is an external component of gender that can be discerned by looking at someone. By contrast, gender identity is an aspect of identity that is not visible to others. Often, there are some similarities between one's gender identity and gender expression if they can live a life in which they do not have to conceal their gender identity. As a result, gender is both an internal sense of self and a performance visible to others.

**Cisgender** refers to those individuals whose sex assigned at birth and gender identity align and “is not indicative of gender expression, sexual orientation, hormonal makeup, physical anatomy, or how one is perceived in daily life” (“LGBTQ+ Definitions”). A cisgender woman is someone who was assigned female at birth and identifies as a woman, while a cisgender man is someone who was assigned male at birth and identifies as a man. I understand the term **transgender** as Susan Stryker explains it: “people who move away from the gender they were assigned at birth, people who cross over (trans-) the boundaries constructed by their culture to define and contain that gender” (2008). Stryker’s definition provides a broad paradigm for viewing which individuals can be included within the term transgender while also directly challenging the hold that cultural boundaries and expectations have over the lives of trans people. It is vital to understand that queerness and transness are not mutually exclusive categories and that it is entirely possible for a transgender person to identify as heterosexual, queer, or with another sexual identity. As such, queerness and transness are identity categories that may overlap in some cases but may not in others.

Within the context of trans studies, it is vital to have an understanding of the identities of intersex individuals. Cheryl Chase’s definition of **intersex** frames the term as applying to “the many individuals who arrive in the world with sexual anatomy that fails to be easily distinguished as male or female” (1998). Typically, doctors discover the status of an infant as intersex at birth, when medical professionals have trouble interpreting whether an infant’s sexual morphology should be categorized as female or male within the constructed binary of human sex. A crucial point to recall is that the human sex binary is socially-constructed. Thus, the naturalization of the female/male binary for human sex does not neatly correspond to how human bodies exist in the world. As I will discuss in the literature review, the interactions between medicine and trans bodies

are firmly rooted in the medicalization of intersex individuals. The next section will discuss some of the most important cultural practices that relate to the language of identity and trans studies.

### 1.1.2 Practices

Practices are cultural patterns of behavior that function to a specific end, usually to control or constrain individuals with regard to their trans identities. **Gatekeeping** within trans studies is the practice of evaluating someone's assertions of identity through socially-constructed beliefs surrounding what such individuals must look like, act like, or do to be seen by another person as a member of the group with which they identify. Gatekeeping is an important concept within medical therapeutic discourses because trans populations are forced to contend with stereotypes and must prove their validity as transgender subjects within the boundaries set by medical institutions. Gatekeeping practices are used to acknowledge only specific forms of existence for transgender subjects who fit within certain criteria. Further, they function to invalidate the experiences of trans individuals who exist outside of the small set of validated experiences. Typically, the experiences of transgender people who fit firmly within the gender binary and seek to transition from one sex to another are the narratives that become accepted under the logic of medical gatekeeping. These practices privilege a select few ways of existing in the world as transgender, while further marginalizing others. For more information on gatekeeping, see the work of Irvine (2005).

**Social stigma**, hereafter referred to as stigma, is a socially-constructed process of assigning a value to and discriminating against individuals based upon beliefs about their worth in regard to their social position or identities (Doyle and Molix 2015). Stigma devalues the lives of members of the population based upon marginalized categories such as race, gender, class, sexual orientation, ability, and more. The term **pathologization** refers to the practice of medical



professionals studying behavioral or physical variations from the norms accepted by the medical community and treating them as if they are a disease or disorder that warrants medical intervention (Gill-Peterson 2018). Pathologizing discourses work to attach stigma to the behaviors, identities, and physiologies that medical authorities deem deviant in some way. When referring to the concept of **othering**, I reference the practice of constructing a population or group as different from the norm in a negative way. Powell and Menendian define othering as “*a set of dynamics, processes, and structures that engender marginality and persistent inequality across any of the full range of human differences based on group identities*” (italics original). Transgender individuals are often othered by cultural assumptions and ideals that treat the identities and experiences of cisgender individuals as the norm to which all others must be compared. Within trans studies, gatekeeping, stigma, pathologization, and othering are essential terms because the practices function together to oppress transgender individuals in medical contexts through marginalization and invalidation.

**Eugenics** refers to a branch of pseudoscience that developed out of biological arguments rooted in racial taxonomies and social Darwinism (Somerville 1994). It aimed to reproduce desirable components of the genetic population (e.g., characteristics associated with whiteness) while decreasing the number of those characteristics deemed unfavorable by societal standards. The goal of eugenics at its founding was to control and limit the number of people of color having children while encouraging whites to reproduce. This effort worked to ensure that whites retained their social position and privilege. For more on eugenics, see Somerville 1994. Related to eugenics is the concept of **anti-miscegenation**, which refers to legislation that prohibited interracial intimate relationships such as in the case of marriage (Frederick 2016). Interracial relationships posed a problem to eugenic scientists because children born from multiracial parents become racially and ethnically ambiguous within the white supremacist black vs. white dichotomy. Eugenics and anti-

miscegenation legislation are examples of institutionalized forms of racism in science and the law, respectively. These concepts relate to transgender studies through the ways in which medicine and the law exercise control in specific ways over the bodies of certain marginalized individuals.

**Western ethnocentrism** is the tendency for Western culture and ideals to be positioned as the norm or standard against which Western observers evaluate other cultures (Mohanty 2003). Western ethnocentrism is a significant term in transgender studies because of the historical lack of representation of non-Western scholarship in this field. Scholars working in the West often have the social power and influence to be able to decide which bodies and experiences become normalized, despite the continued presence of socially, historically, and culturally-specific ways of living that challenge Western conceptions of “normal.” Western ethnocentrism has resulted in a history that centers privileged white bodies while othering the experiences of transgender individuals, especially transgender people of color. Western ethnocentrism is a particularly harmful practice because it can lead to the exoticization of non-Western cultures and identities, which generates one-dimensional cultural stereotyping and harm. While all individuals who identify as transgender experience disproportionate rates of violence, discrimination, and poverty, it is often transgender people of color who suffer the most from these oppressive forces. Transgender people of color are uniquely positioned as both a racial and gender minority, which increases their exposure to these cultural harms due to cultural and institutional racism and transphobia. Finally, **medical tourism** refers to the practice of crossing (often national) borders to access medical care that is either inaccessible or cost-prohibitive in one’s home country (Bookman and Bookman 2007). Medical tourism is a topic that trans studies engages with because some trans individuals seek gender-affirming healthcare in other countries when the healthcare systems in the

United States fail them. The next section of key terms will consider those that are theoretical approaches.

### 1.1.3 Theoretical Approaches

Theoretical approaches differ from practices in that practices are patterned modes of behavior, and theoretical approaches are the cultural ideas that underlie practices and make such patterns of behavior legible. **Biological essentialism** refers to the belief that individuals are gendered beings in particular ways due to their biological and physiological makeup. More specifically, this way of viewing gender supports the view of a conflated sex and gender system, wherein one's anatomy as male or female necessarily determines their gender as a man or a woman. For more work on biological essentialism, see Butler (2006). The **gender binary** is an ideological system that regards gender as two separate categories for human beings that are fundamentally opposed to one another (Rubin 2011, "Understanding Gender"). The gender binary works to force subjects to conform to gendered expectations placed upon them by their assigned sex category. Thus, the gender binary functions alongside biological essentialism to uphold the Western system of conflated sex and gender.

**Gender dysphoria** is a term that the American Psychological Association uses to diagnose individuals experiencing distress related to their gender identity. The 5th edition of the Diagnostic and Statistical Manual (DSM) defines gender dysphoria as

A marked incongruence between one's experienced [or] expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following: 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex

characteristics (or in young adolescents, the anticipated secondary sex characteristics), 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics), 3. A strong desire for the primary and/or secondary sex characteristics of the other<sup>2</sup> gender, 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender), 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender), 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender). (DSM-5)

Gender dysphoria is a contested term within trans studies because some advocates argue that it further pathologizes transgender individuals and generates a narrative of existence in which someone cannot be seen as a valid transgender person in the absence of experiencing gender dysphoria. In effect, dysphoria becomes a requirement for being trans. Proponents of the inclusion of gender dysphoria in the DSM argue that its inclusion generates pathways to healthcare for transgender individuals diagnosed with dysphoria. Their fear is that, should it be removed, gender-related healthcare access would become something that fewer members of the community could

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<sup>2</sup> While the APA definition of gender dysphoria refers to "the other" gender, I resist this terminology because it further reinscribes the gender binary where men and women are seen as the only two gender options. In points 4, 5, and 6, the APA definition cites "or some alternative gender", which is a marginal improvement. It is my hope that the next edition of the DSM includes "another gender" as their language for all points. The changes made thus far in moving against one singular model are encouraging, but there is still work to be done in this area.

access due to cost. Many health insurance companies will likely refuse coverage for gender-related healthcare if such healthcare is conceptualized as merely elective and not medically necessary as a set of treatments for a psychiatric disorder.

While the definition of gender dysphoria in the DSM V is not perfect, it has made enormous improvements on the definition used in the DSM IV. The DSM IV definition states that gender dysphoria is

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following: 1. Repeatedly stated desire to be, or insistence that he or she is, the other sex, 2. In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing, 3. Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex, 4. Intense desire to participate in the stereotypical games and pastimes of the other sex, 5. Strong preference for playmates of the other sex. B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. C. The disturbance is not concurrent with a physical intersex condition. D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.” (DSM-IV)

The DSM V definition improves on that in the DSM IV by expanding their conceptualization of what it means to be transgender. While the DSM IV references the “other” sex or “cross-sex” in all of the listed points, the DSM V allows for medicine to recognize the existence of non-binary

gender identifications in some of its qualifying criteria. The DSM V also eliminated references to the stereotypical evaluations of clothing that are generally given a gender-specific cultural coding. While the DSM V definition of gender dysphoria is not perfect, it represents a substantial positive shift when compared with the definition that preceded it. While definitional shifts are important for tracking the ideals of the medical community, policy changes do not always result in improved healthcare interactions for trans people.

Despite being frequently conceptualized as an issue pertaining only to transgender populations, individuals who identify as cisgender may experience gender dysphoria as well. Cisgender people can feel the effects of the gendered distress that constitutes dysphoria. The cultural conceptions of what it means to exist in the world as a man or a woman can undoubtedly cause psychic pain for those whose bodies do not align with such culturally-specific ideals of masculinity and femininity. Thus, cisgender individuals whose distress is related to their gendered embodiment and is both clinically significant and related to their idea of what the bodies of men or women look like could experience gender dysphoria under these circumstances. Cisgender populations should have a vested interest in the healthcare outcomes for the transgender community because their healthcare could be impacted by the clinical definitions and practices that are currently conceptualized as specific to transgender individuals today.

Finally, I define the term **boundary** as a socially-constructed norm that places pressure on individuals to conform to specific ways of living. Boundaries are often utilized in a binary fashion, wherein individuals are expected to situate themselves easily on one side or the other of the boundary in question. Cultural messages frequently enforce boundaries on the lives of those belonging to marginalized groups. One example of boundaries is how sex and gender are conflated and binarized on medical forms, forcing transgender and intersex patients to categorize themselves

as either male or female. While these questions usually inquire about one's gender, they only list the culturally-accepted options for human sex designation as the answers: female and male. An example of transgender individuals being forced to navigate a boundary that is reinforced by cultural messages lies in how transgender men are expected to present their gender expression in hyper-masculine ways. Similarly, transgender women feel the cultural pressures to present in hyper-feminine styles. Subsequently, trans people are then critiqued for their gender presentations, sometimes by feminist and queer communities in addition to majority cisgender, heterosexual communities. Holding transgender people to gendered standards that cisgender individuals are not expected to live in accordance with illustrates that those who identify as trans are particularly surveilled when it comes to their gender expression. Thus, transgender populations come into contact with boundaries that exert pressure on them and limit their ways of existing in the world as someone who identifies as transgender.

## **1.2 Literature Review**

It is tempting to conflate the increasing visibility of transgender individuals with the belief that trans people are new in some way, or that transgender issues are an emerging phenomenon. The truth, though, is that archival documentation tracing the existence of transgender individuals throughout history exists. The story of transgender woman Christine Jorgensen, who received gender confirmation surgery in Denmark in the 1950s, is frequently cited as the start of United States public consciousness about transgender issues within healthcare (Meyerowitz 2009). However, the medical institution was involved in close studies of transgender bodies far before the 1950s. One obstacle to recognizing and engaging with the earlier medical history of trans lives

is that the language used to describe transgender representations is relatively recent. The nature of gender is complicated because gender has been treated differently and discussed in diverse language and terms throughout time. Thus, locating gender non-conforming lives in these archives can be challenging in that it requires researchers to find individuals who would be conceptualized as trans in today's terms within medical records that had an active interest in erasing their existence.

Consequently, the point at which transgender bodies and medicine begin to overlap changes slightly depending upon which medical interventions on what populations one wishes to include as "transgender healthcare" before trans became a current medical term. Sexual and gender deviancy in previous centuries would have been seen as a sinful or a problem of personal morals, but the enlightenment period brought in the ability to have worldly causes for such behavior (Roberts 2011, McGann 2011). The focus of knowledge production about sex and gender shifted from religion to medicine (Roberts 2011, Foucault 1979, McGann 2011). It was in this space that the field of sexology had its slow beginnings. Within the discourses of sexology, it becomes difficult to untangle the histories of queerness with those of transness (Irvine 2005). As such, these histories have some overlap in that certain aspects of queer history align with transgender history.

Julian Gill-Peterson's book, *Histories of the Transgender Child*, is the first to chart the existence of bodies in medical archives that can be read within today's transgender framework. Their work highlights how early attempts at creating a science of sex during this period set out to establish an unbiased practice both generating and regulating standards of normalcy when it comes to sex, gender, and sexuality. In reality, though, the idea that humans can produce objective science becomes problematic in that humans are fallible beings who work within the context of their own biases, judgments, and worldviews. These factors that influence research and knowledge



production are not always properly controlled for and addressed within scientific research methods. Gill-Peterson discusses the heartbreaking ways that medical providers and researchers from the early 19th century and beyond have conceptualized and interpreted the bodies of queer, gender non-conforming, and transgender children and young adults. In setting standards on the forms that human bodies can take, biologists produced what is considered a “normal” sex, gender, and sexuality, thus creating a paradigm based upon biology that advocates for the normalization of heterosexuality, monogamy, reproduction, and the gender roles that heterosexual relationships produce (Gill-Peterson 2018). Further, biologists also used the medical myth of the “normal” and “healthy” to justify their medical actions on individuals, even those who did not consent to these medical interventions (Gill-Peterson 2018). The ability to set explicit expectations for all human bodies to be held to requires an immense amount of political and cultural power and creates institutionally-sanctioned ways to enforce adherence to these arbitrary but externally-imposed codes of being.

The power of the medical institution and its ensuing ability to carry out the gender and sexual regulation of bodies resulted in the pathologization of queer and transgender experiences, specifically those that did not fit within the socially constructed frameworks accepted as biologically natural by scientists and medical professionals of the day (Gill-Peterson 2018, Chase 1998, Califa 1997, Meyerowitz 2009, Irvine 2005). Cultural anxieties over the status of gender roles in United States society after World War II lead to increased violence toward those deemed “deviant” from the norm set by science and medicine. The development of sexology, a form of science that takes human sex, reproduction, and gender into laboratory study, emerged out of eugenic and anti-miscegenation discourses and legislation from the 19th and 20th centuries that considered human bodies to be legible texts that could be manipulated in specific ways to get

certain results (Somerville 1994). Through the biased and harmful practices of comparative anatomy and psychological pathologization, eugenicists and sexologists promoted the reproduction of white, cisgender, heterosexual married couples by pathologizing all non-white and non-heterosexual bodies (Somerville 1994). This pathologization frequently took the form of othering, characterizing such subjects as deviant, imposing psychological diagnoses through the DSM, and more. In making use of ideologies surrounding race as a white and black polarizing dichotomy, sexologists constructed the binary of the heterosexual and homosexual “types” of individuals through not only placing those bodies into distinctive categories, but also assigning those categories a hierarchical meaning that defines bodies existing beyond cultural norms as faulty or inferior in some capacity (Katz 2007). This binary between heterosexual and homosexual encompassed all behavior that moved against the accepted gender and sexuality norms of the time, positioning all those who transgressed the boundaries of “normal” into the homosexual category and those who acted in accordance with expected gender and sexual roles into the category of heterosexual. This paradigm shift illustrates a rejection of prior thinking that considered sexual acts to be only moral choices in themselves. Rather, the new framework upholds the notion that acts of a sexual nature make a person a specific kind of being with an ascribed social or cultural worth according to the type of person one is (Somerville 1994, Foucault 1979, Irvine 2005). By degrading and seeking to “correct” deviant bodies that subvert the eugenic fantasy of the ideal American population through categorization and medical intervention, sexologists pushed the agenda of heterosexual married reproduction of white subjects.

Further, research in sexology took for granted the biologically essentialist nature of sex and its ability to determine gender. It used the cultural norms of the time to enforce “proper” presentations of both gender and sexuality (Irvine 2005). The medical authority’s institutionalized

attempt to eliminate deviance from sexual and gender norms of the time took the form of clinical programs intending to ‘educate’ individuals in accepted gender tropes to convert homosexuals into heterosexuals (Irvine 2005), as though they had not already been socialized in a society that so strongly asserts the necessity of being cisgender and heterosexual. The driving assumption that sexologists utilized in their work is that any form of gender or sexuality deemed deviant could not lead to a happy, productive life as a member of society (Irvine 2005). Thus, these gender and sexuality programs attempted to stifle and pathologize the diversity of ways in which individuals expressed themselves if these modes of embodied self-expression did not align with the valued characteristics of white, cisgender, heterosexual procreation that were based upon eugenic fantasies.

The often-violent histories of abusive interactions between medical institutions and researchers with queer and trans populations are apparent in twentieth-century medical archives from the United States. Medicine’s function as a gatekeeping force that refused queer and trans individuals the right to autonomy over their own bodies is extensively documented. Bodily control typically took the form of “correcting” the deviant bodies of children when they were born, for instance performing unnecessary genital surgeries on intersex infants to make their genitalia conform to the conceptions of what “normal” genitals look like. By diagnosing deviance from sexual anatomy norms as a form of illness or disease, medical professionals afforded themselves the ability to perform medical interventions without the consent of the patients or patient guardians, thus robbing the patients of their right to bodily autonomy (McGann 2011, Roberts 2011) and informed consent.

In this culture, queer and trans bodies were forced to change in order to fit the cisnormative heterosexual ideal valued by sexologists (Gill-Peterson 2018). Medical discourses also preyed on

the fears of parents by expressing that a refusal to medically intervene early on in the child's life would result in the child becoming a "pervert" as an adult (Irvine 2005). Even the sexologists who held more accepting and empathetic views of gender expansiveness during this time advocated for early intervention with children toward the goal of making them grow up to become cisgender and heterosexual adults. In their view, it was seemingly easier to force one child to change who they are than it would be to advocate for the overhaul of the entirety of a social system that categorizes those who deviate from sexual and gender norms as dangerous or inferior (Irvine 2005). The perceived "easiness" of forcing children to hide who they are to fit into established binaries of gender and sexual being as they grow into adulthood is clearly conceptualized from the perspective of physicians and parents, not the child themselves. There is nothing easy for anyone, much less a child, about processing the fact that those around them expect them to crush who they are to act out normalized tropes for gender and sexual behavior.

Transgender patients were frequently coerced into accepting harmful medical "treatment" in the form of psychotherapeutic abuse when they approached medical providers seeking gender-affirming healthcare (Roberts 2011, McGann 2011, Gill-Peterson 2018, Meyerowitz 2009, Irvine 2005). This medical approach reinforced the existing pathologization of queer and trans identities by mandating that some queer and trans individuals be subjected to damaging psychological interventions. Gill-Peterson highlights the ways in which the bodies of white queer and transgender children were deemed worthy of medical and psychotherapeutic intervention from physicians and hospitals, whereas children of color were often disregarded (2018, Roberts 2011). If their existence was not entirely ignored by medicine, then trans children of color were frequently diagnosed with schizophrenia, taken from their families, and forced to live in abusive mental asylums (Gill-Peterson 2018). In this way, it becomes clear that gender non-conformity was used both as a reason

to surveil and as a reason to treat, but these justifications changed based upon the race of the children in question.

Further, infants born with ambiguous genitalia were often— and continue to be— not merely labeled as intersex but also subjected to destructive surgical procedures that fundamentally alter the appearance and function of their genitals. The medical procedures used on these babies were made possible by medical advances in the form of anesthesia, surgical techniques, and hormonal “treatments.” These practices were performed in an effort to violently normalize the external appearance of these bodies to fit within the cultural conception of a strict male and female sex binary (Chase 1998).

As early as the 1920s, adult patients had begun to resist this surgical mutilation of their intimate bodies. Partially in response to the adamant resistance by intersex adults in addition to the further evolution of medical technologies, physicians began advocating for the performing of these “normalizing” surgeries on the bodies of infants before they had the cognitive capacity to recall the violence that had been carried out against them (Chase 1998). Medical communities valued such procedures because they reduced or eliminated the likelihood that the future child would grow up to identify as either intersex or transgender (Slijper et al. 1998, Cabrera 2018), which the medical establishment conceptualized as catastrophic and projected onto both intersex infants and their parents. Except in very rare cases, these surgeries were entirely medically unnecessary and performed in an effort to prevent parents from having their child grow up with a trans or intersex identity. Because intersex children frequently had the ability to pass fluids properly without surgery, inflicting needless surgical trauma on the bodies of infants was a political choice made by medical institutions to strategically uphold the gender and sex binaries, not to correct any actual medical problem. Clearly, the socially-constructed nature of the female/male binary for human sex

does not neatly correspond with how human bodies come to exist in the world. This work firmly supports the rights of the intersex community and takes the position that no one is born wrong. Thus, no one should be subjected to unnecessary genital mutilation in the form of surgical intervention so long as they have the ability to properly pass fluids at birth.

Transgender identities are so stigmatized in Western cultures that the medical institution favors performing avoidable invasive surgeries on intersex infants in a desperate attempt to prevent them from growing up to be either transgender or perceptibly intersex. Interestingly, surgeons and endocrinologists are the chosen medical professionals in the delivery room with the parents of a newborn intersex child (Chase 1998). Had psychologists, bioethicists, and intersex rights activists been those who were present at the birth of an intersex child, perhaps the outcomes for intersex individuals would be vastly different. Parents often were not given any, much less adequate, knowledge by physicians and surgeons to be able to give informed consent on behalf of their infant child (Cabrera 2018). Despite the fact that doctors arbitrarily ascribe a sex onto the bodies of babies without there being clear guidelines for what qualifies as normal and abnormal genitalia in newborns (e.g. a hypertrophic clitoris compared to a micropenis), a team of medical professionals assigns a “true sex” to the intersex child and then, using invasive surgery and hormones, attempts to make the child’s body conform to this assigned sex as closely as medically possible (Chase 1998). After enduring such procedures, children were often deceived about their intersex status by both medical professionals and parents in an effort to make them believe that they were born as the sex they were surgically assigned. To that end, physicians and hospitals frequently went to great lengths to conceal the early medical records of intersex patients from the patients themselves. Chase recounts the experience of finally being able to view her birth records after fighting for access to that information. Over the course of three years, she fought “to overcome the obstruction

of doctors whom I had asked for help” (Chase 1998). Such intentional obstruction clearly indicates that doctors believed that their interventions would fail if the person knew what had happened to them as an infant; however, the fact that these people were seeking out answers in their medical records in the first place indicates that their interventions had failed long before the individual sought out their official birth records.

Due to their own technological shortcomings in addition to the cultural framing of females as ‘lacking’ a phallus, medical teams assigned 90% of intersex babies female. The basis for that decision was that “You can make a hole, but you can’t build a pole” (Chase 1998). A deciding factor in the decision to assign a child as male or female rested in if physicians believed that the micropenis would ever be functional to “mark masculine status effectively or to penetrate females” (Chase 1998). This kind of short-sighted, damaging, and irresponsible rhetoric came from the medical providers and hospitals that citizens and families trusted to do no harm to them. Thus, it is clear that the medical institution used presumed future heterosexuality and ability to penetrate a female or to be penetrated by a male to police the sexual morphology of an infant. The 10% of infants assigned male frequently had to endure several genital surgeries— up to 22 in one case— which only ceased once the child grew old enough to refuse further bodily violence (Chase 1998). Not only were intersex individuals nonconsensually mutilated by the medical institution, but they were also shamed into absolute silence about their treatment and subsequent suffering by the medical institutions, their families, and broader culture (Chase 1998). Not until after 1993 did a single person speak out to condemn the unnecessary violence enacted upon their intersex body for the benefit of the medical institution (Chase 1998). Even the well-known John/Joan Case was not reported as a failure until 1997 (Sloop 2000). This case is a disastrous example of needless genital mutilation that caused a tremendous amount of pain and suffering. As an infant, David Reimer and

his twin brother both underwent a circumcision surgery. During his botched operation, Reimer's penis was nearly entirely removed (Sloop 2000). The physicians and parents decided to perform an additional operation and hormone therapies to ensure that David would be reassigned as female. When David was a teenager and learned of the violence enacted upon his body, he began to live as a man and elected to be reassigned male surgically and socially (Sloop 2000). Reimer's life ended tragically when he died by suicide at 39 years of age (Sloop 2000). It is vital to note the recent nature of this history, as physicians appallingly still perform these needless genital mutilation surgeries on intersex infants born in the United States today (Cabrera 2018).

Additionally, racialized discourses clearly impacted the decision to medically intervene on the bodies of intersex children. Some surgical outcomes on intersex children resulted in the entire removal of the clitoris. In defense of their decision to perform such an operation, one that awfully closely resembles the practice of female genital mutilation performed elsewhere that United States citizens have mobilized against as a barbaric act of violence against girls and women, physicians commented that the clitoris is "unnecessary" for "normal" sexual function (Chase 1998). In response to this comparison with female genital mutilation, physicians then coined the terms "clitoroplasty," "clitoral reduction," and "clitoral recession" to discuss the surgery, which they then termed a "simple cosmetic procedure" (Chase 1998). Despite sex being thought of as a natural and biologically-determined process that results in the development of male or female genitalia, the medical institution ironically had to work incredibly hard while simultaneously deceiving many to maintain these socially-constructed ideas of what constitutes natural sexual morphology and what is deviant (Chase 1998).

An awareness of the history of state-sanctioned mutilation on the bodies of intersex children is vital to understanding the relationships that transgender individuals have with



healthcare systems today because these dynamic groups of marginalized people are related to one another in ways that overlap at times. The instances in which physicians and surgeons decided to intervene compared to when they decided against such action reveals the importance of upholding the sex/gender binary system and heterosexual structures. Through the political tools of nonconsensual surgical operations on intersex children in tandem with the pathologization of non-heterosexual sexual identities and non-cisgender gender identities, the medical institution has been able to simultaneously reject affirming healthcare for queer and trans individuals while continually enhancing bodily adherence to cisgender heterosexuality.

Despite the irreversible and horrific damages carried out by surgeons on the bodies of intersex individuals without their consent, transgender patients actively seeking gender-related healthcare would sometimes use the rhetoric of intersex patients to describe their own experiences in healthcare settings in an effort to gain access to the healthcare they so desperately needed. In medical offices, these patients would describe the existence of imbalances of hormones or presence of bodily structures associated with the sex they identify as and would sometimes convince physicians to conduct exploratory surgery in search of these bodily variations (Gill-Peterson 2018). These patients, aspiring to be given permission by their doctors for gender confirmation surgery, found a point of entry in the rhetoric of intersex bodies. This entry point is significant because of the refusal of medicine to surgically alter bodies they deemed healthy, as physicians were the very individuals who had the power to define the boundaries between “healthy” and “unhealthy” tissue. Over time, queer and transgender individuals and their allies began exerting pressure on the medical institutions to respect the bodily autonomy of queer and trans patients who sought affirmative healthcare (Gill-Peterson 2018). According to Gill-Peterson, considerations of this

history and the “progress” made must identify the mounting pressure of activists as the source of positive change (2018).

I have outlined the historical context necessary for understanding our investigation into the nature of the relationship between transgender individuals and medicine. In the next section, I will examine aspects of transgender theory when it comes to interactions between the medical institution and transgender bodies.

## **2.0 Chapter 1: Trans Scholarship on Medicine**

What do scholars working on transgender issues have to say about the relationship between transgender patients and medical institutions? This chapter explores transgender theories of medicine to advance an argument for dismantling the barriers, boundaries, and borders that trans people are pushed against by medical institutions. I organize this chapter into two sections: medicalized gatekeeping in the United States and non-Western approaches to healthcare.

### **2.1 Medical Gatekeeping**

The institution of medicine has been and continues to be a battleground for transgender populations. Scholars such as Julian Gill-Peterson discuss the ways in which trans people seeking healthcare in the United States have historically been confronted with tough decisions within constraining borders. Gill-Peterson considers the physician John Money's clinical delineations between the cases of intersex patients, patients viewed as "physical" cases by medical professionals, and transgender patients. In the 1960s, Money argued that the cases of transgender patients were "nonphysical" (Gill-Peterson 136). By constructing a boundary between these two types of patients, Money asserts that intersex patients had a physical deformity, while transgender patients were mentally deranged in some capacity. Making this distinction reinforces the idea that intersex patients are worthy of surgical intervention— even against their will—, while transgender patients who seek transition-related care are "really" in need of psychiatric intervention. Gill-Peterson argues that Money positioned himself as a gatekeeper at Johns Hopkins, frequently

dismissing transgender patients who approached him for help despite his extensive clinical work on the bodies of intersex children (135). Despite their actual interconnected plights, Money's conceptualization that considered intersex and trans patients effectively as opposites established an incredibly narrow narrative of existence for trans people, wherein they could only exist as mentally ill subjects in need of psychiatric— not surgical— intervention.

Gill-Peterson highlights one way that trans people harmfully adapted to medical gatekeeping when they discuss the troubling phenomenon of “trans DIY” surgeries. These surgeries occurred when a transgender person attempted to remove or construct pieces of their genitals in an effort to perform their own gender affirmation surgery. These surgeries were a result of medical institutions refusing to operate on “healthy” tissue, despite the pleas of desperate transgender patients. Gill-Peterson remarks that a few transgender patients “[had gender affirmation] surgery performed ad hoc in the United States, but only after undertaking the dangerous step of [attempting] self-castration to prompt emergency [medical] intervention” (137). What this phenomenon illustrates is that some trans patients, if determined enough, will elect to perform their own surgical intervention despite the life-threatening risks. These actions are clearly rooted in psychological anguish when the process by which accessing gender-related healthcare is full of difficulties and obstacles at each step. Such struggles accessing necessary care ultimately makes receiving healthcare for most transgender people an exhausting feat.<sup>3</sup> Further, gender affirmation surgeries performed by doctors in the United States in an attempt to correct trans DIY surgeries clearly display the ways in which physicians, hesitant to operate on healthy tissue, were only willing to surgically intervene when forced to as a result of self-made surgical disasters. Seen

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<sup>3</sup> It is key to note that some transgender individuals who come from a background of racial and economic privilege often had more agency in their experiences with healthcare than those who come from marginalized racial and class identities.

through a framework of mental instability, trans populations were not permitted to exist outside of such narratives of psychological suffering. Gill-Peterson's work illustrates some of the many ways that trans individuals are forced to contend with gatekeeping physicians and a reluctant medical system, which results in tangible harm for individuals belonging to this marginalized population.

Another scholar who engages with issues surrounding medical gatekeeping for transgender populations is Janice Irvine. In examining sexology practices of the 1970s in her work *Disorders of Desire: Sexuality and Gender in Modern American Sexology*, Irvine discusses the enduring practice of gatekeeping in healthcare for trans individuals. She argues that medical diagnoses shifted from "quantification," which dealt with specific measurable scientific steps and markers, to "phenomenology," which takes the lived and embodied experiences of individuals as its focus (Irvine 210). While this paradigm change had the potential to provide an opportunity for loosening the gatekeeping restrictions on transgender healthcare, a relaxing of restrictions is not what took place. In fact, Irvine argues that, during this time, "an individual's success at getting surgery rested on his or her ability to convince a physician that there was an internal incongruence between emotional perception and physical reality [of one's gender and sex]" (210). In this way, Irvine highlights one obstacle that trans individuals must conquer: persuading a doctor that they have a psychological diagnosis of what is clinically understood today as gender dysphoria in order to receive the healthcare that they seek. Thus, trans patients are coerced into accepting a rhetoric of being trapped in the wrong body, which severely limits the possibilities for how the public can conceptualize the experiences of transgender individuals. Additionally, this approach discredits the experiences of trans people who are able to make sense of their gendered embodiment in ways that are not accepted by medicine. Since "applicants were rejected for surgery [on the basis that] they were not convincing," Irvine argues that many trans patients began to learn that they had to

embody an exaggeration of how they experienced their lives and gender (210), often contributing to the reification of popular gatekeeping narratives that would allow them to have the potential to be medically approved for treatment in the form of surgical intervention (211). Being “convincing” as a transgender patient could mean varying things to different clinicians, but often was connected to the gendered biases of practicing physicians. Transgender women would often be expected to perform their gender in hyper-feminine ways, while transgender men were expected to enact a hyper-masculine gender expression. Thus, Irvine exposes how transgender individuals continue to find themselves pushed up against barriers in accessing healthcare. These practices indicate that medical professionals felt a strong need to align biological sex and gender expression. In this case, the medical institution has the authority to grant or forbid access to life-changing surgical intervention to transgender patients based upon their biased conceptions of what it means to “properly” exist in the world as a woman or man. Transgender patients, stripped of their power to self-identify, must force themselves to conform to the gendered requirements physicians and hospital institutions demand of them or risk being denied the healthcare they seek under this paradigm. Within such a framework of gatekeeping narratives in healthcare, transgender individuals face a conflict over gender expression and socially agreed-upon biological criteria for categorization. Held to extreme gender expectations, some trans people are used to reinforce the gender binary by erasing all traces of non-normative gender presentations.

In a groundbreaking article titled “Doing Gender” that drastically influenced the field of sociology in 1987, Candace West and Don Zimmerman suggest that gender is ultimately a process by which individuals attempt to navigate the expectations placed upon them by virtue of their perceived sex category [and gender presentation] (127). Since “gender is something one is [held] accountable for” (139), West and Zimmerman argue that humans must continue to perform gender

in culturally-specific ways. Since individuals are responsible for and evaluated on the basis of their gender presentation, gender is something that is expressed in ways that are influenced by their culture and traditions. On the subject of trans populations, West and Zimmerman argue that gender affirmation surgeries are “the most radical challenge to our cultural perspective on sex and gender,” but that the systems of accountability to one’s gender are not fundamentally threatened by the practice of transitioning (145). While transgender subjects are not explicitly manipulated into proceeding with transition healthcare, which exists in contrast to their intersex counterparts, West and Zimmerman explain that the available options for trans patients tend to be limited by “the ‘essentialness’ of our sexual natures— as women *or* as men” (italics original 145). This argument is directed toward binary transgender individuals who identify as transgender men or transgender women and who seek to transition from their assigned sex at birth to the sex that aligns with their gender identity. In arguing that trans people are not exempt from being accountable to their gender presentation, West and Zimmerman demonstrate the tensions that this population contend with in terms of making healthcare choices by virtue of ideology surrounding cultural biological essentialism. Once again, we can see that transgender healthcare had the possibility to expand the possibilities of gender in Western societies, but instead served to reinforce the hegemonic conceptions of an inflexible, biologically essentialist gender binary.

Through the work of Gill-Peterson, Irvine, and West and Zimmerman, it is clear that transgender individuals have historically been forced to contend with medical gatekeeping models of healthcare, and that these systems produce and reproduce tangible harm in the transgender population. The next section explores the ways in which global approaches to healthcare vary from the history of Western models.

## 2.2 Global Approaches to Healthcare

Western ethnocentrism presents problems for scholarship in trans studies because it prioritizes and naturalizes the experiences of those with more privilege while marginalizing and othering the experiences of those who lack such social standing if left unexamined. Thus, Western ethnocentrism normalizes the experiences of transgender individuals in the United States and other Western areas while othering the experiences of global gender non-conforming peoples who may not identify themselves within the framework and rhetoric of transness. It is crucial to deconstruct gatekeeping narratives in an effort to allow trans populations the ability to self-identify and receive necessary healthcare outside of the context of an exported Western sex and gender model.

Aren Aizura's discussion of transgender healthcare in his work "The Romance of the Amazing Scalpel" challenges Western ethnocentrism by highlighting the differences in experiences trans individuals have when navigating the healthcare systems of the United States compared with those in Thailand. In having to literally cross national borders to access healthcare, Western transgender subjects partake in medical tourism. Aizura effectively illustrates the tension between cultural discourses surrounding mental health and transgender identity in the two countries. Since "psychiatric evaluation is regarded as unnecessary" in Thai gender reassignment clinics (Aizura 149), the Thai model allows for possibilities of giving trans populations the gender-affirming healthcare they desire outside the "dysphoria" narrative, wherein suffering is conflated with the very experience of being transgender. This model rooted in psychological suffering exists in contrast to gender-affirming healthcare that takes informed consent and the desire for bodily modification as the main requirements for accessing care. The model requiring a diagnosis of psychological dysfunction in the United States for a patient to access gender-affirming healthcare makes the Thai model seem less restrictive to Western transgender patients. A healthcare paradigm



that operates outside of the existing pathologizing discourses could provide the basis for acquiring higher levels of cultural acceptance for transgender populations, as their status as trans would not be immediately connected with discourses of mental disorder and inherent suffering by virtue of their gender identity.

Despite this initial difference from systems of trans healthcare in the United States, Thai gender clinics began requiring their patients to show official documentation that they had undergone an extensive psychiatric evaluation and also lived in their gender identity for a certain length of time prior to receiving gender-related healthcare in Thailand. In essence, Thai gender clinics moved toward a model of care that more closely resembles that of the United States, with certain gatekeeping validation requirements of trans patients prior to their approval for gender reassignment surgery [sic] (Aizura 151). The goal of this shift, Aizura argues, was to show that the Thai clinics “comply with internationally recognized standards,” which would allow these clinics to receive “recognition as an elite and globally competitive cohort of biomedical specialists” (151). Despite the early lack of evaluative requirements for trans patients in terms of their psychological health, Thai gender care clinics elected to enact such measures. These new conditions create additional barriers that transgender patients must navigate when accessing transition-related care as a medical tourist in Thailand. Despite the initial rejection of modeling their healthcare systems after those that are rooted in pathologizing narratives of psychological distress, Thai gender transition clinics began to require similar conditions to those of Western healthcare, thus becoming another one of the many places that situate the burden of undeniable “proof” of one’s transness on the patients seeking care themselves. For Western medicine, this switch aligns with the accepted best practices and becomes “up to date;” however, for advocates of trans-affirmative healthcare, this shift is a negative outcome wrought with gatekeeping

narratives and is, arguably, a step backward. Within the medical model of care in Thailand, one can see the ongoing construction of boundaries and borders that trans individuals are forced to navigate. Further, Western stereotypes surrounding Thai gender clinics tend to exoticize their supposed openness and freedom when compared to Western transgender healthcare, but this view fails to recognize many of the cultural nuances such as race privilege, class privilege, and national origin that make gender healthcare in Thailand constrictive for tourists and non-tourists alike.

In continuing with the global evaluation of boundaries, Toby Beauchamp discusses borders both of nations and bodies within the context of governmental regulation of testosterone in the early 1990s in their work “The Substance of Borders: Transgender Politics, Mobility, and US State Regulation of Testosterone.” They argue that gender non-conforming individuals are “a menacing reminder of state regulations’ tenuous hold on shifting identity categories and cultural norms” (67), specifically those norms concerning gender, race, class, and national health (66). By intentionally constructing gatekeeping boundaries, the state attempts to control the possibilities that a body can take to ease cultural anxieties surrounding bodily mobility through identity categories (Beauchamp 57). Further, Beauchamp comments that the governmental regulation of testosterone in the midst of changing patterns and practices of immigration suggest “that gender-nonconformity [sic] is linked to cultural anxieties about the permeability of various borders” (59) within discourses of foreign relations and the protection of United States citizens. In response, Beauchamp critically analyzes the “discursive linking of synthetic testosterone with both smuggling and Mexico, [which] helps position it as a ‘foreign’ substance against which US borders must be guarded to ensure national well-being” (69). Part of these cultural anxieties concerns the fact that the existence of immigrants entering the United States is characterized by “[their] bodies’ disruption of dominant gender norms in part by bringing different frameworks of gender ... into a United States imagined

to have been otherwise homogeneous in these areas” (70). Beauchamp’s key insight allows one to see that the borders constructed by the United States rest upon a false framework that denies the existing variability of bodies and sex/gender systems within the United States as a nation. Moreover, these attempts at controlling synthetic testosterone by framing it as an illicit, foreign substance in some bodies that reside in certain locations completely disregard the fact that synthetic testosterone is created by United States-based pharmaceutical companies that are merely stationed across the border in Mexico (Beauchamp 70). While the debates themselves excluded discussions of transgender individuals, Beauchamp argues that this construction of testosterone as a dangerous foreign substance through the practices of state regulation “come to bear directly on the transgender-identified” (73). Thus, the transgender individuals seeking out testosterone as one component of a gender-affirming regimen of healthcare bear the consequences of these policies and cultural narratives, which subsequently results in their struggle to gain access to testosterone.

Further, Beauchamp argues that the state assumes transgender people will both begin hormones and elect to have surgery to “eradicate any markers of gender nonconformity and presume an ultimate goal of transitioning *linearly* from one gender to another” (emphasis added, 58). Under this paradigm, state-sanctioned transitions happen in a constrained, binary fashion, wherein transgender individuals who lie outside of this traditional binary of transgender man and transgender woman are effectively barred from accessing gender-related healthcare. Once again, transgender patients are faced with having to convince medical professionals that they are “trans enough” in an effort to receive the transition-related healthcare that they need. As a result, trans individuals seeking care come to suffer not only under gatekeeping narratives surrounding what it means to be transgender but also under narratives constructed as a result of racist and nationalistic fears.

In looking at international approaches that challenge the Western sex/gender system, one finds that some rights for transgender populations can function to attack the rights of queer individuals in certain non-Western places. Through her work “Verdicts of Science, Rulings of Faith: Transgender/Sexuality in Contemporary Iran,” Afsaneh Najmabadi discusses the existence of state-sanctioned gender transition healthcare that serves to normalize bodies within a heterosexual framework through a process of gender transition (535). Najmabadi argues that trans individuals living in Iran “[carry] a particular set of affiliations and dis-affiliations— identifications and dis-identifications— that are specific to this national-transnational nexus” (535-536). For Najmabadi, it is clear that the experience of living as a transgender subject in Iran is different from living as transgender in other parts of the world, which is due to the state project that outlaws and attempts to eradicate homosexuality but subsidizes the cost of gender reassignment surgery [sic] (548). The patients seeking trans-related healthcare in Iran did, however, face similar difficulties in terms of gatekeeping while managing the required process for receiving clearances for their transition. In addition to going through an extensive psychological evaluation process that determines if the client qualifies as transgender or is “actually” homosexual, intersex, or suffering from a mental disorder that is not homosexuality or “transgenderism [sic]” (537), individuals must also convince a board of specialists from the Legal Medicine Organization of Iran that they truly are transgender before being able to receive care. This thorough evaluation process, similar to that of the United States and Thailand, serves to protect the state in Iran from allowing or inadvertently condoning homosexuality. Despite the fact that being “transsexual [sic] has been taken up as a legitimate category of being [in Iran], ... criteria for establishing belonging in that category, and its legitimacy as such, is a matter of considerable debate, concern, and ambivalence” (Najmabadi 539). In this way, transgender individuals in Iran

seeking healthcare are forced to engage with institutions that practice gatekeeping and have incredibly specific criteria one must meet to be considered transgender but not queer. It is not difficult to imagine that, much like the early Western transgender patients forced to accept a rhetoric of being born in the wrong body, perform a heterosexual identity, or accept a coercive narrative of forced asexuality, transgender individuals seeking healthcare in Iran could have had to mindfully rehearse the scripted information that they disclosed to physicians and the state in order to ensure that they would be deemed eligible for transition-related healthcare.

This societal structure is not inherently anti-transgender rights, but rather positions itself as generally opposed to the rights of nonbinary and gender-nonconforming individuals who do not necessarily wish to transition. Najmabadi argues that, in the linguistic traditions of Iran, sexuality and gender identifications were not separated and that “[n]ot only [did they have no] distinction between sexuality and gender ... but more significantly, lives were possible through that very nondistinction” (549). In other words, possibilities for living as transgender in Iran come into existence through this linguistic conflation of gender and sexuality as opposed to them having distinct meanings. Existing as transgender was a possibility for Iranians within a state that sought to eradicate homosexuality. It is culturally significant to recognize the local traditions and situated contexts of those who Western scholars would consider transgender under the Western sex/gender system and to investigate how the frameworks that circulate in Western ethnocentric fields of study fail when exported to another geographic location by scholars of culture (Najmabadi 550). Cross-cultural comparisons between Western and non-Western areas are complicated for these reasons in addition to the fact that cultural scholars bring to their research certain ideas about how social systems work that are rooted in their experiences in the cultures they have experienced first-hand.

Through the work of Aizura, Beauchamp, and Najmabadi, one can see that the Western sex/gender system is culturally and historically situated and produced. This system does not function well when mapped onto other geographic locations and cultures. In fact, the attempt to do so results in the production of Western ethnocentric ways of studying and viewing global cultures. The vital history of healthcare for transgender populations becomes far more complex when considering geographic areas that are not centered in the West.

### 3.0 Chapter 2: Health Disparities and Experiences in Transgender Medicine

While some aspects of the treatment transgender patients experience by medical institutions have improved over time, adequate healthcare for this population remains elusive. Health needs for transgender patients are just as diverse as the patients themselves. Health should be conceptualized in a whole-person wellness approach that includes physical health in addition to mental health, spiritual health, and more. Trans patients have unique health needs that span from transition-related care such as hormone replacement therapy and gender affirmation surgeries to mental health resources in addition to all of the services and procedures that cisgender individuals require for maintaining general health as an adult living in the United States. In this chapter, I will begin with the account of Robyn Kanner, a transgender woman, who outlines her experiences with the healthcare system that she published in *The Atlantic* to illustrate some of the ways that healthcare is failing transgender people in the United States today. Then, part one will discuss the healthcare needs that arise as a result of having a transgender identity and part two will analyze healthcare disparities that exist for trans populations when compared to both the cisgender, heterosexual general population as well as their queer counterparts.

Ultimately, it was years of pushing back on adults and navigating my identity alone that helped me find my way. Unable to find a doctor to prescribe me hormones, I'd go on to transition without them. I was presenting as a woman, but there was still testosterone flowing through my veins, which never felt right. That was difficult. So was the way I was viewed, and treated, by others. After a late-night walk home from work,

three men shouted at me that I was a tranny [sic]. They would go on to physically assault me.

After that, I detransitioned. I did not detransition because I wasn't trans. I detransitioned because cisgender people physically and mentally beat me down until I gave in.

After a few years of building my confidence back up, I would go on to transition again, this time with access to culturally competent health care. My anxieties could have been alleviated if adults had simply listened, paid attention, and trusted me. It shouldn't be [this] difficult for the generations to come. (Kanner)

Kanner's narrative provides an excellent example of how difficult it can be for transgender people to access the culturally-competent healthcare that they so desperately need. After experiencing the rejection of several medical professionals, the first time that she attempted to medically transition, Kanner became determined to transition without the assistance of medicine. The harm that she experienced ultimately led Kanner to retreat to the relative safety of being in the closet until she was ready to attempt medical transition once more. While Kanner's story has a positive final outcome, not all transgender folks are so lucky.



### 3.1 Healthcare Needs Related to Transgender Identity

As ‘bathroom bill’ legislation— legal measures that attempt to restrict the ability of transgender people to use the restroom that aligns with their gender identity by requiring individuals to use the bathroom of their assigned sex at birth— have gained visibility in the United States over the last few years, it has become more common in the public imagination to think of bathroom access as a critical issue facing trans populations. Access to a public restroom in which one feels safe is a crucial aspect of health for many trans people. Aside from the physical discomfort one endures when they are unable to use bathroom facilities throughout the day, there are several tangible health problems related to lack of bathroom access. As Schuster et al. argue in their article titled “Beyond Bathrooms— Meeting the Health Needs of Transgender People,” delayed use of restroom facilities has been connected to health problems such as “urinary tract or kidney infections, stool impaction, and hemorrhoids” (101). Further, some trans individuals attempt to avoid these anxiety-inducing situations entirely by significantly decreasing the amount of fluid and food they consume throughout the day, which can lead to symptoms such as headaches and dehydration, among other things (Schuster et al. 101). It is clear that access to public restroom facilities is vital for the health and safety of those who identify as transgender, but negative interactions that trans people experience when attempting to use public facilities continue to make the decision to use restrooms a difficult one fraught with complications.

Despite these dire and avoidable health consequences of not using bathrooms when necessary, some trans people continue to avoid public restrooms for fear of harassment or violence. When merely trying to use public bathrooms, trans people often face the threat of physical assault

that can result in them “[suffering] bruises, broken bones, or worse” (Schuster et al. 101). In addition to the risk of physical and sexual violence posed by using public facilities, trans people must also contend with gender policing such as mocking, having derogatory comments made about them, aggressive questioning as to why they are in the bathroom they elected to use, looks of disgust, having security called on them, and more (Bender-Baird 986-987). As a result, “Transgender people who are barred from using bathrooms where they feel safe might feel they have no choice but to suppress [their] basic bodily needs” (Schuster et al. 101). Thus, the precarious situation of public restrooms turns into a double-bind for trans people merely looking to exist in the world as someone who identifies with a gender that does not align with the sex that they were assigned at birth: choosing to use public facilities can lead to violence, and suppressing basic bodily needs has significant consequences on their overall health and wellness.

It is well documented that marginalized communities face additional barriers in their struggle to access general healthcare. These challenges are often magnified for the transgender community, as unemployment affects transgender individuals in higher percentages than the general population (Poteat et al. 2013:23) because of transphobia in the workplace and in hiring practices. The transgender community also faces homelessness and housing instability at approximately twice the rates of the general population (Fletcher et al. 1652). Due to the fact that some trans people face the rejection of their families because of family members’ transphobic

attitudes toward their gender identity, “many trans[ ]women<sup>4</sup> “age out” of homelessness<sup>5</sup>, living out their young adulthood on the streets and regaining stable housing only after significant exposure to HIV and other health risks” (Fletcher et al. 1656). As a result, HIV is another example of a healthcare concern for transgender individuals, especially with regard to trans women. Without access to a stable income and affordable housing, healthcare is simply not something that transgender people struggling with finances have the ability to afford.

A study from Philadelphia, Pennsylvania in 2005 found that 33% of transgender respondents did not have a primary care physician and 25% did not have access to basic medical care (Kenagy 23). Lack of access to basic healthcare can lead to the contraction of preventable diseases and results in health problems that could once be treated easily worsening to a more severe or urgent emergency state. Such health emergencies “are often exacerbations of routine primary care issues that go unrecognized and untreated because of fear of marginalization by health care providers” (Dutton et al. 331). Thus, the lack of access to healthcare has tangible consequences for transgender populations. Further, Poteat et al. discuss how those who identify as a transgender are less likely to have health insurance either privately or through an employer (2013:23). Unemployment, housing discrimination, and lack of access to health insurance all contribute to the inability of transgender individuals to access even the most basic healthcare, which puts trans lives at heightened risk for negative health outcomes, especially those which are avoidable through

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<sup>4</sup> “Transwomen” is the phrase that Fletcher et al. use to describe transgender women. I insert the space between trans and woman in an effort to further deconstruct the notion that trans women are other when compared with cisgender women. Linguistically, trans woman uses trans as the adjective describing the type of woman, while “transwoman” implies the assumption of a conceptual other gender separate from cisgender woman. While trans woman is the accepted terminology in trans studies in 2019, Fletcher et al. published their study in 2014. This could be a potential reason for their linguistic choice compared with mine.

<sup>5</sup> This does not refer to homeless trans youth aging out of the foster care system, but rather describes the struggles that trans youth dealing with housing instability face but can eventually overcome through time.

preventative care. All of the aforementioned problems present themselves before transgender people even cross the threshold of a medical office.

When trans clients can manage to access healthcare in some capacity, often the healthcare they receive is far from ideal. A huge problem facing transgender patients engaging with clinicians is the lack of culturally-competent education for healthcare professionals on the specific issues with which the transgender community contends. Over 25% of transgender respondents in Philadelphia had been denied healthcare solely due to the discriminatory attitudes that providers hold toward the gender identity of transgender patients (Kenagy 23). These statistics are especially shocking, given that only 7.7% of cisgender queer individuals and 19% of those living with HIV have been denied care because of insensitive clinician attitudes toward their identity or HIV status respectively, according to a national survey (Poteat et al. 2013:23). It is clear that, for transgender Americans seeking care, making the time and necessary sacrifices to get themselves to a healthcare provider is not a guarantee that they will receive healthcare. For the cisgender population, being denied healthcare solely due to their gender identity is a concern that they have the privilege of not needing to consider.

If not denied services by physicians and clinics who hold transphobic attitudes toward their gender identity, some transgender patients find themselves faced with discriminatory treatment while in the care of an insensitive provider. One transgender patient commented

I visited a doctor at one point that almost ran out of the room when he got a sense I was different somehow. He could not leave the examination room fast enough. You could just smell the fear on him that I was different.

(Transgender patient quoted in Hinrichs et al. 78)

For this patient, it became quite clear that the physician that they had an appointment with was woefully unprepared to treat a transgender person. The doctor's actions had the effect of not only failing to provide the adequate healthcare that the patient paid for and rightfully deserved, but also made this patient acutely aware of their status as a marginalized individual.

The statistics indicate that transgender patients are forced to contend with harmful healthcare experiences. Such experiences are a result of the ignorance of providers in addition to institutionalized transphobia, but are not ever the fault of individual patients or the transgender community as a whole. 20.9% of transgender respondents reported being “subjected to harsh language” and 20.3% were outright “blamed for their own health problems” when seeking care (Poteat et al. 2013:23). The level of mistreatment continues, however, with 15% reporting that health care professionals issued a refusal to touch them while providing care and 7.8% “experienced physically rough or abusive treatment by a medical provider” (Poteat et al. 2013:23). These rates of violence and medical mistreatment are absolutely unacceptable, especially at the hands of the medical professionals who took an oath to do no harm to their patients. When such harms take place, the instinct of medical authorities is to place blame upon the transgender patients or disguise the underlying problems rather than to examine the validity, fairness, and ethics of medical institutions with regard to transgender patients. To add a layer of complexity to this situation, trans folks seeking healthcare may not have another option. For those who are uninsured or facing housing insecurity and managed to scrape together the funds to visit with a physician, one rejection or instance of abuse can have a devastating effect on the future of their health. Often, it is not as simple as finding another healthcare provider because of the underlying factors of precarious living conditions such as poverty and homelessness that transgender individuals face.

Furthermore, trans patients are often expected to provide education on their gender identity and healthcare needs to medical professionals, many of whom are unsure in their clinical knowledge of transgender issues. While some level of education is necessary for clinical interactions because not every person of a certain identity has the same experiences, the statistics suggest that this is a significant problem that leads to poor health outcomes for transgender patients. In the first-ever statewide study on the healthcare needs of the trans population in the United States, 46% of transgender patients in Virginia reported having to educate their physicians on their identity and healthcare needs in clinical settings (Xavier et al. 4). This gap in medical education is revealing, given that it would be unacceptable for a physician to ask any patient to explain how they could help treat something like a deviated septum through plastic surgery or how to manage HIV in patients to ensure they reach an undetectable viral load.<sup>6</sup> Prospective patients for plastic surgery and those with HIV are not expected to bear the burden of educating their medical professionals in nearly the same ways that transgender patients are expected to educate their clinicians. Inviting individuals from specific backgrounds, identities, and cultures to participate in educating healthcare professionals on their medical needs is not always a harmful phenomenon, but forcing patients seeking care to do so in their clinical appointments with physicians causes adverse consequences. Not only are transgender patients expected to seek

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<sup>6</sup> Throughout the course of this thesis, I make comparisons between healthcare for trans populations and care for those seeking plastic surgery, those with diabetes, and those who have been diagnosed with HIV. While diabetes and HIV are clinical pathologies that can be diagnosed unlike being transgender, I find these comparisons helpful because the level of care that trans patients require is similar in that it is crucial that patients on hormone regimens follow up with physicians for routine health monitoring. Diabetes and HIV also have multiple methods of treatment and do not follow a one-size-fits-all standardized treatment plan. I chose to include patients seeking plastic surgery because some transgender patients elect to have such procedures done as well.

healthcare against sometimes-insurmountable odds, but patients who identify as trans have huge knowledge demands placed upon them from those who should have the clinical competency to work with all patients, including transgender patients. The existence of these expectations for trans people indicates that there are structural failings in the education of physicians in how to treat transgender patients. Chapter three will discuss these educational shortcomings in more detail.

Poteat et al. cite two first person narratives highlighting the experiences that one trans man and one trans woman have had when dealing with healthcare providers who were not educated on issues of trans healthcare. One of the patients states that

I was trying to figure out what was going on with me. I didn't want the additional burden of having to educate my provider on top of that. And the last thing I wanted was to be a training case for a practitioner who had never provided care to a transgendered [sic] person before.” (Trans man quoted in Poteat et al. 2013:26)

In this passage, a participant who identifies as a transgender man discusses his frustration with being expected to provide education to inexperienced healthcare providers. Further, he asserts that he does not wish to be the first transgender patient that the clinicians have ever treated. These concerns are understandable, given his comment that he was struggling with something and did not need the added responsibility of educating a group of physicians and nurses about what exactly his needs and experiences are. The rhetoric of rejecting being a “training case” illuminates the theme of feeling isolated or othered in medical settings that were created with providing care to cisgender populations in mind.

The account of a transgender woman discusses some similar themes, frustrations, and concerns regarding healthcare providers who evidently lacked basic knowledge or clinical training with regard to her hormone replacement therapy healthcare needs. She remarks that

I even went on the internet myself and I printed out hormone regimens for oral and for injections and everything ... I shouldn't have to go online and pull up a transgendered [sic] hormone regimen because I feel as though my doctor isn't prescribing the right hormone regimen for me. I shouldn't have to take that in there. You should already know. So I think that's one of the only things that kind of makes me angry. (Trans woman quoted in Poteat et al. 2013:26)

Like the transgender man, this transgender participant expresses frustration at being expected to shoulder the burden of educating the doctor who is prescribing her hormones. While a doctor would ideally do their own research in between the visits of their transgender patients, that is not what took place for this transgender woman. The patient felt as though her ability to receive competent healthcare was threatened by the clinician's lack of knowledge. As a result, she had to consult internet sources that could have provided questionable information in an effort to educate her physician. This transgender woman's frustrations are logical, as diabetics seeking medical assistance with insulin management are not expected to do their own online research, print out insulin schedules, network among others who have been diagnosed with diabetes, and bring their findings to appointments in an effort to educate practicing clinicians. In fact, it is entirely possible that a practicing physician with no knowledge for how to treat someone with diabetes would be characterized as inadequate and their ability to treat patients may even be called into question. Diabetes, of course, is a clinical pathology that does not depend on social identities, but the



comparison is effective in illustrating the differences in education and healthcare management between individuals of various types of group identities. For transgender patients needing help with medical transition, though, the reality of their interactions with medical institutions can involve being forced to provide high levels of medical knowledge.

Another instance in which transgender populations struggle to get healthcare is in having to navigate healthcare hierarchies and systems. Patients seeking care face “challenges related to finding providers for a range of different care needs, moving between systems of care, and navigating the disconnect between the participants’ own gender identities and the gender identity used by insurance companies or health electronic health [sic] systems” (Hinrichs et al. 78). In discussing his inability to change his legal gender marker because of his health insurance company’s refusal to cover standard preventative care for those who have cervixes, a transgender man exclaims

I have to stay female [legally] until next year or [the health insurance company] won’t pay for me to have a pap smear. So, I get shit in the mail that says, “You ready for a pap smear, Ms. blah blah blah?” And I’m like, “I am so fucking tired of being called Ms.” You know? I— it’s frustrating as hell. (Transgender man quoted in Hinrichs et al. 78)

Rather than covering routine procedures for patients based upon which bodily anatomy they possess, insurance companies retain a narrow framework of gender as biologically essentialist, which forces transgender clients to make disheartening and gender dysphoria-inducing decisions about their healthcare. This trans man who conveyed his story to researchers felt coerced into delaying changing his legal gender marker to align with his gender identity simply because doing so would result in his inability to access the healthcare he needs as someone with a cervix. The

psychological anguish caused by being addressed as a woman regardless of his gender identity is clear in his statement. Thus, the inability to access cervical cancer screenings as a transgender man causes unnecessary psychological stress for patients. A physician discussing similar concerns for transgender women comments

If I had a [transgender woman] who needs to get a prostate ultrasound— so this is a born male but now is a [transgender woman]— unfortunately, that can be problematic at the lab doing the ultrasound. (Physician quoted in Snelgrove et al. 8)

The invisibility of men with vaginas or women with penises places limitations upon the ability of trans populations to make informed decisions regarding their healthcare, right to bodily autonomy, and gender identity.

Transgender men face unique challenges in terms of maintaining sexual health through regular visits with gynecologists. When one's gender identity does not align with the sex one was assigned at birth, interactions with the patients and doctors in gynecologic healthcare systems can become distressing. For example, many transgender people struggle with discerning if and when to disclose their identity as transgender. Studies show that these decisions are usually made “based on what type of health care provider they are seeing, the type of relationship they have previously established with that health care provider, and their current emotional patience and tolerance for explaining themselves” (Dutton et al. 335). If transgender patients perceive that their gender identity is not related to the care that they are seeking, sometimes they will choose not to mention it. Even if gender identity is applicable to the symptoms they are experiencing, some patients lacking the energy to perform the emotional labor of answering continual lines of questioning choose not to disclose such information. Appearing masculine in a feminized space such as the

waiting room of a gynecologist office can attract unwanted attention and confusion, which can exacerbate feelings of personal distress. Being forced to manage such anxiety-inducing situations often leads to transgender patients postponing the preventative healthcare that they are due for if they have the economic privilege to be able to afford it. Statistics from the National Transgender Discrimination Survey indicate that 33% of transgender respondents disclosed making the decision to postpone preventative medical care because of fears of discrimination. Further, 28% reported delaying care even when they were clearly aware of being sick or injured for the same reasons (Poteat et al. 2013:23). The discrimination that transgender individuals face in medical care settings creates situations in which they delay necessary healthcare due to rational fears of discrimination and discomfort as a result of healthcare provider attitudes toward their gender identity. Thus, delaying necessary healthcare becomes both a barrier and a coping mechanism in that trans people are aware that they need care but postpone seeking out such care because of past experiences of discomfort, distress, and discrimination.

Like transgender men, transgender women have some specific health concerns that need to be addressed by culturally competent health clinicians. Although the statistics vary by study, a meta-analysis studying HIV infection rates in the transgender population in the United States found that trans women engage in street economy labor such as sex work in large numbers (Herbst et al. 8-9). Factors such as “stigma, discrimination, and exclusion from social and economic opportunities were common and served as the impetus for many transgender women to sell sex” (Poteat et al. 2015:283). Transgender women who work in the sex work industry do so for both financial and social reasons. Sex work provides opportunities for some transgender women to earn desperately-needed income that allows them to live. Income from sex work can also go toward gender-affirming healthcare such as hormones, injections, and surgeries because a more feminine

appearance can “increase sex work earning power” (Poteat et al. 2015:276). Additionally, sex work provides transgender women with both a sense of community with others who partake in the same work and gender validation from the cisgender male clients for whom the transgender women work (Poteat et al. 2015:276). Aside from these positive aspects, sex work poses specific health risks to those who engage in such practices.

When compared to cisgender men and cisgender women engaging in sex work, “transgender women who engage in sex work have a disproportionate risk for HIV” in addition to a heightened risk of violence and abuse from both clients and police (Poteat et al. 2015:274-276). Transgender women frequently have anal sex with both partners and clients. The HIV transmission risk is higher for the receptive partner during anal intercourse, especially without the use of condoms. Because police and law enforcement use condoms as an indicator that someone is participating in sex work, some sex workers report not carrying or using condoms while they are working (Poteat et al. 2015:276). The confiscation of “multiple condoms from an individual as evidence of prostitution [sic] appears to be a fairly common and widespread practice” in the United States (Collier E353), which indicates that sex workers located in the United States are at particular risk for avoidable sexually-transmitted infections as a result of the organized actions of law enforcement. Sex workers making this tremendously challenging choice decide to do so in an effort to protect themselves from legal repercussions from the police; however, these choices ultimately put them at higher risk for sexually-transmitted infections such as HIV. Condom use is further complicated for transgender women who are taking feminizing hormones, as “Hormones used for feminisation [sic] can result in erectile dysfunction and interfere with correct condom use, thereby increasing HIV [transmission] risk during anal insertive sex” (Poteat et al. 2015:277). In these instances, identifying as transgender and beginning a gender-affirming hormone regimen can put

transgender women at higher risks for HIV, regardless of their participation in sex work, because they cannot use condoms properly.

Trans women who have been diagnosed with HIV face particular health disparities when it comes to the treatment and progression of their HIV. They are “less likely to receive antiretroviral therapy and less likely to report adherence [to medication regimens]” than cisgender individuals who are diagnosed with HIV. Some factors that influence whether transgender women will continue with their HIV treatment plan include “Stigma, past negative experiences [in healthcare], prioritization of hormone therapy, and concerns about drug interactions between antiretroviral drugs and hormone therapy” (Poteat et al. 2015:279). Thus, trans women who receive a diagnosis of HIV find themselves considering many aspects of their lives when deciding how to proceed with managing their health. Additional areas of concern could include housing status and stability, economic class, and education, as only those who have some level of sexual health knowledge and economic and housing stability will be able to access medical services such as HIV testing in addition to testing for other sexually-transmitted infections.

In addition to the increased risks of HIV, trans women who experience violence sometimes hesitate to seek out medical care when they have been injured for fear that they will be arrested for engaging in sex work and/or be discriminated against by healthcare providers and police. Trace, a study participant who identifies as a transgender sex worker and works in Vancouver, Canada, discusses her uncertainty as to whether she should seek healthcare after experiencing violence while on the job.

I just went home and I told my friend this is what happened and they wanted me to go see a doctor, but I was too embarrassed by the whole ordeal and I just didn't want to. I didn't want to get in trouble 'cause I thought I would

get arrested for being on the streets prostituting [sic] myself, so I thought well I guess I was kind of asking for it. (Transgender woman quoted in Lyons et al. 186)

Trace's account is unfortunately not an uncommon one. The internalized shame and stigma that is a product of being a marginalized individual participating in sex work clearly comes to light through her story. In choosing not to pursue medical care, Trace believes she is making the best decision given the circumstances of a potentially-hostile medical institution and the threat of arrest for participating in sex work. She justifies making this decision to both the researcher and herself by using internalized victim-blaming rhetoric. Ultimately, she seems to believe that not seeking healthcare was the best option for her in this complex situation.

Trans populations also face a specific health risk in terms of which avenues they take to procure their gender-affirming hormones. With the difficulties that some transgender individuals experience in their interactions with the healthcare system, some trans folks opt out of consulting physicians and clinicians to have their hormones prescribed. In the statewide Virginia health survey, half of those who were taking hormones reported obtaining them from someone who was not a doctor (Xavier et al. 4). These alternative sources can include through connections with friends, networks of street dealers, and purchase through the internet (Xavier et al. 4). An astounding 60% of transgender women in the Virginia study partook in this practice, while only 22% of trans men reported doing so (Xavier et al. 4). Furthermore, 46% of those who had used hormones injected themselves with them or opted to be injected with them by someone who was not a medical professional. These statistics have a similar disparity between trans women and men, where 71% of transgender women and 37% of trans men reported doing so (Xavier et al. 4). It is unclear in this study whether the researchers decided to count the transgender patients who had

been taught by medical professionals how to give themselves gender-affirming hormone injections in these statistics. Patients who have had such education could face lower health risks as a result of injecting their own hormones. Not all transgender individuals who obtain hormones from non-medicalized spaces do so long term, however. The barriers creating problems for trans patients to see clinicians, including long wait times without a provider in the interim to prescribe hormones, can lead some trans people to seek out hormones in other ways (Abramowitz 3). This can be of particular interest when transgender adolescents find themselves needing to make the switch from pediatric to adult primary care (Abramowitz 3). There are risks with this practice, as it is difficult to ensure that the products trans individuals are purchasing in unconventional ways are standardized in terms of dosage, ingredients, laboratory testing, and more.

For many transgender patients, having prior negative experiences with healthcare can create heightened stress when approaching any healthcare situation, for the first time or otherwise. Upsetting experiences in medical settings can include “being misgendered, insistent use of a nonpreferred [legal] name, being assumed to be sex workers, being assumed to be [transgender or gender non-conforming] because of trauma-related experiences, not being believed or understood in relation to their transition journey or needs, and stigma or rejection from providers” (Hinrichs et al. 78). Once more, experiences such as these can lead transgender patients to delay necessary medical care. Within the context of these complex systems of interaction between transgender patients and medical care providers, it is clear that the transgender community has basic care needs that the medical institution is not meeting.

### **3.2 Health Disparities in the Transgender Community**

The health disparities that exist between the transgender community and the general population are sobering. The transgender community needs healthcare to address structural problems that disproportionately affect trans lives. Trans people are at a significantly higher risk for physical and sexual violence than their cisgender peers. Additional areas in which transgender populations face significant health disparities include mental health, substance abuse, alcohol abuse, and rates of contracting sexually-transmitted infections. These health disparities are not the fault of transgender individuals, but rather are the product of many social forces such as interpersonal and institutional discrimination. Thus, this section discusses specific problems that the transgender community faces in terms of health risks, but actively resists all attempts to use these statistics and information to pathologize individuals because of their transgender identity. Since transgender communities have historically been under-researched in ways that are gender-affirming rather than pathologizing, it is difficult to find data that can be generalized to the entire transgender community in the United States. The lack of national data for United States-based transgender people is a problem of political origin because this community has not yet been the focus of demographic studies measuring size, distribution, or health outcomes. Due to the nature of cultural transphobia and the potential harms of discriminatory actions, though, increasing the salience of a stigmatized identity should not be the end goal for research on transgender individuals. Rather, researchers must conduct this work in an effort to reduce the discrimination, harm, and health disparities between members of the transgender community when compared with their cisgender counterparts. For this section, I make use of the large published datasets that exist on the health needs of the transgender community in Virginia and Colorado specifically and



supplement these considerations with national datasets concerning general national populations where possible to draw comparisons.

The transgender community is exposed to significantly higher rates of physical and sexual violence than the general population. A study conducted by Testa et al. reports that 38% of their transgender participants reported experiencing physical violence and 26.6% reported experiencing past sexual violence (455). Of those who had experienced such violence, 97.7% attributed physical violence to the attacker's bias against their gender identity and 89.2 attributed sexual violence to the perpetrator's prejudice against their gender identity (Testa et al. 455). Furthermore, the authors take care to mention that "despite suspicions that gender nonconformity exhibited by those assigned male at birth would elicit more violence, trans men reported rates of physical and sexual violence related to their gender identity or expression that were comparable to those reported by trans women" (Testa et al. 457). This study illustrates that, despite a cultural assumption that trans women may bear the brunt of violence due to the transphobic reactions of attackers toward their gender identity, transgender men and transgender women report similar amounts of violence. The Virginia statewide transgender health study found that 40% of the participants reported surviving physical assault since the age of 13, including 45% of trans men and 36% of trans women (Xavier et al. 5). Further, that same study found that 35% of transgender men and 22% of transgender women reported surviving sexual assault since the age of 13 (Xavier et al. 5). While the startling statistics change depending on the study being considered, they indicate that trans people face particular risks of bodily harm due to the transphobia of others. Thus, as a population that is exposed to high rates of physical and sexual violence, it is clear that the transgender community has unique health needs in terms of violence prevention, treatment, and community outreach.

Another area in which transgender populations face severe health disparities is in mental health. A Colorado statewide transgender health survey reports that transgender communities experience high rates of “depression, anxiety, self-harm, and eating disorders” (Christian et al. 1655). Social stress theory helps to illustrate how these increased risks for mental illness for transgender people when compared to cisgender people are not a result of some internal failing or weakness on behalf of those who identify as transgender. According to Meyer, social stress theory refers to the occurrences and events that “are taxing to individuals and exceed their capacity to endure, therefore having potential to induce mental or somatic illness” (675). Further, “For minorities, this social stress can be amplified from the typical levels of stress experienced by majority populations due to the disadvantaged societal position many minorities inhabit, a phenomenon Meyer calls “minority stress”” (Scull 80). Minority stress is a phenomenon that can take many different forms. It “includes practices such as discrimination, microaggressions, hate, and other social conditions that are brought on as a result of an individual belonging to a particular marginalized in-group” (Scull 80). Trans individuals are clearly at risk for mental and physical illness due to the cultural transphobia that generates minority stress within individuals who inhabit intersecting identities.

Data from a 2018 study indicate that transgender individuals suffer from mental illness at higher rates than the general population, as 43% of transgender respondents disclosed dealing with current depression, while only 6.8% of the general population in Colorado reports having depression currently (Christian et al. 1657). Furthermore, 52.1% of transgender respondents were diagnosed with an anxiety disorder, compared with only 15.1% of Colorado residents (Christian et al. 1657). Additionally, 36% of transgender participants reported having thoughts of suicide in the last year and 10.2% of transgender people made a suicide attempt. For the general Colorado

population, these rates are 3.8% and .8%, respectively (Christian et al. 1657). According to these statistics, transgender individuals in Colorado are approximately ten times more likely to experience suicidal ideation, and about 13 times more likely to attempt suicide than the general population in their state. Clearly, there are disparities in mental health outcomes in the transgender community in Colorado. Similarly, the Virginia statewide study on transgender health found that approximately 66% of contributors reported having suicidal thoughts, which broke down to 79% of transgender men and 58% of transgender women (Xavier et al. 5). Of those who disclosed having thoughts of suicide, 41% reported making a suicide attempt, with transgender men and transgender women attempting suicide in similar percentages (Xavier et al. 5). While there are no corresponding state statistics for the Virginia population as part of this study, it is clear that the disparities in mental health because of cultural transphobia are alarmingly high.

The national average percentage of adults living with major depressive disorder in 2016 was 6.7% according to the National Institute of Mental Health (NIMH). The percentage of all United States adults living with a diagnosed anxiety disorder was 19.1% in the most recent dataset from 2001-2003 (“Statistics”). Further, the NIMH reports that 4% of all adults in the United States live with suicidal ideation, while .5% of all adults in the United States attempted suicide in 2016 (“Statistics”). The Colorado statistics for their general adult population are quite similar to the national United States general adult statistics. Compared with the United States adult population, transgender respondents in Colorado are approximately 6.4 times more likely to have depression, 2.7 times more likely to be diagnosed with an anxiety disorder, 9 times more likely to experience suicidal ideation, and 20.4 times more likely to attempt suicide than the general United States adult

population.<sup>7</sup> In Virginia, transgender individuals are 16.5 times more likely to report experiencing suicidal ideation, and 82 times more likely to attempt suicide. A transgender identity is not the result of poor mental health, however. Testa et al. eloquently highlight the fact that social factors such as discrimination and violence lead to a multitude of physical and mental health problems (454). Thus, the high rates of mental illness in the transgender community do not occur because of an internal failing of trans people, but rather exist because of the mistreatment that transgender individuals experience.

Related to mental health, substance abuse is another area in which transgender populations face health disparities due to negative social factors. Due to the lack of access to healthcare that transgender individuals face, it is possible that some of the following substance abuse statistics could be influenced by attempts for trans people to self-medicate. In Colorado, transgender study participants are more likely to report smoking (17.3% vs 15.7%), binge drinking (25.7% vs 17.5%), marijuana use (32.8% vs 13.6%), and prescription drugs (10.6% vs 5.6%) than the general Colorado adult population (Christian et al. 1657). Interestingly, transgender individuals in Colorado are less likely to use illicit drugs than the general population (9.3% vs 16.6%) (Christian et al. 1657). In Virginia, 18% of transgender study participants currently used marijuana, 5% used depressants or “downers,” 5% used painkillers, and 3% used powder cocaine (3%). These were the most common drugs reportedly used by transgender individuals in Virginia (Xavier et al. 5).

As with mental health, transgender populations face clear health disparities in their exposure to and use of certain types of drugs. According to the 2013 National Survey of Drug Use

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<sup>7</sup> In this sentence as well as in the next, I calculate the statistics by dividing the percentage of transgender participants who reported dealing with each mental illness category by the percentage of all United States adults who struggle with the same mental illness. Results are rounded to the nearest tenth.

and Health conducted by the US Department of Health and Human Services, 12.4% of adults use marijuana, 31.4% use tobacco, 36.2% report binge drinking, 14.4% use illicit drugs, 3.5% use depressants, and .8% use cocaine<sup>8</sup> (Center for Behavioral Health Statistics). The only drug category that was accounted for in all three studies was marijuana use. With a national average of 12.4% use in adults, both the Virginia and Colorado percentages at 18% and 32.8% respectively indicate higher average use among trans individuals. A possible explanation as to why the transgender community in Colorado uses marijuana in much higher percentages than the Virginia sample or the national average could be that recreational marijuana usage was legalized in the state through a 2012 constitutional amendment (“Colorado Marijuana Legalization Initiative”). Due to increased ease of access and reduced fear of legal repercussions, the legalization of marijuana in Colorado could have either inflated the percentage of transgender survey respondents who reported using marijuana or improved the accuracy of Colorado data when compared with the national averages reported by study respondents.

The national average of 31.4% provides a decent measure of current tobacco use in the United States; however, the Colorado study only included smoking in their measures. 17.3% of the transgender population in Colorado reported smoking (Christian et al. 1657). While this number is below the national average, the national average includes more forms of tobacco. Had the Colorado study asked about all forms of tobacco use, the percentage of respondents who indicated that they used tobacco may have been higher. The study from Virginia had a similar

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<sup>8</sup> These percentages come from averaging together the statistics of all adults who used these substances. The Center for Behavioral Health Statistics initially broke drug usage into categories based upon age. Because neither of the comparison studies done in Virginia or Colorado had the same age group categorizations, I took the average of these numbers and excluded the rates of use for those under 18 years of age.

discrepancy, where it asked only about lifetime tobacco usage, and not current usage. 66% of the transgender population surveyed in Virginia indicated that they had used tobacco at some point in their lives (Xavier et al. 5). Binge consumption of alcohol, which was reported at 36.2% in the general adult population, came up in 25.7% of transgender participants' responses in Colorado.<sup>9</sup> While the Virginia study did not specifically inquire about current binge drinking, 93% of respondents had indicated that they drank alcohol in their lifetime, and 25% categorized their drinking as problematic at some point (Xavier et al. 5).

Transgender respondents have reported use of depressants and cocaine in higher rates than cisgender respondents. The national average percent of use for depressants in the United States is 3.5%. 5% of the participants in the Virginia study indicated that they used depressants, which is slightly above the national average. The Colorado study did not inquire about depressants specifically. It is possible that they could have grouped downers within the category of prescription drug use, which they report at 10.6%, although this possibility is unclear depending on the type of depressant (Christian et al. 1657). Likewise, the national rate of use for cocaine is .8%. The trans individuals who completed the study in Virginia reported engaging in cocaine use more frequently, as 3% indicated that they had personally used the substance. The Colorado study did not specifically inquire about cocaine use, so the percentage of transgender people who use cocaine in Colorado is unclear. The available statistics indicate that the transgender population uses depressants and cocaine in slightly higher percentages than the general population, which could

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<sup>9</sup> Christian et al. used the current legal definition of binge consumption of alcohol. This definition, rooted in the conflated gender and sex binary, considers the number of alcoholic drinks required for "binge drinking" to be dependent on one's sex at birth, not one's gender identity. It is not mentioned how hormones or medical transition affects one's bodily tolerance of alcohol, if at all.

be influenced by the positionality of trans people as a marginalized target group that experiences minority stress, discrimination, and transphobia.

There is a compelling correlation between the national average of illicit drug use, which is 14.4%, and the Colorado transgender population's use of illicit drugs, which was reported at 9.3%. Just as with the statewide average percent of illicit drug use in Colorado, transgender individuals living in Colorado indicate lower rates of use for illicit drugs than both cisgender Colorado residents and the national average. It is unclear what exactly causes these lower rates of use, so further research must be done in this area to investigate the use of illicit drugs to find correlations between demographics and those who use such drugs. Because transgender populations generally report higher rates of drug use, it is possible that this trend is inverted for illicit drugs in Colorado because legalized marijuana would not be counted as illicit in that state, but would be included in United States national statistics. These findings illustrate that it is crucial for healthcare providers to be aware of the heightened risks for exposure to drugs in transgender patients and to consider the range of social factors that can contribute to drug use in transgender patients.

Transgender populations also report higher rates of sexually-transmitted infections than their cisgender counterparts. In their 2016 study, Nuttbrock and Hwahng discussed how “community-based surveys of [the transgender] population in the U.S. [find that] reports of HIV prevalence have ranged from 22.5 to 48.5%” and that rates of infection for other sexually-transmitted infections are higher in transgender populations as well (3328). They elaborate that “World-wide, the prevalence of HIV among transgender women has been estimated to be 48.8 times higher than the corresponding estimates in the general [cisgender] population” (Nuttbrock and Hwahng 3328). The conclusions of this study are that a racial component exists with regard to sexually-transmitted infections, where people of color have a higher risk of infection than those

who are white (Nuttbrock and Hwahng 3328). Furthermore, the authors found a strong connection between sexual orientation and risk factors for sexually-transmitted infections, such as sex work and unprotected receptive anal intercourse. The study discovered that sexual attraction to men has a specific association with increased risk of HIV and other sexually-transmitted infections when compared to those who are sexually attracted to women solely or to multiple genders (Nuttbrock and Hwahng 3334). Thus, transgender women who are attracted to men only may engage in practices that create heightened risk of sexually-transmitted diseases. The statewide transgender health survey in Virginia found that half of the transgender women participants with primary romantic and sexual partners did not use condoms while 22% reported always using condoms (Xavier et al. 6). For transgender men with primary romantic and sexual partners, 51% reported not using protective barriers while only 19% reported always using condoms (Xavier et al. 6). For trans women who have multiple partners, 39% indicated that they always used condoms and 10% disclosed that they rarely or never used protective barriers during intercourse. For trans men with multiple partners, 53% stated that they used condoms and 13% indicated that they never used them (Xavier et al. 6). Thus, it is clear that the transgender community is disproportionately exposed to sexually-transmitted infections and face specific sexual health risks, which can negatively affect overall health outcomes for transgender populations.

The transgender community in the United States faces heightened health risks compared to the cisgender population including in the areas of physical and sexual violence, mental health, substance abuse and alcohol use, and rates of acquiring sexually-transmitted infections. These health disparities negatively impact transgender individuals and “are influenced greatly by social conditions and limited access to quality healthcare” (Carabez 260). The next chapter will discuss



ways that medical institutions can break down some of the social and institutional factors and practices that marginalize transgender individuals and result in these striking health disparities.

#### 4.0 Chapter 3: Medical Perspectives on Transgender Patients

We have taken a critical look at the ways in which medical institutions have historically and continue to marginalize transgender patients seeking care. Given the startling statistics of health outcomes and healthcare disparities that exist for the transgender population, it is clear that healthcare is a contentious terrain for those who do not identify as cisgender. Due to the reality that “Discrimination in health-care settings is pervasive for transgender [people] who are recognized as transgender” (Rodriguez et al. 984), this chapter will focus on tangible ways that those working within the healthcare institution in the United States can make healthcare more accessible to transgender patients. Healthcare accessibility for the transgender population is crucial because “Transgender patients may access care for medical or surgical treatments related to transition, but are much more likely to need care for any of the myriad acute or chronic illnesses or injuries that anyone in the population may experience, from sprained ankles to colon cancer, from birthing to open heart surgery” (Carabez et al. 259). Beyond healthcare directly related to gender transition, the transgender community needs access to services that treat the range of conditions and injuries that humans experience throughout the course of a lifetime. This chapter addresses some methods of breaking down healthcare barriers for transgender individuals through three sections: Initial impressions, interpersonal interactions, and structural education. This work on the part of healthcare providers is crucial in ensuring the health and safety of trans populations.

In an article published in *The Atlantic* on October 23, 2018, Khazan discusses the impact of the Trump Administration’s memo suggesting that the federal government move to adopt a biologically essentialist definition of gender conflating assigned sex at birth with gender identity. Khazan argues that the medical professionals who treat trans patients understand the harm that this

type of policy could potentially have. The subtitle reads “Discrimination against trans people is rife in the medical field, and it could get even worse if sex is defined as unchangeable” (Khazan). As has been discussed in the last two chapters, Khazan is correct: transgender individuals seeking healthcare are already forced to contend with discrimination and institutional barriers preventing them from accessing desperately-needed services. This suggestion for federal policy breaks with the Obama Administration’s inclusion of gender identity under Section 1557 of the Affordable Care Act, which forbids health institutions that are funded with federal dollars from discriminating against patients in the areas of “race, color, national origin, disability, age, or sex” (Khazan). Physicians indicated that they believed the adoption of this strict definition of gender would make patients less inclined to speak with their healthcare providers about their gender identity (Khazan). If the United States government takes a formal position that denies the existence of transgender individuals, health disparities among the transgender population are bound to increase. Not only will more patients be closeted in their interactions with healthcare specialists, but the current research on issues of transgender identity and health would suffer as well. Khazan quotes a pediatrician who comments, “with this new definition, medical research on transgender issues would be rolled back— why research something that isn’t real?” Within the context of the current political climate in the United States, improving healthcare for transgender patients is as vital as ever. The Trump administration, working to strip transgender Americans of their basic rights, pushes back against the “Obama administration policy changes [that] includ[ed] transgender people in essential aspects of the fabric of society[, which] ... [promoted] transgender health” (Karasic 246). Should this new definition of gender be adopted and enacted on a federal level, the health disparities between transgender populations and the general public will continue to increase. The rest of this chapter outlines possibilities for improving the status of healthcare in the United

States for transgender populations, which would reduce these overall health disparities and work toward a goal of deconstructing barriers to care.

The World Professional Association for Transgender Health (WPATH) generated an extensive document referred to as the Standards of Care. This document outlines how clinicians can work to ensure the health of transgender and gender non-conforming individuals. The Standards of Care offers clinical guidelines that illustrate best practices for healthcare that affirms the gender identities of clients and works to ensure that they receive adequate healthcare in professional settings. According to WPATH,

The overall goal of the [Standards of Care] is to provide clinical guidance for health professionals to assist transsexual [sic], transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. (1)

Available free of cost in 18 languages, WPATH does their best to make this 120-page volume accessible to as many medical professionals as possible. In agreement with an expanded definition of health that considers whole-person wellness, WPATH writes that

health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and

legal reforms that promote tolerance and equity for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms. (1-2)

The Standards of Care is an excellent place to look for both detailed information specific to both treating transgender patients in a clinical setting and learning about the changes in structural policy that would be beneficial in improving healthcare for the transgender community. For healthcare professionals looking for ways to be affirming providers for their transgender patients, the Standards of Care is an amazing resource.

#### **4.1 Initial Impressions**

To members of a community who have often endured negative, stigmatizing experiences in healthcare settings, the first impression that clinicians make with potential patients is crucial. There are a few ways that the clinicians working in healthcare settings can make themselves known as affirming allies to transgender individuals seeking healthcare, such as through the clinic's online presence, intake forms, and in wall signage both in waiting rooms and examination rooms.

Before a patient crosses the threshold of a medical office, they may research clinic websites or social media pages when looking for a care provider. Including write ups about LGBTQIA+ healthcare on clinic websites is a great way to begin letting prospective patients know that they will be safe and treated with respect should they decide to seek healthcare within that specific practice. Similarly, providing social media coverage or blog posts highlighting the clinic's available gender-affirming healthcare services and outlining the procedure for accessing such care

could be helpful, as it publicizes that gender-related healthcare is a priority for the health clinic. Furthermore, disclosing the process for receiving gender-affirming healthcare through the practice can help reduce feelings of anxiety on behalf of the patients seeking these services because they will know both what to expect from clinicians in each appointment and what types of demands the physicians will anticipate from them.

Additionally, an area in which the comfort level of transgender patients can be increased is by reevaluating the content of the patient medical history and intake forms, as many scholars and patients discuss. As one patient put it,

*when people don't respect my name and my pronouns, it can feel really frustrating, and that definitely doesn't make me feel very comfortable or welcome in a medical situation. More options on the forms means there is room in people's minds. (Italics original, transgender person quoted in Dutton et al. 335)*

As this patient illustrates, the consequences of not respecting the chosen name or pronouns of trans patients negatively impacts the relationship between the patient and provider by making the patient feel uncomfortable and unwelcome.

Prospective patients deciding upon a healthcare provider are often obligated to fill out paperwork detailing their health history and includes any present health concerns they may have. An alienating experience for transgender individuals being forced to fill out this paperwork comes when they are confronted with the “gender” demographic questions, which often only have a female and male option. For patients whose gender identity does not align with their assigned sex at birth, these questions can cause confusion, frustration, and dysphoria. The transgender men who participated in Dutton et al.’s study commented

that “Deciding if the M and F boxes on the intake forms were referring to sex or gender caused conflict” (335). Attempting to discern if providers are hoping to learn the biologic sex of their patients even though they are asking for the patient’s gender remains an essential concern for transgender individuals filling out intake paperwork. Being forced to categorize oneself as only male or female “on a health care intake form implie[s] certain aspects of one’s physical body, biologic sex, as well as physical appearance and gender expression. All individuals interviewed [in the study] had stories of the conflict between the box marked on intake forms and their appearance, name, anatomy, and identity” (Dutton et al. 335). In filling out intake paperwork, transgender patients often feel conflicted and unsure of which information the healthcare providers are really looking for. Thus, one relatively easy way to show the transgender community that a healthcare practice is gender-affirming and supportive would be to expand the options listed on intake paperwork (Schuster et al. 102). For example, clinicians could include a question that asks specifically about biologic sex assigned at birth, which should at least include male, female, and intersex. In a question following that of a patient’s assigned sex at birth, clinicians should inquire about the patient’s gender identity. Options for gender identity should, at the very least, include woman, man, transgender woman, transgender man<sup>10</sup>, nonbinary, genderqueer/genderfluid, agender, unsure, prefer not to say, and a final option that allows patients to self-identify with their preferred terminology if their gender identity is not included by other options. Expanding the included options beyond the standard

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<sup>10</sup> Some transgender individuals prefer to identify themselves as transgender, and others do not. Thus, it is important to include the additional options for trans man and trans women, but include them with the knowledge that it is possible that a transgender woman will feel most comfortable identifying with the woman category or a transgender man may identify with the man category.

female/male binary shows transgender patients that the clinicians working at the practice are knowledgeable about issues of gender identity and will likely be affirming allies to them in their healthcare journey. Furthermore, if a transgender patient does not wish to be identified as such, they should have the option to leave the question unanswered or opt out in some other way. This gives transgender patients the right to self-identify in cases where they wish to do so but also allows for the possibility that patients can elect to not identify their gender if they decide that they would rather not disclose such information upon intake.

Another way for a provider to enhance the comfort level of transgender patients would be to include a question on intake forms about whether or not the patient has a preferred name and which pronouns they use. Having such information inquired about and disclosed if applicable at intake would remove some of the hesitation and confusion surrounding how clinicians should ask these questions in an empathetic and respectful manner. Including preferred name and pronouns as a universal intake demographic question would also remove the human error associated with attempting to ask only gender non-conforming individuals what their preferred name and pronouns are. Gender identity is not something that can be discerned by looking at someone's appearance. Therefore, making decisions about who should be given the ability to self-identify can be problematic because such methods rely on gendered assumptions rooted in the gender binary. McCarthy et al. discuss the potential othering effects of asking only those who "look" trans about their name and pronouns, as this method may offend patients whose gender expression appears of a certain nature due to underlying medical conditions. For example, a bald cisgender woman who lost her hair to chemotherapy treatment or a cisgender man who suffers from gynecomastia, a condition that causes excess breast tissue in men, may find these direct questions isolating, othering, or shame-inducing (McCarthy et al. 237). Due to the sensitive nature of appearance and



identity, inquiring about assigned sex at birth, gender identity, preferred name, and pronoun universally on intake paperwork serves to assure transgender patients that the clinic is one that will support and affirm their gender identity while avoiding the harmful consequences of relying on visual cues to assess gender non-conformity in patients who may be suffering from an acute medical condition.

A final way that clinics can ensure that patients who identify as transgender feel supported prior to receiving services would be to display inclusive signage or handouts in the medical office's waiting rooms and examination rooms. Hanging a poster that indicates support for LGBTQIA+ identities in a waiting room can go a long way to convey to marginalized patients that they are welcomed and accepted for who they are in that space (Mayer et al. 993). Including educational pamphlets that detail LGBTQIA+ health and wellness can have a large impact beyond the patients themselves, too. Displaying such signage can also ease the concerns of worried parents or caregivers if they are bringing their child to the clinic to discuss the available options in terms of medical transition or identity-specific care. Viewing positive images of queer and trans adults living happy and healthy lives may aid in assuaging the anxieties of caregivers by illustrating the ways that those who identify as queer or trans can be successful and live meaningful lives. These images also function to decenter the norms of cisgender heterosexuality and reduce the stigmas surrounding identifying as transgender or queer. Such actions thereby have the potential to increase the comfort level and therapeutic relationship between patient and practitioner while supporting concerned parents and caregivers.

Medical practices that wish to provide culturally-competent care can begin working toward that goal before a patient ever arrives at their clinic. Effective methods to signal that a practice is accepting and affirming of LGBTQIA+ patients and their gender and sexual identities can include

strategies rooted in online presence, intake forms, and signage in waiting rooms and examination rooms.

## **4.2 Interpersonal Interactions**

Another approach that clinicians can use to position their practices as safe spaces for transgender patients is through mindfulness in their interpersonal interactions. Asking patients if they have a preferred name and which pronouns they use, giving patients a sufficient amount of time to gain trust in the provider and clinic, allowing trans patients to discuss their specific experiences and goals for seeking care, and treating trans patients as unique individuals with other aspects to their lives beyond their gender identity are all tactics that can help to enhance the provider patient relationship in tangible ways.

McCarthy et al. discuss humanizing ways to take a medical history for transgender clients in hospital settings. They discuss how “When a patient has self-identified as transgender, we advise health-care providers to ask the patient if [they have] a preferred pronoun. This small act of engagement has the potential to enhance the therapeutic alliance between doctor and patient and may enable the patient to be more forthcoming about sex and gender issues that could be relevant to the clinical presentation” (236). Being cognizant of the many different ways that patients may identify in terms of gender helps the physician build a relationship of respect with transgender patients. Creating an environment in which this relationship is established can help the patient feel comfortable sharing sensitive information on topics that are difficult to discuss with medical professionals. Offices that do not foster this type of relationship can face difficulties in encouraging patients to disclose health information. One patient comments that

When you transition, it's kind of very nerve wracking, especially when you have to tell that to the doctor. And sometimes, I think for example, in my experience, ... when I came to the clinic and the nurse asked me what are you here for, I didn't really know how to answer that because I wasn't comfortable sharing that with the nurse. (Transgender person quoted in Hinrichs et al. 78)

Had the office this transgender patient was visiting done the work of communicating that they are a supportive and affirming provider, perhaps this interaction would not have been so strained. If the patient was still uncomfortable disclosing the reason for their visit, perhaps they would have felt secure in expressing their discomfort in some way.

Interpersonal interactions that strengthen the relationship between provider and patient allow trans patients time to become comfortable at their own pace. Some patients emphasize the importance of “Needing time to build a trust and mutual understanding” because

If I'm nervous to tell you about something, like it burns to pee, it might take me a bit to jump out and say that. Give me that patience just to know that it's safe. (Transgender individual quoted in Hinrichs et al. 78)

The respondent from this passage expresses their feeling that allowing patients to gradually disclose information throughout the course of the interaction is helpful, particularly with regard to bringing up topics that are difficult to discuss.

Allowing trans patients to discuss their specific life experiences and goals for seeking care is an additional strategy that providers can use to increase the comfort of patients through interpersonal interactions. Since transgender healthcare does not have a singular system that can be applied universally to all patients who identify as trans, it is crucial to allow each individual

patient the opportunity and space to safely discuss which forms of transition-related healthcare they are interested in learning about and potentially receiving, if any. While individual experiences vary from person to person, all healthcare professionals should have a basic understanding of how the experiences and stressors of transgender people can differ from those of their cisgender counterparts.

Another way that clinicians can foster a mutually beneficial and healthy relationship with their transgender patients is to allow trans individuals the space to discuss their gender identity when it is medically relevant or when the patient brings it up themselves. Clinicians should refrain making gender identity the center of every health conversation and interaction with their transgender patients. One patient discusses how, in their experience,

it's really nice when I come here, because I think I have the flu or something else, that my trans status doesn't come into it. Maybe I just need antibiotics and not talking about surgery. (Transgender patient quoted in Hinrichs et al. 78)

Discussing gender-related care when patients approach clinicians for such care is essential, but attempting to talk through surgery or hormone regimen options with a patient who is seeking care for a sinus infection or another routine physical ailment sends the message that the provider is considering the patient's gender identity above all else. Ultimately, physicians should take the time to truly listen to the patient, letting them lead the discussion of what care they feel as though they need. Another patient relays

I really appreciate when people can see me as a whole person. Like being trans is part of me, but I'm also a parent, and I— there's a lot of other parts

of me that come into play [beyond having a transgender identity].

(Transgender person quoted in Hinrichs et al. 79)

Effective healthcare for transgender individuals entails addressing all aspects of a patient's needs, rather than focusing in on one specific component of a patient's identity.

Clearly, culturally competent care for transgender patients is made possible through affirming and empathetic interpersonal interactions in combination with creating positive first impressions both for queer and transgender individuals in addition to their caretakers. Such encouraging initial experiences can have an incredibly positive impact on transgender health, as affirming healthcare experiences can prevent harmful delays of care later in life. These interpersonal interactions can take the form of asking patients if they have a preferred name and which pronouns they use, allowing patients sufficient time to gain trust in the provider and clinic, and treating trans patients as unique individuals with other aspects to their lives beyond their gender identity. All of these tactics are specific strategies that can help to enhance the provider patient relationship in tangible ways.

### **4.3 Structural Education**

One of the most crucial ways that medicine can work to address the structural harms being carried out on trans populations is through education on an institutional level. Snelgrove et al. argue that physicians struggle to treat transgender patients because of a “lack of training, limited medical knowledge, and scant access to information sources” (3). They elaborate by arguing that the practice of assuming “that most physicians will never encounter a trans patient contributes to informational erasure, whereby the need for healthcare training, research, and policies inclusive of

trans people is systematically unrecognised [sic]" (Snelgrove et al. 11). Poteat et al. also acknowledge the dismal state of medical education on transgender patients when they argue that there is "little to no education on transgender health [in medical curricula in the United States]" (Poteat et al. 2013:23). Due to these shortcomings of medical education, training and education must be implemented at all levels of the medical institution to ensure that those coming into contact with transgender patients in healthcare contexts are equipped with the knowledge they need to provide care to trans patients without inflicting harm. First, we will take a look at one theory as to why these educational gaps exist in medicine today.

Mayer et al. discuss some reasons why the medical institution is unable to adequately care for gender and sexual minorities. They find that "neither professional schools nor continuing education programs provide the training needed to improve the attitudes, knowledge, and skills of physicians and other health care [sic] professionals in caring for LGBTQIA+ people" (Mayer et al. 993). As a result of a general lack of training, providers simply lack the education to provide adequate healthcare to queer and trans populations. Moreover, the authors argue that public health policy and programs addressing LGBTQIA+ needs have suffered "by a lack of resources as well as by limited population-based data and the need to focus advocacy efforts on basic civil rights issues (Mayer et al. 993). Thus, Mayer et al. argue that, since advocacy has historically been forced to focus on basic human rights issues such as housing and employment discrimination, advocates for transgender rights have not yet been able to address the knowledge gaps that exist within medicine. Furthermore, the general lack of resources allocated to assisting the marginalized LGBTQIA+ community combined with the invisibility of the transgender population in national datasets and surveys has created an environment in which medical ignorance has been permitted to linger.

Carabez et al.'s study of nurses specifically makes a similar conclusion. They argue that the existing literature has observed "that providers are uninformed, uncomfortable, and sometimes hostile [when engaging with transgender patients], but thus far, no studies have focused on nurses' attitudes and knowledge of transgender patients' healthcare needs" (Carabez et al. 260). Once more, institutional ignorance surrounding marginalized trans individuals had been unaddressed by medicine. The next section will analyze ways of examining this educational scarcity in an effort to make medicine a more affirming and supportive space for transgender patients seeking healthcare.

One form of institution-wide education that has the potential to vastly improve the experiences of transgender individuals seeking healthcare would be if physicians, nurses, and institutions related to health insurance were "taught to address health-care needs related to a person's anatomy regardless of gender identity" (McCarthy et al. 239). Should such a model of addressing healthcare needs based on each individual's anatomy be introduced to the medical establishment, transgender patients could experience more freedom in having the ability to dictate the terms of both their identity and healthcare. The transgender man from Chapter two who was unable to change his legal gender marker to align with his gender identity due to the insurance company's refusal to cover a cervical cancer screening for a man would, under such a paradigm, be able to make the gender-affirming choice to change his legal gender marker. He would be able to do so while also remaining eligible for the preventative healthcare that he needs as someone with a cervix.

McCarthy et al. argue that "Rather than wait[ing] for a transgender patient to be admitted to the hospital to illustrate salient teaching points, transgender issues should be incorporated into daily discussions on rounds about cardiovascular disease, endocrinology, hematology, or

metabolic diseases” (242). In this way, medical professionals would already have the knowledge required to treat transgender patients before they meet someone who identifies as trans seeking healthcare. The authors go one step further by arguing that “hospitalists should build on these important initiatives by introducing a formal curriculum into the third and fourth years of medical school, during the medical clerkship, where students learn to confront medical and ethical issues in real time” (McCarthy et al. 242). Such a program for medical students could prove incredibly beneficial in increasing the clinical knowledge that physicians have with regard to trans issues. The burden of education should fall on the medical school curriculum, though, and not on the patients as it does today. One trans person writes

With the training, my doctor’s always training someone, and that’s really cool, and I’m excited for the new providers to get that knowledge, but sometimes I just don’t want 50 people in the room when I’m trying to talk about this really difficult thing. (Transgender patient quoted in Hinrichs et al. 78)

Through their account, this individual expresses gratitude in having a way for the next generation of healthcare providers to learn about the most effective ways to treat transgender patients. Their ambivalence, however, comes from being uncomfortable with having several medical students in the examination room during their appointments. Perhaps clinicians could mediate this situation by having a staff member check in with the patient beforehand to inquire if they would feel comfortable with a student or two sitting in on that particular appointment. That way, the patient has the ability to freely consent without feeling pressured to approve of having others sit in on the appointment if the physician asks with the students right behind them.



Doctors who had treated a trans patient in the past were able to identify specific trans-related healthcare needs and institutional barriers better than those who had never had contact with a trans patient. Snelgrove et al. thus argue that having a transgender patient was an “instigating event for physician reflection and education on the healthcare needs of this patient group” (4). Perhaps if medical students were exposed to treating and interacting with transgender patients during their educational experiences, these “instigating events” could happen during a time frame that would allow future providers to ask questions of those who have experience in caring for marginalized communities. One physician commented

I have wondered if a patient like that [trans] was to come along what I would do. And the answer is I have no idea ... I mean if a patient was looking for sex reassignment surgery [sic] or something along those lines, I would have no idea who to send them to. (Family physician quoted in Snelgrove et al. 4)

This clinician conveys complete confusion and a sense of uncertainty when it comes to the thought of treating a patient who identifies as transgender. Another clinician explains

I would imagine that the average physician, especially if you're a family doctor, has had no exposure to these sorts of things. You know, the first time you get a transgendered [sic] patient come into your office, you're sort of lost and you don't really know what to do. (Nuclear medicine physician quoted in Snelgrove et al. 5)

While not all doctors will have expertise in clinical trans issues, it is crucial that practicing medical professionals have a basic knowledge of how to interact with patients who are situated within a marginalized identity. Since the office of a family doctor is often a first stop that supportive parents

make when their child discloses identifying as transgender, primary care physicians may be some of the first medical professionals to be fielding questions from concerned caregivers. If these medical professionals had learned about transgender identities and engaged with trans patients in medical school, perhaps they could have developed a basic framework for understanding what these patients need in clinical settings.

Even physicians who desire to be an affirming ally to their transgender patients can struggle to find resources that help them provide care. One doctor explains

despite trying to find ways to improve my expertise, I just didn't know where to go or who to talk to, or where to get the information, and I felt really bad because some of my initial attempts to help these people—I sent them to people I wish I hadn't sent them to. (Family/HIV primary care physician quoted in Snelgrove et al. 4)

Since this clinician did not have the resources to know which clinics were gender-affirming, it was not possible for them to make educated referral decisions with regard to having empathy and understanding for patients who identify as transgender. Similarly, another doctor comments that patient referral for transgender individuals seeking healthcare is

trial and error, like you know you refer somebody and they come back and say, “you know that guy was a total dickhead” or “you know he treated me like I was from another planet” and so you just know not to refer to those people again. (Family/HIV primary care physician quoted in Snelgrove et al. 5)

This method of attempting to help transgender patients can be tricky, as the first few trans people to visit any given clinician could be blindly referred to unsupportive or blatantly transphobic

providers and thus exposed to significant harm. Given the structural challenges that exist for transgender patients to receive healthcare, a few referrals that go poorly could have a disastrous effect on the overall health and wellbeing of those trans individuals.

Nurses, similar to doctors, receive very little— if any— education on transgender issues while in school before they are licensed to practice. In fact, a national study found that the mean number of hours spent teaching LGBTQIA+ community issues to nursing students is 2.12 hours (Lim et al. 144). Given the many diverse ways that individuals can identify within the LGBTQIA+ community, it is clear that the nursing curriculum in the United States pays very minimal attention to the health and needs of the entire LGBTQIA+ community, but especially lacks information with regard to transgender patients. When asked about trans patients, one nurse unsurely responded with a question.

I would assume in my understanding of this, that, and this could be wrong so please forgive me if I'm wrong. If they are transgender is it that it is just a relating to a different orientation? Or is it that they actually have both components? (Respondent 28 quoted in Carabez et al. 262)

This nurse appears to be unsure whether the term she is being asked to speak on— trans— refers to those who are queer, those who are transgender, or those are intersex. Referring to patients who have a different orientation appears to be referencing queer individuals; however, her final comment inquiring whether trans refers to those who “have both components” seems as though she is trying to discern if she is being asked about an intersex patient. It does not appear as though this nurse was able to arrive at the correct answer through this question, as the actual meaning of transgender was never mentioned. Thus, it is clear that there are distinct gaps in the nursing education curriculum.

Sometimes, a lack of knowledge on how to treat and care for transgender patients can lead to more harmful interactions, however. One moment in which a participant described such an occurrence happening was when she discussed how

One nurse innocently described the curiosity that the staff had about seeing a female-identified patient's penis, noting, "We all took turns putting her on the bed pan because we all wanted to see." (Carabez et al. 263)

This nurse admitted to researchers that a group of her coworkers intentionally took action so that several of the nurses could glance at a transgender patient's genitals. These healthcare professionals who have been entrusted with caring for patients of all body types, diagnoses, and identities organized a scheme so that a group of them could look upon the genitals of a transgender woman as an object of interest. Such explicit objectification is incredibly harmful, and should be grounds for immediate dismissal from nursing responsibilities in the same way that a similar series of orchestrated acts objectifying cisgender bodies would be. If nurses are carrying out such actions against transgender patients, it seems likely that those who are assigned intersex at birth would experience similar damaging experiences. Trans and intersex patients deserve much better than being subjected to a sinister set of practices within a system in which they experience harmful objectification from those who are tasked with caring for them.

In addition to objectification, some nurses reported making jokes about the transgender patients in their care. She explained that such jokes were not uttered

in front of the patient, but in particular like if it is a male to female and it is not that successful, people come back to the nurses' station and make a few comments like, "Well, that's not working. Another described a transgender

patient as having five o'clock shadow in a skirt." (Nurse quoted in Carabez et al 263)

Such unprofessional and harmful comments designed to mock transgender patients— particularly transgender women— reveal the seriousness with which LGBTQIA+ education must be integrated into nursing school curriculum. Such casual transphobia existing within groups of nurses is disheartening because transgender individuals receiving care from nurses deserve the same amount of respect as any other patient.

This chapter addressed some methods of breaking down healthcare barriers for transgender individuals through sections on initial impressions, interpersonal interactions, and structural education. Making these structural changes and engaging in this work is crucial in ensuring the health and safety of trans populations.

## 5.0 Conclusion

This thesis addressed issues of boundary enforcement and Western ethnocentrism by taking a historical approach while also advocating for the deconstruction of the borders and constricting categories facing transgender individuals today. The first chapter, Trans Scholarship on Medicine, discussed ways of conceptualizing trans experiences in healthcare from the perspective of scholars working in the field of trans studies. It focused on highlighting some of the many barriers, boundaries, and borders that transgender populations must contend with when seeking healthcare. The second chapter, Health Disparities and Experiences in Transgender Medicine, discussed the many areas in which alarming health disparities exist between transgender individuals and the general population. It also included firsthand accounts of transgender patients' experiences interacting with medical institutions to illustrate the lived impacts of discrimination in medical settings. The third chapter, Medical Perspectives on Transgender Patients, examines the problems that transgender patients experience from the perspective of medical providers and discusses ways that the relationships between transgender patients and their healthcare providers can improve through strategic uses of communication.

This project ultimately contributes to trans studies via an exploration of some of the nuanced experiences transgender individuals face within healthcare settings. Furthermore, this work strives toward a goal of deconstructing boundaries, specifically those that exist within the medical field, to improve the quality of and access to healthcare for the transgender community. It is the obligation of the next generation of researchers in transgender studies to deconstruct constricting boundaries and categories while rejecting ethnocentric practices in scholarship to make a more livable world for transgender individuals seeking healthcare. Further research must

be conducted to obtain national statistics on the healthcare experiences and health disparities between the transgender population and general population living in the United States. Other areas in which researchers should focus are elder care for transgender individuals, the differential treatment between white transgender people and transgender people of color, the health needs of single trans people compared to those in relationships, the experiences of transgender children in their interactions with medicine, and effective strategies for intervening in the health disparities that exist between transgender individuals and the cisgender population living in the United States. Since there is not one singular narrative of transgender experiences and needs within healthcare institutions, deconstructing structural and cultural borders and boundaries while allowing patients to decide which, if any, healthcare interventions they desire for their own bodies are crucial.

As a group of young trans patients have said,

there is no one “trans experience,” but there is trans inclusive medicine, which fosters respect, cooperation, and the best experiences and outcomes. ... Although these ideas might seem new, that’s not the case. I’ve always been here, as your trans patient; it’s just I’m not hiding any more. ... We are your trans patients. We are one in 100 of your patients. You won’t always know who we are ... when our trans status wasn’t relevant, so we didn’t bring it up. We know it’s difficult sometimes when your systems struggle to include us, or the literature you rely on doesn’t tell you how to treat us. But we’re here, we exist; and we’re counting on you. (Lewis et al. 1-2)

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