# AUDITIONING FOR CARE:
# TRANSSEXUAL MEN ACCESSING HEALTH CARE

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By

WILL ROWE
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AUTHOR: Will Rowe, B.A.(Hons) (Guelph), B.S.W. (Ryerson)

SUPERVISOR: Dr. Chris Sinding

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# Abstract

Utilizing an Institutional Ethnographic framework, the aim of this research project is to make visible the interconnected, often complex forms of work that transsexual men in Ontario do in order to access trans specific health care. The forms of work were made visible beginning from the experiential standpoint of transsexual men. This work was mapped onto the specific sites of health care access and traced up through the discourses and practices that socially and institutionally shape this work. The originating texts of these discourses were illuminated. This was accomplished by interviewing four transsexual men who had accessed health care services in Ontario during their process of transitioning. Findings indicated that much of the work that transsexual men complete is linked to their knowledge of the discourses that have directly informed what is deemed a credible transsexual identity and transsexual trajectory in Ontario. Findings suggest that further exploration of these texts and the specific institutional sites and processes where these discourses circulate would illuminate how trans specific health care is socially organized to unfold in Ontario.

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> "That we can return again, and at different points, to the utterance embodied in the printed text permits, perhaps even creates, the appearance of discourse as statements or meaning" (Smith, 1999, p.134).

> "To solicit changes in any process, which is of course an overarching intention of any critical research strategy, one must first know *how* the crucial linkages are put together and organized" (Adams, 2009, p.208).

## ***Introduction***

During the summer of 2006, after having worked within women's services for thirteen years, I was coming to the conclusion that the identity that I had laid claim to twenty years previously no longer adequately (if it ever had) represented, and was often at odds with, how I experienced myself in the world. The categories of female and dyke began to make less sense to me as I became aware of a burgeoning new language being made available via trans activism within a North American context and specifically within Toronto. Trans men were becoming vocal and visible and a potentially viable identity that made the most sense for me.

Along with lesbian, gay and bisexual activism, the trans community – including those who identify as transgender and transsexual – has, over the past few decades, become a growing vocal and visible community demanding rights and access to competent, sensitive and trans-positive services, particularly services involving the health care system.[1] As with other historically marginalized communities, access to these services and continuing barriers has often made negotiating and maneuvering through the health care system a difficult task for trans identified individuals, especially those who define as transsexual and who often want/need to make use of the health care system in order to facilitate the transitioning process.

I began to physically transition from female-to-male when I left women's services and became coordinator of an LGBTQ service agency. It was while working as coordinator of this agency that political activism became much more central to my social work practice and I became very much involved in trans politics within the context of supporting institutional level policy changes. It was an attempt on my part to make use of the incredible amount of cultural capital I embodied, especially now that my subject position had shifted to the more privileged (precariously so but privileged nonetheless) site of white, heterosexual male (though still very much queer identified).

As I was embarking upon my own journey of negotiating and maneuvering through institutional bureaucracies in attempting to legally change my identity and medically re-construct my body, I began to realize that the

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[1] I am choosing to use the terms transsexual, transgender and 'trans' throughout this work as a reminder that use of these words within this community are often interchangeable. As a member of this community, I am well aware that identities of individuals who define as trans can be fluid and contested. Although the terms transgender and transsexual have arisen out of distinct cultural and historical times within the community and at various points in time have been considered antagonistic, it is near impossible to create definitions of these terms without someone challenging the very definitions.

dominant, readily accessible trans narrative or discourse was increasingly becoming a part of my own narrative of trans identity. This trans discourse is a powerful organizer of people's actions and interrelations and highlights "how ideas from elsewhere penetrate everyday life, organizing people's relation to health care and affecting their everyday choices about how to act" (Campbell & Gregor, 2002, p. 43). In needing to access the psycho-medical institutions that assist us with aligning our experienced selves with that of our born selves, trans people have learned to adapt our lived experiences to reflect the meta narratives created for us by those within the psycho-medical field. As Shelley (2008) describes:

> Narrating the body becomes a necessary skill, and self-narration is a key element in persuading the authorities to permit SRS. The interiority of memory, and the need to ex/press trauma in a cohesive storied form, intersects with negotiating the exterior social world and its institutions. The self as an integrating story is re/called in pursuit of healing or repairing the mis-sexed body…( p.28).

While completing the course work portion of the MSW Program, I continued my journey of transitioning. During this past academic year, I utilized the services of a plastic surgeon and paid to have 'top' surgery.[2] Via my extensive network of trans male friends and online Internet sources, as well as the knowledge and support of my family doctor (who provided access to the surgeon by agreeing to refer me), I had a hysterectomy completed and fully covered by

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[2] 'Top' surgery is a term frequently used within transsexual communities and includes surgical procedures such as double mastectomy with male contouring. 'Bottom' surgery is a term frequently used within transsexual communities as well, and includes surgical procedures such as metoidoplasty and phalloplasty.

OHIP due to my surgeon's creative use of text in the form of an Ontario Health Insurance Plan (OHIP) billing document. As such, my experiences in accessing Ontario's healthcare system for trans specific care is still fresh.

Having steeped myself in postmodern theory over the past few years and familiarized myself with both academic and non-academic literature on the topic of trans, I have become alert to the psycho-medical discourses which have created and perpetuated trans bodies as identifiable bodies. At this same time we have been erased from the social world due to our lack of access to institutional health and social services and the bureaucratic burden of attempting to match our lived experiences with that of our legally defined and identified birth documents. I was still left wondering, however, about the everyday material reality of trans existence and experience and our engagement with the psycho-medical institutions we were reliant upon in order to create the feminine or masculine bodies we needed to be in the world. I became particularly interested in how transsexual males such as myself were not only learning to negotiate these systems but how in fact our everyday lives had become entangled with these systems in ways that we may not even be wary or aware of. The question I returned to again and again was how is it that our access to health care unfolds as it does?

Enter Institutional Ethnography (IE) and my return to theory grounded in Marxist and feminist critical social science. According to Mykhalovskiy & McCoy (2002):

> Unlike much ethnographic research, IE is not empirically focused on 'experience' or 'culture'. Instead, it addresses processes of social organization. Institutional ethnographers are primarily concerned with exploring and describing the various social and institutional forces that shape, limit and otherwise organize people's actual, everyday/night worlds (p.19).

IE's focus on the work of health care access with linkages to broader social movements made it an important theoretical framework in which to base my research project.

As such, the purpose of this research project is to illuminate the ways that transsexual males (including me) eighteen years of age and older learn to negotiate access to trans specific health care in Ontario and the work we do to maneuver through these sites. The focus is on the work that transsexual males do to meet their transitioning needs and how this work is shaped by and linked to institutional relations within the healthcare system. Work is defined as everything that people know how to do and what their daily lives require them to do, whether or not this activity is recognized as work (Campbell and Gregor, 2002).

Following on the work of Dorothy Smith (1987, 1999), the central focus of the study is not transsexual men's experiences, but rather the social and institutional process within which our experiences are embedded; my goal is to uncover these often invisible 'ruling relations'. According to Smith (1987):

> They are those forms that we know as bureaucracy, administration, management, professional organization, and the media. They include also the complex of discourses, scientific, technical, and cultural, that intersect, interpenetrate, and coordinate the multiple sites of ruling (p.6).

### *Historical Context*

A particular identity formation of 'transsexual' arose out of a Westernized medical and psychiatric discourse during the early to middle half of the 20th century at a time in which psychiatry and medicine were establishing and securing a dominant role. Although trans people existed before the advancement of medicine and psychiatry, our lives became entangled within these establishments as we struggled with our inability to fit into the sex category we were born into and as we made attempts to live with our sense of self via the use of clothing and 'roles' outside of our birth sex. At this time the concept of gender used specifically to delineate that which was not biological had yet to be integrated within these discourses.

In the early part of the 20th century, Freud's theories influenced European as well as North American thought and became part of the dominant discourse within early psychiatry. 1930 saw Wilhelm Stekel's treatise *Sexual Aberrations: The Phenomenon of Fetishism in Relation to Sex* (translated into English in 1952) coining the term 'paraphilia', which replaced 'perversion' as the word of choice and began the psychiatric distinction between transsexual and transvestite or cross-dresser. Viewing transsexual identity as gender dysphoric and as a sexual pathology, the field of psychoanalysis relied heavily upon finding cures or treatment for the transsexual and focused on the psychological make-up of transsexuals as opposed to the earlier medical model of biologically based views of transsexuals as diseased. As explained by Bullough (2000):

> Analysts tended to explain trans behaviour either as a type of homosexuality, or a flight from homosexuality caused by some event in childhood that caused castration anxiety. Cross dressing also continued …to be looked upon as an attempt to overcome the fear of castration by creating an imaginary phallic woman and identifying with her…[although] vestiges of concern for hereditary factors also appeared in some psychiatric literature, which lead therapists to scrutinize the relatives of clients (p.22).

It is important to keep in mind the legal, social and medical culture of the United States, and that of many other Western countries, at this time. Wearing items of clothing associated with the opposite sex in public was deemed illegal; castration of a male was also often considered illegal and anything seen as homosexuality was often persecuted. Many doctors considered such individuals best treated by forced treatments such as drugged detention, electroconvulsive therapy or lobotomy (Califia, 1997).

A medical doctor who spent most of his career working on transsexualism and thus came to be considered the 'father of transsexuality', Harry Benjamin emigrated from Germany to America in the early part of the 20th century. He became interested in endocrinology and began to get requests from patients for referrals to doctors outside of North America who would be willing to prescribe hormones and perform early forms of SRS. Benjamin advocated extensively for the American Medical Association to approve hormones and SRS for transsexuals. Thanks to Christine Jorgensen, perhaps the most infamous transsexual within early American history due in large part to her very smart use of the media, Benjamin became a very familiar name to those who were struggling with a transsexual identity.

Benjamin's first published paper in 1954, entitled *Transsexualism and Transvestism as Psycho-Somatic and Somato-Psychic Syndromes,* laid the ground work for his most influential work in 1966, known as *The Transsexual Phenomenon,* which began to make tangible the recommendations later set out in the *Standards of Care*, a call for the ethical medical and psychiatric care of transsexuality. As he concludes in his first paper, originally published in 1954 and reproduced in the 2006 *Transgender Studies Reader*:

> "Transsexualism is inaccessible to any curative methods at present at our disposal. Nevertheless the condition requires psychiatric help, reinforced by hormone treatment and, in some cases, by surgery. In this way a reasonably contented existence may be worked out for these patients" (Benjamin, 2006, p.52)

With the advancement of surgery techniques and the discovery of sex hormones, sex reassignment became an option for trans people. However, within a North American context, access to Sex Reassignment Surgery (SRS) became largely controlled under the domain of psychiatry and this was solidified during the 1952 development of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The concept of transsexuality was introduced under the category of a sexual disorder and has remained within the *DSM* throughout its four incarnations, although it currently sits under the category of Gender Identity Disorder (GID) and has since 1994.

In 1968, under the direction of John Money, the first SRS surgery took place in North America at John Hopkin's University Hospital in Baltimore, and Gender Identity Clinics were formed soon after. The culminating entanglement of medicine and psychiatry occurred with the *Harry Benjamin International Gender Dysphoria Association Standards of Care for the Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons* created and published in 1979. As postulated by Coleman (2009):

> The aim of the original standards was to set minimal standards for assessment and determination of eligibility for hormonal and sex reassignment. They were also designed to provide optimal care for patients. There was a clear subtext that these *Standards* were designed to protect professionals who prescribed hormones or performed surgery from legal, ethical, or moral scrutiny or liability. They were also designed to legitimize these procedures and to help the medical establishment recognize these as medically viable procedures and promote health care coverage (p.2).

The *Standards of Care (SOC)* proceeded to give mental health and medical practitioners complete control over either denying or granting access to hormones and SRS for trans people.

It is important to note, however, that although trans identity and what is deemed by some as the need to access crucial health services created a reliance upon psychiatry and medicine, trans folks have not been completely passive agents within this discourse. From the beginning of our implications within the medicalized and psychiatrized narrative, those who were trans identified found creative ways to 'pass' without the use of surgery, started underground support groups and began to reclaim a trans identity outside of the dominant discourse. "Transgender issues have become a site of activism, resistance, and social change, …from a pathologized transsexual population that existed around support and informational groups to a politicized transgender community that challenges society's gender paradigms" (Shapiro, 2004, p. 166). Trans people also became savvy consumers of the psycho-medical industry and learned to mimic the very narratives created about us to gain access to surgery and hormones (Namaste, 2005).

In 1978, the Ontario Ministry of Health began providing funds towards the development of a Gender Identity Clinic in Toronto. Funding for this specialized clinic was integrated into the budget of the Clarke Institute of Psychiatry[3] and SRS was listed under OHIP in 1980 for the first time. The Ontario Ministry of Health designated the Clarke as the only site authorized to evaluate trans people who wanted access to hormones and SRS. Without authorization from the Clarke, OHIP would not cover SRS for Ontario residents. The Clarke's gatekeeper role, however, went beyond the borders of Ontario to include all other provinces except PEI, Quebec, the Northwest Territories and the Yukon.

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[3] In 1998, the Clarke Institute of Psychiatry merged with the Addiction Research Foundation, the Donwood Institute and Queen Street Mental Health to become known as the Centre for Addiction and Mental Health (CAMH). Depending on timeline and context, both the Clarke and/or CAMH will be utilized

During the eighteen years that the Clarke performed this role of gatekeeper –from listing of SRS in 1980 to the de-listing of SRS by the Harris government in 1998 – the psychiatrists who worked at the Clarke became infamous for their sexist, classist, masculinist views on trans issues, and trans clients who were referred to the Clarke often experienced harassment and abuse (Namaste, 1995, 2000). Long after other Gender Identity Clinics in North America recognized the *SOC* as minimum guidelines, the Clarke apparently became more stringent in their reading of the *SOC* and modified the guidelines such that they imposed more rigid controls over eligibility criteria and made the recommendations set out in the Real Life Experience a mandatory requirement. According to Clemmensen (1990, in Namaste, 1995):

> The GIC [at the Clarke] has established guidelines for patients to be eligible for sex reassignment surgery. The individual must live in the chosen (the "opposite sex") full-time for at least two years. The GIC requires that this person provide written documentation supporting this claim. People can work, study, or do volunteer work full-time in order to meet this requirement. People can also engage in a variety of these activities, as long as the total is equivalent to full-time work or school. This guideline is commonly referred to as the "real life test". ..After one year of cross-living, the individual is eligible for hormones. There is an endocrinologist associated with the GIC, who monitors the health of people who obtain their hormones through the GIC. After two years o f cross-living, the individual is eligible for surgery. Before an individual is recommended for surgery, however, several other conditions must be fulfilled: he or she must be legally divorced, if once married; the person must be at least 21 years of age; there must be no evidence of psychosis; and there should be no recent record of criminal activity (p.17).

Namaste (2000) has also reported that sex work is not deemed as qualifying work by The Clarke and anyone who is seropositive for HIV is automatically disqualified. Female-to-male trans identified clients have rarely qualified for services at the Clarke. Even once phalloplasty and metoidoplasty became accepted SRS procedures, the Clarke still issued fewer than one female-to-male SRS recommendation per year compared to the four-to-six SRS recommendations for male-to-female transsexuals. During an Ontario Human Rights Tribunal Hearing in 1998, Dr. Dickey, one of the psychiatrists from the Clarke, conceded that 90% of trans clients who they see requesting OHIP covered SRS and access to hormones are denied.

Despite its very significant limitations and the oppressive ways in which it operated, from 1980 to 1998 the Clarke enabled some trans people to access hormones and SRS through public funds. In 1998, that access ended when the Ontario Provincial Conservatives de-listed SRS as an OHIP funded service. According to Shelley (2008):

> De-listing SRS as a procedure that can be publicly funded is a policy issue with concrete impacts on trans people's everyday/night worlds and embodied lives. The neo-liberal favouring of private, consumer models of health care exacerbates class divisions that privilege those with the economic ability to pay for private services. In Ontario, the election of a neo-liberal government in 1995 led to a fairly swift de-listing of SRS as a publicly funded procedure (Shelley, 2008, p.70).

In the ten years that SRS was de-listed, a number of alternate routes were employed by transsexuals in Ontario to access transitioning healthcare services without engaging with CAMH. As such, Ontario provides a unique problematic and disjuncture. Trans specific health care had been limited to those who were successful in meeting the 'version' of the *SOC* that the Clarke Institute was sole gatekeeper of, due to being made the only site recognized by the Ontario Ministry of Health. Hormones and SRS were publicly funded for trans people upon their recommendation alone. That has changed, particularly for trans people who reside in urban centres of Ontario, especially Toronto. The Sherbourne Health Centre was developed in 2003 and part of its mandate was to provide a holistic approach to health care for the LGBT community in Toronto. To date, the Sherbourne Health Centre has approximately four hundred trans identified clients (www.sherbourne.on.ca).

For trans identified people outside of Toronto, the path to trans health care continues to be precarious. However, trans individuals have managed to find sympathetic family physicians who have been either willing to write prescriptions for hormones or give referrals to endocrinologists in order to assist their trans clients with accessing hormones. Trans men have, and continue to, pay out of pocket for 'top' surgery and there are now a handful of plastic surgeons in Ontario willing to perform this surgery without a referral from a mental health and/or a primary health care physician, thus creating space for trans men to have surgery without an official diagnosis of Gender Identity Disorder.

Within this ten year time frame, trans political activism also gained momentum. The Trans Health Lobby Group (more information can be found on the website at www.rainbowhealthnetwork.ca/transhealth ), of which I have been an active member since 2006, consists of members of the trans community and ally organizations such as the Ontario Public Health Association, the Sherbourne Health Centre, the Canadian Union of Public Employees, the Canadian Federation of Students - Ontario, Egale Canada and the Rainbow Health Network. This group has been the main advocate for publicly funded SRS and related procedures as well as the education of media and politicians on issues of health care needs for trans communities. They have also been successful in keeping hormones covered for those on Ontario Works (OW) and the Ontario Disability Support Program (ODSP) and are continuing to fight for the coverage of electrolysis.

In the spring of 2008, the Ontario Liberals re-listed hormones and SRS as funded under OHIP (See Appendix 1) and once again reinstated CAMH as the gatekeeper to this funding source. The Trans Health Lobby has demanded to be part of implementing policy changes to ensure that CAMH does not continue as the sole gatekeeper. Until such time as this happens – trans activists are hopeful that these talks will resume with the newly appointed Minister of Health – some trans women and men are again seeking referrals to the GIC at CAMH for SRS, likely due to the financial cost of the procedures and not because they necessarily support or have had positive interactions with CAMH.

## *Literature Review*

A review of literature on the topic of transsexuals and healthcare services shows a plethora of research, both qualitative and quantitative. However, due to transsexuality being viewed as a psychiatric diagnosis, much of the research concerning the health of transsexuals has been organized under the domain of medical research. Social science specific research has become more prolific over the past decade. Themes in social science research have been mostly organized around the topics of access and barriers to health care services in general and access and barriers to trans specific healthcare - meaning our ability to find health care practitioners knowledgeable and willing to assist us with hormones and SRS related surgeries. This research on access and barriers is often framed within a "social determinants of health" model and uses language and concepts of vulnerabilities and risk factors taken from health research. Issues of marginalization in the form of poverty, homelessness, violence, increased susceptibility to using drugs and/or alcohol, the need to engage in survival sex work, and HIV/AIDS, have been explored. A gap in the health literature is the lack of available research on the effects of and/or risks of using cross-gender hormones for extended periods of time.

Another issue in the literature is the often non or cursory distinction made between the specific health care needs and issues for trans women versus those of trans men. Research often uses the term transgender or transsexual without demarcating whether participants in these studies have been female or male identified, lumping us as a homogenous group with implications being that the trans community has the same experience with healthcare or has the same healthcare needs. When clarification as to participant identities has occurred, predominantly, male- to- female transsexuals have been utilized within the research with often very few or no female- to- males participating. This has perpetuated further invisibility of trans men. The everyday reality for many trans men is quite different than that for trans women. Trans men's ability to 'pass' if desired, although at times a hurdle to healthcare, generally does limit our exposure to the experiences of marginalization often faced by trans women, including risk factors and increased vulnerability to HIV/AIDS.

A few large scale American needs assessments have illuminated the barriers and difficulties faced by the trans community when attempting to access health care services. Research by JSI Training Institute Inc.(2000) in Boston and the San Francisco Public Health Department (1999) concluded that health care providers lacked the necessary knowledge about trans people to be able to perform routine health care, often refused to care for trans people once trans people identified as such, and failed to acknowledge them by choosing to not refer to them using appropriate pronouns. These studies also found that many trans people avoided contact with the health care system and often went without care due to this fear of poor treatment and discrimination.

Utilizing self-administered surveys completed by 180 trans identified individuals within the Philadelphia area in 1997, Kenagy (2005) found that a third of those surveyed did not have a family physician due to fears of discrimination and an inability to find a doctor willing to work with them, and that a quarter of those interviewed had been denied medical care because they were trans. These findings are consistent with those of the aforementioned studies conducted in San Francisco and Boston as well as research completed by FTM Alliance of Los Angeles (2004), which, unlike the previous research, relied specifically on data collected from transsexual men only. However, Rachlin, Green and Lombardi (2008) found that 70 % of the trans men they surveyed rated their overall quality of health care as good or excellent. They concluded that the 122 trans men who participated in the survey were located in urban centres, connected to extensive peer support and had access to trans specific transition support services and health care in their communities and that this had a large impact on the overall positive results of the survey.

Closer to home, the Trans Health Project, which was sponsored by the Ontario Public Health Association and used investigators from the trans community, explored the specific needs, barriers and gaps in service for trans people in Ontario. Once again, similar themes emerged with the need for health care services to become comprehensive and trans-inclusive, for health care providers to become educated on trans specific health care and transpositive to limit discriminatory practices, and that trans people need to be a meaningful part of input into the health care process (Gapka & Raj, 2003).

Namaste (1995, 1999, 2000, 2005) is one of the most prolific researchers and has provided important ground breaking studies of transsexual experiences particularly within a Quebec and Ontario context. Although her work has been mostly specific to transsexual and transgender women who are often marginalized via their sex work, she has completed some research with trans men in the areas of HIV/AIDS vulnerability and does acknowledge that more research should be completed with this community. In a ground breaking project in 1995 entitled *Access Denied*, Namaste interviewed thirty three trans identified individuals – unfortunately only two were male identified- about their everyday experiences of social services and health care within Ontario. Namaste framed this study within an Institutional Ethnographic framework to demonstrate:

> that the experience of transgendered people contradicts an "official" version of reality, in which all Ontario residents have the same rights and opportunities to access health care and social services. This report clearly documents that transgendered people are habitually refused the services they seek to live their bodies as they choose. Furthermore, my study indicates the situation is perhaps most serious for transgendered people with few resources (p. 42).

Namaste 's research looked specifically at access to and knowledge of hormones, primary care physicians, the Gender Identity Clinic at the Clarke Institute, experiences with hospitals and emergency rooms, time spent in shelters, relations with police and incidences of violence. Due to funding constraints, this research was limited to trans people in Toronto.

Namaste's research was completed at a time when the Ontario Ministry of Health was covering hormones and SRS - although electrolysis had already been de-listed in 1992 by the Ontario NDP - and the Clarke Institute was still the main access point with few sympathetic doctors willing to provide trans specific health care. According to Namaste, not only are most trans people not provided with appropriate, knowledgeable service at most health care and social service organizations, they also end up consulting sometimes up to more than a dozen health care practitioners before finding a practitioner willing to take them as a client. This puts added, unnecessary stress on the health care system. Due to the lack of access to health care, trans people are also taking hormones without being properly monitored, increasing their chances of negative reactions and side effects. Namaste also found that transsexuals transitioned without the support or recommendation of the GIC at the Clarke because they felt the clinic does not provide them with adequate information about transsexuality.

Namaste (1995) recommends that the Ministry of Health provide funding for a health care centre offering a harm reduction model of care that would be used as a one-stop centre providing trans people with all their health care needs, including transitioning services. She also suggests that an independent committee comprised of representatives from the Clarke and trans clients be established to ensure that services provided by the Clarke are clarified and that the Real Life Test criteria be reviewed. Her recommendations also include mandatory training of police, hospital and emergency room staff as well as shelter workers with regards to trans issues in order to increase provider competency and sensitivity.

As pointed out by Kammerer, Mason & Connors (1999), "difficulties transgenders have in gaining access to shelters, securing safety in prisons, obtaining appropriate mental health counseling, as well as other health and social services, are related to their risks of HIV infection"(p.2). Workplace discrimination and lack of employment rights, lack of legal identity in one's chosen gender and undocumented status are all significant correlations leading to increased risk/vulnerability to HIV/AIDS (Reback & Lombardi, 1999, Namaste, 1999, 2000). Although most HIV/AIDS prevention programmes including educational and outreach strategies are non-inclusive of trans bodies and sexual activities, and do not often include hormones and silicone as 'street drugs' nor intramuscular needles as 'works' (Namaste, 2000, Lombardi, 2001, Rachlin, Green & Lombardi, 2008, Ware, 2004, Kenagy, 2005), trans men have nowhere near the rates of HIV/AIDS that trans women do based on our minimal engagement with sex work for survival. This is not to say that trans women are not fully educated on risks and most times practice higher rates of safer sex than non-sex workers do (Reback & Lombardi, 1999).

Namaste (1999) concludes that for trans men, an integration of HIV/AIDS education as part of holistic, health promotion services would be a useful way to impart this knowledge. However, this is cautioned by Kammerer, Mason & Connors (1999) who suggest that increased sex drive within trans men brought on by hormones and vulnerability of becoming entangled within culturally reinforced masculine sexual expression can lead to risk behaviours. According to Rachlin et al (2008):

> HIV prevention is important, but not yet critical for FTM health care. Certainly FTMs have acquired HIV and succumbed to it, and some transmen do engage in unprotected sex with non-trans men, but the most serious HIV seroprevalence rates are presently occurring in MTF populations (p.244).

Returning to American research, smaller scale qualitative studies by Hussey (2006) and Dewey (2008) provide important insight into the everyday realities of transsexual males when attempting to access health care. Employing the use of photovoice to record and critically reflect transsexual males experience of health care, Hussey (2006) found that the main themes that emerged centered on feelings of vulnerability and invisibility experienced by transsexual males when utilizing health care services:

> In this study, invisibility was described as (1) inaccurate information, or complete lack of information about transgender specific health care, (2) a general lack of understanding or acknowledgment about the existence of transgender people, and (3) the disbelief, shock and other negative reactions on the part of practitioners including incorrect female pronoun use, despite the patient's insistence upon his male identity. In those moments of invisibility, participants also described feeling vulnerable. Because of their experience of being made to feel invisible by providers,

> and their ensuing sense of vulnerability, the FTMs in this study often felt reluctant to seek care. Those two themes of invisibility and vulnerability thus interact to create a barrier to gaining access to health care (p.152-153).

According to Dewey (2008), trans patients are made aware of larger political and cultural ideologies via their experiences with the health care system. Dewey suggests that trans patients internalize these views which "affect[s] how they make sense of their medical treatment and how they choose to alter their behavior in future medical encounters" (p.1345). In order to get the medical treatment they need, trans people will go to great lengths to prove to their health care providers that they are credible, real, and deserving of treatment, knowing that the providers play a large gatekeeping role to trans specific care such as hormones and SRS. As such, trans people will often legitimate medical knowledge by using the language and perspectives readily available to them via the medical discourse - for example, reflecting back a personal history that exemplifies the criteria for Gender Identity Disorder laid out in the DSM. Dewey also acknowledges that there is some space for resisting this dominant discourse and that politicized trans people have worked to push for alternate trans paths and medical treatments that have not been available previously.

To conclude, it appears that the bulk of research on trans access to health care has focused on the experiences of trans women, particularly in areas of vulnerability and risk to HIV/AIDS. Although trans men may not be as marginalized economically and do not often turn to sex work to survive financially due to discriminatory practices within legal, employment and social environments, and do not have the same high rates of HIV seroprevalence, when it comes to our ability to access health care services, similar themes emerge. Discrimination and transphobia by health care professionals limits our interface with the health care system and we often go without care or wait long periods of time before finally becoming willing to access care. The literature also points to a need for training for health care professionals that is specific to trans care such as the effects of hormones on our bodies and what surgeries we may want, as well as general health care knowledge such as continuing to monitor our bodies once on hormones and an ongoing need for breast and pelvic exams as preventative health care.

Although both quantitative and qualitative research has been undertaken on trans communities, with experiential information being a large component of findings and discussions, there is little research that actually considers and further explores the day to day reality of the work it takes to find competent transpositive/knowledgeable health care and the ongoing work of building relationships with health care providers in order to educate and convince them of our credibility as knowing bodies. In what institutional discourses are notions of trans identity embedded? According to McCoy (2006):

> …acquiring this level of expertise usually means that [trans people] assimilate the institutional gaze; they come to know themselves and their families as objects of institutional settings. They work on themselves; they produce their actions in ways that more tightly articulate the institutional

> process. Learning the discourse carries the intentionality of the discourse into the personal spaces of people's lives (p.119).

How do we come to know what is a credible trans narrative within health care services? From where do we learn the discourses that provide us with the knowledge to access the services we need in order to transition and maintain our health? In taking up the notion of discourse, I am using the definition postulated by Bresalier, Gillis, McClure, McCoy, Mykhalovskiy, Taylor and Webber (2002):

> The term "discourse" as we use it does not refer to discussion or dialogue as it does in everyday speech. Rather, we mean by discourse a systematic way of knowing something, that is grounded in expert knowledge and that circulates widely in society through language, including most importantly language vested in texts (p.39).

It is this definition of discourse that grounds the analysis within the Marxist framework that IE is built upon. According to Smith (1999) "I know this discourse as an 'insider'; I am a participant; I know it as a local practice in my own life. In this I move away from Foucault's (1981) conception of discourse. Brilliant as it is, it accredits the stasis of the text" (p.134). It is my hope that the research undertaken in this project will show how our everyday worlds are connected to larger institutional requirements and discourses.

***Research Methodology***

This project is positioned within an Institutional Ethnographic (IE) framework. "Institutional ethnography, like other forms of ethnography, relies on interviewing, observation, and documents as data. Institutional Ethnography departs from other ethnographic approaches by treating those data not as the topic or object of interest, but as 'entry' into the social relations of the setting" (Campbell, 2006 p.56). IE is a form of sociological inquiry developed by Dorothy Smith (1987, 1999) and has grown over the past few decades, finding its base within the early women's movement and later utilized within other progressive social movements such as those dealing with discrimination and marginalization like racism and colonialism, LGB issues, and HIV/AIDS. IE connects with these movements as practical knowledge (Mykhalovskiy & McCoy, 2002). While my research does bring forward issues of transphobia that trans men face when attempting to access health care services in Ontario, to be clear, it is not a critique of, but rather, an exploration of practitioners' work and of the bureaucratic burden placed upon trans men who are medically, legally and socially transitioning.

G. W. Smith (1990, 1995), Kinsman (1997), Bresalier et al (2002) and Sneider (2001) have all utilized Institutional Ethnography beginning from the standpoint of individuals within marginalized communities to examine the work that is done by those individuals to gain access to social and health services and how that work is organized and linked to larger ‘ruling relations’ beyond their everyday experiences. Researchers such as Ng (1996), Campbell (2001) and Jung (2003) have taken this method of investigation a step further by also including the examination of texts that mediate and shape this process. I have drawn explicitly from these studies in organizing the design of this research project.

Ethnography is used quite extensively within social science research but has been criticized within the more critical social science streams as having remained implicit in perpetuating and maintaining the dominant cultural hegemony of White, Western, masculinist discourses (Spry, 2001). And although IE grew directly out of the feminist movement of the ’60 and ‘70’s, as pointed out by Campbell (2006)), IE has also come under fire by postmodern/poststructuralists, particularly within feminist domains, who have rightfully critiqued “the questionable status of experiential accounts produced by people whose knowing is discursively organized’ (p.56). Recognizing this however does not take away the material corporeality of constituted bodily beings. And much like Campbell, I “want to attend in my analysis to differences in the possibility of knowing that relate to the knower’s location and everyday/everynight work as well as to how such local experiences are ruled, discursively, and thus constructed ideologically as the same across knowers” (p.58).

That said, Institutional Ethnography is committed to understanding the social world from the standpoint of those who have particular experiences (in this case, transsexual males) rather than beginning with the activities of those located within the institutional discourses (in this case, the healthcare system). The focus of the research is concerned with types of experiences and is not reflective of the experience itself. As stated by Campbell and Gregor (2002), "What are the connections across and beyond the boundaries of this setting and how are they enacted by actual people?...how things happen here as they happen over there…something is organized to recur" (p.69). This methodology is useful in making visible dominant and subordinate 'ruling relations' (Smith, 1987). According to Adams (2009):

> Rather than explaining behaviors or cultures through particular theoretical frameworks, or developing theories using empirical data gathered as in conventional ethnographies, the analytic focus is on discovering and documenting the organization of activities and coordinated work processes through each subject's reality as directly experienced. The data collection process is itself where analysis takes place (p.187).

I enter this research via a few explicit points. As a transsexual male I have had first hand experience with healthcare services in Ontario that have enabled my transitioning process. Another layer that I bring to this research is a history of support work with transgender/transsexual identified individuals as 'clients'. As such, I am implicated within the web of 'ruling relations' in the ways in which I have framed my own 'work' with this community. The information, support and advocacy I provide is reflected and entangled within the dominant discourses of Ontario's health care system.

The definition of transsexual male that is being used for this research project is defined as an individual who has utilized medical, legal and mental health resources to transition from female to male and who lives full time in this gender. Transsexual specific health care, for this research project, is defined as any health care practitioner or organization utilized during the process of medically, legally and socially transitioning which would include family physicians, endocrinologists, mental health professionals and surgeons who perform Sex Reassignment Surgeries such as hysterectomies, 'top' and 'bottom' surgeries.

**Recruitment of Participants**

An initial email was sent out to two email list serves that transsexual males may be members of, outlining the research project and inviting them to participate via an email correspondence (see Appendix 2). These two list serves were the Rainbow Health Ontario email list serve (RHN@yahoogroups.com) as well as the Trans Health Lobby list serve (transhealthlobbyrhn@yahoogroups.com) which is supported by Rainbow Health Ontario. This Yahoo Group (email list): "supports the exchange of information by RHN members about LGBTTTIQ health, and RHN activities, projects, and events. RHN activities include monthly network and committee meetings, project work, training and education, advocacy, strategic planning, and special events" (www.rainbowhealthnetwork.ca).

List serves and emails can enhance research by potentially reaching a large audience, including those living in a rural or isolated area, and allows minimal risk for physical harm or the need to be 'out' as transsexual. "The move away from physical location is especially important for identity movements in which members are linked by a shared understanding of self rather than a shared working environment or geographic location' (Shapiro, 2004, p.175). Although this form of participant recruitment can reach a large audience, I am cognizant of the fact that individuals who have been marginalized within the transsexual community up to this time may not be reached via the Internet. "The dynamics of race, class and nation affect who has access to the Internet. The Internet is not removed from the race and class divisions within the trans community and may indeed reinforce them" (Shapiro, 2004, p. 175).

It was clarified in this email that I was interested specifically in completing one-on-one interviews with transsexual men, eighteen years of age and older, who reside within Ontario communities that are within a 100 kilometer radius of the city of Hamilton, Ontario. The 100 kilometer radius was suggested as I was able to drive to the city or town where the participant resides. Unfortunately, of the transsexual men who answered this email, although two resided outside of Toronto, almost all had received their transitioning health care services within that city. As such, this limited the scope of experience that was captured.

Interested individuals were able to contact me via an email account. A letter of introduction and consent form (see Appendix 3) as well as the interview guide (see Appendix 4) and a demographics sheet (see Appendix 5) were emailed by me to individuals expressing initial interest in participating in the research. They were given the opportunity to ask questions and get any clarification needed to make an informed decision to participate. If they were still interested in participating after viewing this information, further email correspondence occurred to set up a mutually agreeable place and time for a one-on-one interview.

**Interviews**

The interviews were structured as conversations. Questions I asked assisted in clarifying the interface between how the experiences of the participants were connected to the rules and policies of health care professionals and organizations they are in contact with, and how these interactions shaped their everyday experiences. Participants were asked to share their experiences of accessing transsexual specific health care services in Ontario including their initial contact with the professionals and organizations providing transitioning services; how they became aware of these services; the steps they needed to take to access these services and any steps they needed to follow afterwards.

I conducted four interviews with self identified transsexual males that lasted between forty minutes and two hours. At the end of the interview, participants were given a $5.00 gift card as honorarium for participating in the research. The interviews were audio-taped with the explicit permission of participants. The participants agreed to be available for one or two further email correspondences should any follow up questions be required to clarify any parts of their transcribed interviews. Participants were reminded that their participation was completely voluntary and they were informed of their right to withdraw from the project at any point. This was outlined within the content of the initial recruitment email letter sent out inviting individuals to participate as well as outlined within the consent form. Their right to withdraw was explained again fully before the interview began and before signing the consent form.

There were social risks involved in this research. Participants may have worried that they would be identified and that others would react negatively to what they had to say. As a transsexual man, I was well informed of these risks and was well positioned to conduct myself and the research with this in mind. These risks were fully explained to the participants. They were able to skip any questions that they preferred not to answer. I offered to show completed transcripts of their individual interviews and they had the opportunity to change any of the information within the transcript before I proceeded to the writing of the findings and discussion sections.

I was also aware that the interview questions could remind participants of negative experiences that occurred during attempts to access transsexual specific health care services in Ontario. Dealing with transphobia is very much a part of the lived experience of transsexual individuals. A verbal check-in occurred at the end of the interview to see how they were feeling after having answered the interview questions. I also offered to email to them a referral list of services and resources available within the community where they reside in order to access support if needed. Specific lists were created once I become aware of the communities that each participant resided within.

Participants created their own pseudonyms and were made aware that any identifying information would be left out. All audio tapes used during the interview process were transcribed by a paid professional. The audio tapes were hand delivered directly. Once transcribed, the notes in word format were emailed to me and the tapes were picked up by me. The audio tapes were then erased. Any hard copies of transcribed notes made were kept in a locked cabinet other than when I was working on them. Once in word file format, the files were password protected such that only I had access to these files. These word files were kept password protected until data collection and analysis was completed, after which all files were deleted and all transcribed notes shredded.

**Data Analysis**

The analytic intent of this research project is to produce a detailed account of, and explore how, these experiences of work take shape in a particular social and institutional context and to identify where policy and change would improve the healthcare outcomes for transsexual males (Smith, G, 1990, McCoy, 2006). As such, finding a way to analyze the data that kept the institution in view was important. The investigation and analysis are both emergent (McCoy, 2006).

As pointed out by Campbell and Gregor (2002) "when it comes to interpreting data, institutional ethnography relies on, explores and explicates linkages that are lived, brought into existence in time and space by actual people doing actual things"(p85). Returning to the concept of work that is central to this research, throughout the course of the interviews, and later, during further reading and re-reading of the transcribed interviews, I listened for talk that contained and expressed the participants' expertise of living their lives and in doing so, the various sorts of problems or barriers in the work of getting care emerged. I was also particularly attuned to institutional language expressed within the transcribed interviews and how transsexual males were drawn into this specific set of organizational processes. Following McCoy (2006), the data was interrogated/subjected to the following line of inquiry:

> What is the work that these informants are describing or alluding to? What does it involve for them? How is their work connected to the work of other people? What particular skills or knowledge seems to be required? What does it feel like to do this work? What are the troubles or successes that

> arise from doing this work? What evokes the work? How is the work articulated to institutional work processes and the institutional order (p.110)?

I have also included certain texts in this research. According to Campbell & Gregor (2002), "the texts that researchers see being used by informants during field observations are often central to everything that happens …rather than being used as sources of factual information, texts are relied on as crystallized social relations" (p.79). Returning to Smith (1999), "texts are the mediators and bases of discourses and ruling relations that regulate and coordinate beyond the particular local setting of their reading and writing" (p.80). Although I have not as yet attended any appointments at the Gender Identity Clinic at CAMH, I did request a referral to do so from my family doctor. I was sent a form letter and intake application from CAMH that is a requirement before any appointments take place. The letter and intake application were referred to by the informants throughout the interviews and have been included (See Appendix 6). My personal knowledge of being transsexual and transitioning services afforded me the ability to spot the originating site of much of the discourse that has socially organized trans specific health care in Ontario – The *Standards of Care (SOC)*.[4] I returned to this text again and again as the findings emerged.

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[4] For further information, a complete version of the latest *SOC* is available at www.*wpath.org*/Documents2/socv6.pdf

### *Findings*

Within a very short time after posting the invite to the RHN listserve, I received replies from men who identified as transsexual who were interested and willing to participate in the research. As a transsexual identified male, being a part of this community afforded me a certain level of trust with these men that may have increased my initial response rates and their willingness to take part in the research. I interviewed four men who had had interactions with the healthcare system in Ontario and were or are actively engaged in transitioning. The men were mid-twenties to early forties, White and able bodied with English as a main spoken language. I am cognizant that the small size of the research sample and the similar amount of cultural capital that these men embodied limited the research scope of this project. The interviews took place during June and July, 2009. Below is a short profile of each these men.

### Profiles of Participants

#### Thobias

I met with Thobias at a post secondary institution in the urban core of a large southern Ontario city. Thobias defines his gender as male and his sexual identity as bi. He has a female partner and a young child. He is college educated, is fully employed with workplace benefits and began transitioning from female to male around three years earlier. Due mostly to Thobias' geographic location in Ontario, he has had access to trans specific support in the form of peer support meetings for trans men, counseling in group format facilitated by trans social workers and a family doctor with a large trans identified clientele.

**Henry**

I met with Henry at his home that he shares with his female partner and their young child, also located within a large southern Ontario city. Henry defines his gender as FtM (female to male) and his sexual identity as bi. Henry began transitioning eight years ago. He currently works full time within the trades but has also just completed a University degree and is hoping to go on to graduate work. He has been receiving health benefits covered under a student health plan. Henry has had the support of a community of trans men and a knowledgeable family doctor with a large trans clientele.

**Jason**

I met with Jason on the grounds of the library of the mid-size southern Ontario city where he resides with his trans male partner. Jason began transitioning around a decade ago. He defines his gender as trans and his sexual identity as queer. Jason is university educated and is employed fulltime. He does not have any health coverage other than OHIP. Jason does not have a family physician and relies upon a walk-in clinic for his healthcare needs.

**Wayne**

I met with Wayne at his office where he holds a fulltime job within an academic setting. Wayne resides in a small city in southwestern Ontario. He lives with his female partner and their two young children. Wayne began transitioning approximately a year and eight months ago. Wayne defines his gender identity as FtM and his sexual identity as queer. Wayne has a graduate degree and workplace health insurance. He has a family doctor who he has worked with in educating on trans issues. He has no other support in the form of counseling nor is he actively involved in any sort of trans community.

## The Work

Work was divided into subsets based on the kind of work that was utilized by these men to access trans specific health care, then further divided based on the specific service they were attempting to access. Two main kinds of work emerged – the material work and the emotional work involved in accessing trans specific healthcare. I define material work as that which involves doing physical activities such as phone calls, internet research, attending support groups for information, attending appointments, filling out forms, appointments to complete blood work, finding needles, injecting hormones and educating health care providers about trans bodies and trans specific health care needs. I defined emotional work as that which gets completed that is troublesome for the men and takes a psychic toll such as having to be convincing and credible as trans, or negative or puzzling interactions with health care providers. The material and emotional work was explored based on specific services the men were attempting to access. As such, these experiences of work were mapped onto the main areas of access which emerged—the family doctor and the Gender Identity Clinic at the Centre for Addiction and Mental Health.

IE analysis "uses what informants know and what they are observed doing for the analytic purpose of identifying, tracing and describing the social relations that extend beyond the boundaries of any one informant's experiences" (Campbell & Gregor, 2002, p.90). It appeared from this research project that the material and emotional work was intricately connected to the men's and the health care practitioners' narrative of what constitutes a transsexual identity and the appropriate transsexual trajectory. This narrative, in turn, could be traced directly to the text that has socially organized trans specific health care in Ontario. That text is the Harry Benjamin International Gender Dysphoria Association's *Standards of Care for the Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons*, currently renamed the World Professional Association for Transgender Health (WPATH) *Standards of Care*.

### Family doctor

The Ontario Ministry of Health has organized access to health care in Ontario such that the family doctor is the usual access point before any further specialized health care can be sought. Without a referral from a family doctor, it is next to impossible to move forward with health care concerns or needs. Another layer complicates this organization of how health care unfolds when one is trans identified and needs a family doctor who is familiar with the psycho-medical discourse that not only sets the criteria for who is determined to be transsexual but also informs the treatment options for trans people.

The family doctor is the site most often considered the access point for trans people who are interested in seeking transitioning health care services such as hormones and SRS. Although some trans people have used alternate routes to accessing hormones and SRS, the trans men I interviewed all opted to find service via this traditional health care route. For some trans people, informing a long time family doctor about their gender identity and wish to transition can result, at worst, in their family doctor no longer being comfortable in keeping them on as clients. Or, as with trans men such as Jason and Wayne, a family doctor's initial lack of knowledge with regards to trans specific health care needs can lead to having to do further material work in order to get the service requested.

Jason began inquiring about transitioning services in Toronto about a decade ago – just before SRS was de-listed by OHIP in 1998. According to Jason, his family doctor, although not informed about trans specific health care, was supportive. She did not however extend her support towards offering any practical assistance such as finding appropriate referrals for him. Jason did this work on his own:

> I had done my own research. I did go to an FtM support group out of the 519 twice when I was looking for hormones. Um and looking for a doctor

> to prescribe hormones. And at that point, Dr. _______ was sort of the doctor that people were seeing. And I did see Dr. ______ as an access point.

Because his family doctor was uninformed, Jason chose to take it upon himself to find ways to access the service he wanted – his desire to begin on hormones. Via a support network of other trans men, Jason managed to get the name of a doctor who was familiar with trans health care and willing to provide what he wanted.

Wayne came 'out' as trans to his long time family doctor within a smaller Ontario city. He asked her if she would be comfortable prescribing and following the protocol for testosterone:

> She had never done it before, she didn't know the protocol. She wasn't comfortable proceeding on her own. She wanted to refer me to, she wanted to find a clinic or a doctor or something that had more expertise in Trans health care.

Due to her lack of knowledge about trans health care, Wayne offered to do the material work of researching available health care options for himself:

> I did some of the footwork. I looked around for places that did health care for Trans people and the only places that I found were 3 places in Toronto. I didn't find any in __________and I don't know maybe I missed something but I found 3 in Toronto.

With the knowledge provided by Wayne, his doctor was now willing to make a referral for him, however only after he had invested much material and emotional work into the process:

> And you know she knew that I'd been, it had been 2 years since I initially asked her for testosterone, maybe over 2 years and she said fine, that's enough, you've jumped through enough hoops let's get you started ...

Wayne also points to a common thread – resources for trans people in Toronto that are often not available elsewhere in the province.

Thobias and Henry have different experiences than Wayne in regards to their family or primary doctors. Although Henry began seeking trans health care services in the early 2000s, several years before Thobias began transitioning, both men sought services in Toronto at agencies that were actively supporting trans clients and had staff who were knowledgeable about the transitioning process. Both men had already completed the work of researching information that would assist them with acquiring the services they needed. Much like Jason, Henry began transitioning almost a decade ago when resources were scarce:

> I was attending the FtM support group which was relatively small. I attended a few Trans conferences in the States… I got more information just through word of mouth. Like there was really, it was hard to get a pamphlet or anything sort of in writing. The web sites didn't really ... exist the way that they do now. A lot of it was just through word of mouth and just like personal research, researching drug company web sites on testosterone. But there wasn't a happy little pamphlet sitting for me in the doctor's office telling me about testosterone and what to expect from the effects.

However, once he does find a knowledgeable family doctor, the process is quite swift and does not require much in the way of work:

> I think we covered, you know he kind of asked me why I IDed as Trans or why I thought that that identity appealed to me. So I gave him like a few sort of historical points in my life but he didn't really, we didn't expand on… There wasn't anything to it it was ok I have no doubt that you're Trans, you have no doubt that you're Trans so here's what you do. I think … extra blood work to assess if there's health risks and then I got my prescription.

Thobias came armed with stories and examples from his history that would assist in making him appear credible as a transsexual. He shared the following:

> I wrote this long thing, sort of a list, I called it Transsexual Evidence in my Life History or something I had this long list of all the things. But she said ok before I even needed to get it out. And then afterwards I said well I went to all the trouble to write this out so she looked at it out of interest but not, it wasn't a requirement.

All four men had familiarized themselves with what was needed to gain access to trans health care by knowing what and how to 'present' to the family doctor. They complete this work even when, through word of mouth, the family doctor is known to be familiar with the transsexual narrative. If the doctor is not knowledgeable about this narrative, as was Henry's case, even more work is required of the trans person to bring forth this mutual understanding of how trans specific health care is socially organized to unfold. This knowledge comes directly from the language and concepts embedded within the *Standards of Care*.

Once a knowledgeable and willing family doctor is located, the next step in the process of transitioning can be starting on hormones. For trans men this hormone is testosterone usually administered in injectable format. Injectable testosterone, however is not necessarily utilized because it is the most effective way for the body to make use of the hormone but because it is the only form of testosterone historically covered by OHIP and private health plans. Gels and trans dermal patches are available and work well for trans men who may have other health issues that make injecting testosterone nonviable, but the hormone in these formats is expensive and not readily accessible at pharmacies. Outlined below are some of the steps that the trans men undertook during the process of hormone acquisition and the work, both material and emotional, that occurred.

Jason, Henry and Wayne all had clear recollections of the process:

Jason: Dr. _____was a fairly easy - phone him up, get an appointment next week, um, I don't remember it being very long between my appointments, maybe ten days. And he did insist on seeing people twice before prescribing hormones but it also really felt like he was pretty clear that people were showing up wanting hormones and that he was going to do the sort of minimum required and that's how you got a prescription. And at the time I had drug coverage because I was a student so that then made that fairly easy and fairly cheap.

Henry: I did my first intake with the, Dr. __________... he sent me up for blood work that day. We kind of talked about testosterone a little bit but he sort of understood that the community had educated me and that I had educated myself in the process so there was kind of a mutual respect there. So it was kind of neat. And it felt like he was, it was pretty instant. He gave me a time frame sort of this is how long its going to take the blood work to happen, you need to do a physical exam and I need to, I think he had to see me one more time.

Wayne:[My family doctor] has never treated anybody else whose Trans, she's never seen the protocol. I gave her the protocol which I found on the internet for, the protocol for the testosterone... She didn't, well ... I've kind of had to tell her what to monitor she didn't ...I was on testosterone for over a year before I brought to her attention that she might want to be measuring my testosterone levels in my blood.

Wayne also expressed uncertainty in how to go about the work of utilizing the hormones:

> My doctor didn't really tell me, well my doctor didn't provide me with needles, the pharmacy also didn't have the correct needles. I got a hold of a few and then I went to a different pharmacy and bought some. I still, I actually don't think to this day that I'm using the right needles, I don't think I'm using the needles that are meant to deliver something as viscous

> as the testosterone. It's suspended in oil right? I don't think I'm using the right needles but they're doing the job.

As Wayne makes clear, the medically correct way to inject testosterone, including appropriate physical sites on the body, the type and size of intramuscular needles, where to acquire them, and appropriate extraction and injection of the hormone, was not always apparent. Henry and Thobias had access to nursing care to assist with these aspects of transitioning. Thobias attended the trans knowledgeable health care clinic where his family doctor works for a year and a half so a nurse could give him the injections; she eventually told him that he could inject himself in the shoulder. Henry also traveled to get his injections, and, like Thobias, found the nurse offered the actual injection, training and support so he could do the injections himself, and practical advice on the process:

> she did it and then the next time we did it… But really it was just to get the needle and to talk about safe injection, what to do with your sharps, where to get sharps, what gauge to use to draw, what gauge to use to inject.

Having access to hormones is an important step in the transitioning process: "They change one's physical appearance, and aid in an individual's level of comfort with one's body. In the case of female-to-male transsexuals, the administration of testosterone has dramatic effects: the voice lowers, facial and body hair develops, muscles develop, and menstruation ceases" (Namaste, 1995). Without access to hormones, it is difficult for most trans men to be perceived by others as male. The work of being able to access hormones and to administer them effectively can be a crucial part of the transitioning process. If access is difficult due to having a doctor who is not knowledgeable or is unwilling to prescribe or if men lack the appropriate knowledge of how to administer the hormones, the work undertaken by the men becomes arduous.

Henry also described the work he did in convincing his trans knowledgeable family doctor that a hysterectomy was an important health care issue for him. Some trans men want a hysterectomy as they do not want to have female reproductive organs such as fallopian tubes, uterus and/or ovaries as these can be constant reminders of a sexed body that does not match their gendered body. Although Henry was given a referral to a specialist by his doctor, it still took much dialogue and convincing that for him and other trans men, it is a necessary surgery:

> [My doctor] went through a period where she didn't believe that hysterectomies were necessary … she felt that it was very drastic, that it was kind of unnecessary, that it could be managed. And I had a series of conversations with her after my hysterectomy, I showed her, I actually had photos of my, I brought in a disposable camera and got pictures of my ovaries in a little petri dish. But you could see they were active, the ovaries were active, they were making follicles so that shows that actually it's still working and that it's not actually shut down, it's not actually dormant so what is it actually doing in there? And so I feel like I had some conversations with my doctor and sort of she came around and changed her mind as well. But she went through with a good 2 years where it just wasn't necessary, she didn't think it was necessary. But I kept pushing for it.

In returning to the point made earlier, a mutual knowledge of the institutional discourses and the originating sites of the discourses must exist in order for health care to unfold relatively easily. These institutional discourses are sometimes trans specific, at other times they are not. Mainstream health care discourses are also selectively appropriated by trans men and their health care practitioners. This becomes apparent during Henry's initial consultation with the gynecologist he was referred to by his family doctor:

R: Yea so she, you know she asked about PAPs like whether or not they came out normal or fine or whether there was any problem. I do remember her vaguely, she sort of hinted around that oh well there is a problem with one of your PAPs, it's irregular. And then she kind of checked off a few things on a form and then said that that was going to be sent off to whatever and then she went over what to expect on the operating day and what to expect after.

I And had you ever heard that there had ever been an irregular PAP? Had anyone ever said to you gee this PAP has come back irregular?

R No I knew that there was never an irregular PAP. So no I knew what she was doing, she knew that I knew what she was doing. Yea. No we definitely talked about how it was that it was going to be covered. She asked me a few times, the first time to leave, that I still have an F (for female) on health card cause that's necessary to get it covered.

At that particular point in time in Ontario, hysterectomies as an SRS procedure were no longer financially covered under OHIP. Henry knew this. The gynecologist knew this. They both understand however that a female bodied individual with a history of reproductive organ irregularities is usually assured a hysterectomy as an OHIP covered procedure – not as related to trans specific health care but under general health. This knowledge is necessary for the interaction to unfurl in a way that allows Henry access to a hysterectomy.

Together, Henry and the specialist perform the work that reflects and maintains this social organization of health care in Ontario.

So what happens when the discourses that are known to trans men do not entirely match or are not reflected back in the health care services they are receiving? Gender Identity Disorder (GID) is the first component of the *SOC*. According to the *SOC*, the criteria for GID must be met before any transitioning services are recommended. Trans people are often aware that they must convince those in the health care system that they do in fact have this diagnosis. According to research by Denny and Roberts (1997), 80% of the trans identified people they interviewed were aware of the *SOC* in one version or another. We 'know' that transitioning is a huge step and we have done the work to learn that hormones and surgeries can be harmful to us physically and psychologically.

When the interface between patient and health care practitioner occurs and the expected difficulties in accessing services – transphobic attitudes, providing and maintaining a credible trans identity, or as has happened many times to trans people, a family doctor just refuses to provide trans specific health care - and the discourses do not align, trans men experience uneasy and puzzling emotions and extend the work we have to do to make sense of this incongruence. The men who took part in this research draw our attention to shifts in this discourse, and, thus, new sorts of experiences. According to Jason:

> Although I do remember at the time feeling concerned about his lack of follow up and concerned that he was not doing much monitoring of

> people's hormone levels. But in two visits to his office I walked out with a script and could start injecting 't' by myself.

Henry: I was amazed at how easy it was to get testosterone and [my family doctor] sort of kept returning to 'well it doesn't necessarily have to be as difficult as the Clarke'... or 'it doesn't have to be that way'. Nobody was really too interested in sort of flushing that out it was sort of a general acceptance that I as a patient was able to determine my own needs.

Henry continued to feel unnerved by the easiness of the process because he was not being asked to meet the protocols set forth in the *SOC* – he was not given a diagnosis of GID and yet he was still able to begin taking hormones:

> All these insecurities sort of followed, so am I falling through the cracks? Am I actually like not a Trans person and just because there's so many trannies now like you know and how do I like as a psychologically not sound person because that's kind of what you get labelled, well how is it that I'm able to determine this?... so just kind of all these head trips. Like how do I know that I'm making the right decision for myself if I'm the one that's crazy?

Interestingly, several months into treatment, Henry's expectations of meeting the discourses were finally realized when his family physician referred him to a psychiatrist:

R [My family doctor] got a little bit worried about 8 months into treating all these Trans people so off the cuff ...I don't know I think he had this friend for quite some time, a shrink at _______ so he referred all of his Trans patients for a 1 hour evaluation to include in everybody's file just to ensure that everybody was of sound mind so that he could protect himself. So I did that.

I Can you talk a bit about how that happened and ...

R Well he just basically said you know I'm referring all my Trans patients to a colleague of mine.

I Was it mandatory? Did you feel it was like ...

R Well it was pretty mandatory. Yea... but out of all the sort of psychological evaluations he was the most sort of stereotypical you know sort of 'did you prefer to play with trucks as a child?' and sort of these kinds of like really like text book tranny stories which was interesting. But I ... fall into those just fine.

The textbook tranny stories and stereotypical language that Henry comments on is the psychiatrist building a case that Henry does indeed fit the criteria for GID outlined in the DSM- IV. Although Henry was now officially sent to a psychiatrist for this diagnosis of GID via his family doctor, he had already sought counseling on his own after being on hormones for about six months in an attempt to make some sense of the dissonance between what he knew as the dominant trajectory of how the trans narrative should be unfolding and what in fact was occurring for him. The confusion experienced by these men points to some of the on-going changes that have occurred in Ontario as more family doctors became willing to provide trans specific health care that is framed outside of the discourses that have historically circulated. This shift in discourses increased in large urban cities such as Toronto after SRS was de-listed. Alternative health care resources began to emerge along with a more politically active trans community that demanded access to such.

**The Gender Identity Clinic (GIC) at CAMH**

For many trans men SRS is not financially feasible. The out of pocket cost of top surgery averages between $5000-7000, bottom surgery, depending on the procedure, can cost $20 000 for metoidioplasty to upwards of $60000 – 90000 for phalloplasty. During the ten years SRS was de-listed, trans men who had access to financial resources opted to pay for these procedures on their own, bypassing many of the criteria laid out in the *SOC*. Unfortunately a two tiered system within the domain of trans specific health care has emerged in Ontario.

CAMH is the sole gatekeeper to OHIP covered hormones and SRS - a fact readily available to and long established within trans communities in Ontario and other parts of Canada. As previously outlined, this has been a sore spot for trans activists who have lobbied, with the re-listing of SRS under OHIP, to have other health care agencies across the province become recommendation sites as well, thereby diminishing the control historically maintained by CAMH. Whether one has had any personal interactions with CAMH or not, "the Clarke" (which CAMH is still often referred to as) has come to signify, within trans communities, the largest hurdle to overcome in having the transitioning process fully covered. This site that has controlled access to hormones and SRS in Ontario, as previously discussed, has had a negative impact on the lives of many trans women and men. According to the men I interviewed, this has not changed. It would appear that interactions with the health care practitioners at CAMH's GIC continue to be difficult and often degrading.

Each of the men who participated in this study alluded to the GIC at different points in time during their interview. The actual process of getting from the decision to consider CAMH as a service option to an on-site appointment requires an incredible amount of work. These distinct areas of work that emerged during the men's engagement with CAMH began with the work that went into the decision making process of considering CAMH as an option for service; completing the initial intake package; the consultation process; and coping with the outcomes of the interactions with CAMH's GIC. All four men had completed the infamous intake questionnaire that is sent out by mail (see Appendix 7). This text is the access point to CAMH's GIC and to the initial consultation with the psychiatrists who decide whether one is in fact a transsexual as defined by the criteria outlined in the *DSM-IV* under Gender Identity Disorder. Questions that are asked in this text are those pulled directly from the *DSM-IV* GID criteria as well as from the *SOC*, particularly concerning the Real Life Experience.

The men I interviewed had put much material and emotional work into their decisions to include CAMH as a possible site to receive trans specific health care. The men spoke at length about the work they did to come to terms with their decisions to, as Thobias stated, "give the Clarke a go and see what happens." He also spoke about the reactions he has received from other trans men who questioned this decision:

> And I've been wondering and sort of challenged by other Trans guys why ? I guess I don't feel very vulnerable. I'm out everywhere and my life is pretty secure, what are they going to do to me? I'm not in an emotionally fragile space, I'm not in a financially fragile space, I've got lots of family and friends support, I work in a job that everybody knows and they all support it. What are they going to do to me?

Aware of this gatekeeper role of CAMH and the negative attitudes expressed towards other trans clients, Henry decides he does not have “the capacity or the energy” to confront the psychiatrists directly:

> like how do you even begin to go to war with someone like that? How do you begin to intellectually compete with somebody who has established themselves in their mind as whoever they are.

Rather, he decides to ‘play along’ during the process, choosing to be “just as cheeky and ridiculous as the psychiatrists are.”

Another sort of work is generated for trans men by the CAMH intake process. The intake process at CAMH’s GIC is organized such that an initial letter is written by the family doctor requesting a referral for their trans patient. A waiting period of about two months happens before a package in the mail arrives for the trans person. This package contains a letter outlining that CAMH has received a referral from your family doctor, a request to complete their intake form and mail it back to them and notice that you will receive an appointment to see various health care practitioners such as psychiatrists and an endocrinologist at the GIC via another letter from them in the mail. This letter also states that there is an extended period of time before an appointment occurs –upwards to a year (See Appendix 6).

Henry and Wayne expressed frustration with their lack of control in how appointments are made by CAMH.

Henry: I had a terrible flu I had gotten it and you need 48 hours to cancel appointments, they’re very clear about that in all of their letters that they

> sent me - 48 hour cancellation... It had taken me 3 months to get in and then they rescheduled it for 2 months later so when I came down with the flu I was going hell or high water. I think I had 101 fever that morning, I could barely, like I fell asleep a few times in the chair refilling out my intake...because you don't set appointments like a regular human being with agency and with a life. They contact you with a date, they just send you a letter and they tell you the date that you're coming in and the time that you're coming in... Here's the number you can call if that doesn't work for you - but if you don't take it you're booking 2 months later.

Wayne's experience paralleled Henry's: "sort of drop everything and you go up to accommodate their schedule." In describing this controlling aspect of the process, the men, during the interviews, appeared to become quite exasperated and discussed at length how demoralizing this process was to their already minimal sense of autonomy within the health care system in Ontario.

Although trans identity has shifted over the years since the GIC was first developed, the intake questionnaire is still shaping and privileging a trans narrative that for some is no longer valid or relevant.

Thobias: The paperwork is designed for someone who is just starting, so it starts with like what makes you think you might be Transsexual? It's for somebody who's just beginning to question that and it's not all set up for someone whose already made some fairly significant steps in this process. Which is probably because they're used to ... the world's changed but the forms haven't.

Henry made a similar comment:

> .... it was very much a standard form like I'm a little trannie in a town or like a little female in a town dreaming about being a man and this is my first step. It's very much that's what the form was, how it was written. So no there was no room for, to even acknowledge that there was an alternative path that anyone could access health care in any other way, there was none of that.

The questions and layout of the intake questionnaire come directly from the *SOC* and are framed to capture the qualifying nomenclature of Gender Identity Disorder and to ensure that the Real Life Experience is underway. The Real Life Experience is used very inflexibly by CAMH and failure by trans people to be able to show that they have indeed begun this process does result in failure to qualify for the services at CAMH and hence, any possibility of having hormones and SRS funded.

For some trans people, following the Real Life Experience is much more complicated than it is for others and goes beyond merely being invested in the process of transitioning. There appears to be little room afforded for considering possible extenuating circumstances by CAMH. For example, an area of the Real Life Experience involves acquiring a first name presumed appropriate to one's gender which requires securing original birth documents and having to pay an amount of money which is attached to the government paper work that is filled out. For some, this is not a financially feasible option; as well, some men experienced the requirement as unnecessary, or even inappropriate. Jason has done what he felt was necessary: he shortened his female name such that it is gender neutral. Unfortunately for him, this neutrality disqualified him from receiving services from CAMH. Jason was told at his one and only appointment with the psychiatrists at the GIC to come back when he could make a commitment to a masculine name (or, as stated in the Real Life Experience, a gender identity-appropriate first name).

Wayne stated:

> for me so it seems sort of odd that my, the people who are providing me medical care are making that legal decision for me and that that legal stuff is a prerequisite to medical care. So you know if I did I'd be doing it for them not for me, not because it was something I wanted to do.

Wayne is also aware of the text which outlines the name-change criteria. He knows as well that this text is written as minimum guidelines that can and have been interpreted in a more flexible manner by some health care practitioners in Ontario such as family doctors, endocrinologists and surgeons:

> Their logic is they think that they're following the Benjamin standards but their interpretation of the Benjamin standards are ... really radical and so because, so you know what the Benjamin standards say is you're suppose to live full time for a year before you basically have surgery or ... but their interpretation is that you're suppose to live full time for a year before you do anything that has a permanent, that will change your body permanently and testosterone does change your body permanently in some ways. So they're not going to give you testosterone until you live full time for a year but living full time for them means having your legal documents changed which is not how everybody interprets the Benjamin standards.

Yet despite Wayne's well-informed analysis of the situation, his lack of adherence to the standards meant he was denied access to care: "because my documents don't say I'm male that's why I don't qualify for their [CAMH] program".

Their situations are also complicated by having dual citizenship and different legal realities to contend with for countries outside of Canada. In Wayne's case:

> I'm a US citizen and in the US the process is very different, you have to do ... I mean it's almost ironic but it's flip flopped, you have to have done something that permanently changes your body before you can legally change your sex...So if I start changing Canadian documents I'm going to be in a situation where I have mixed documentation for a while which is you know I don't know anything about that.

The essentialist interpretation of the text of the *SOC* by CAMH disallows Wayne and Jason access to trans specific health care and in turn disavows their official status as trans men. Although trans identity has shifted over the years since the GIC was first developed, the intake questionnaire is still shaping and privileging a trans narrative that for some is no longer valid or relevant. As pointed out by Matte, Devor & Vladicka (2009) "the *SOC* should recognize a wider range of potential identities among transgendered people, acknowledging that the concept of binary origins and destinations is not universally applicable" (p.50).

The following excerpts are quite long but including them in their entirety is important as the institutional sites of and social organization of trans specific health care can be spotted. Henry reminds us of the strict adherence that CAMH takes in their interpretation of the *SOC's* Real Life Experience:

> there was this Trans guy that was getting an intake and he, you know they asked, the receptionist came out and sort of like flushed out some of the questions with him and I guess his, she was able to figure out that his address was the same as his parents' address and then he started sort of apologizing profusely and promising that he would be moved out within the next 3 months and that this was only temporary and this was because he just lost his job and he's definitely going to get a job and he was definitely going to be living by ... It was just... sad, it was a little bit sickening to observe this kind of like ... apologetic process where he was willing to just jump through any hoops to be able to get what he thought he could only get from the Clarke.

Henry acknowledges that this policy has framed the unfolding of trans heath care via CAMH:

> I'm very cynical at these things so I have my own idea about why that is but there's some sort of institutional process where they can't really get past all of these sort of bureaucratic check points it's just how they do, it's how they've always done…they aren't able to sort of think in a real life circumstance. I'm sure that there's some sort of process, some sort of check point, some sort of bureaucratic something. It became this policy and it will therefore remain this policy forever regardless of whether or not they can reason around it. Which seems to be the way that the entire system operates any way, it seems to be very much this is how we've done and this is how we're going to continue to do and let's not question because it's exactly right.

Even with this knowledge, Henry still works at negotiating some control in the process and attempts to manoeuvre around what he deems a static policy:

> I tried to argue a little bit with him that I shouldn't have to wait the year, that it didn't really go that well. Sort of like well it could be 2 years and this is sort of the minimum wait time for someone who is on testosterone and sort of already transitioned. Although he never used that term already transitioned but he said for somebody who's on testosterone. I don't think he would until you've had bottom surgery I'm pretty sure.

CAMH's role as the site of the very strict gatekeeper to trans specific health services is further illuminated via these comments by Wayne:

> … I think that's what the whole process was. It was like an audition. It was very much like an audition…they were trying to see if I qualified for their program. They had set questions. There were correct answers to the questions. Most of the answers I knew the right answer because I read the *DSM-IV*. Some of the questions I knew the right answer because I could just guess. So yea the whole thing was really, like I said it was not health care and it was not treatment it was an audition.

In the following statements Wayne is making visible the accepted, credible trans discourse that has been socially organized directly from the *SOC's* inclusion of the *DSM-IV* GID criteria. Further to that, what is also illuminated is not only CAMH's strict gate keeper role but their interpretation of the text. Namaste's research (2000) has shown that CAMH has privileged a heterosexual version of the credible trans narrative. According to Wayne:

> Well there were questions that they wanted to know about my childhood, my relationship with my mother, my gender identity when I was a child. They wanted to know about my sexual relationships, my sort of romantic history. Whether I dated men or women. The longevity of my relationships. They asked me whether or not I stand up when I peed. They asked me if I was binding my chest. They asked me when I have sexual fantasies do I fantasize about penetrating or being penetrated? And that I hadn't read in the *DSM* form but I could guess what the right answer was.

After the initial consultation, there is another waiting period for results informing the trans client as to whether CAMH has deemed them as meeting the criteria for GID and that they are indeed transsexual and as such, eligible for the GIC program. However, as Jason and Wayne experienced, meeting the criteria for GID is only one step in the process. Even if a diagnosis of GID is given, if the Real Life Experience has not been adequately started by the trans client, the client is rejected by CAMH as a candidate for publicly funded hormones and SRS. Wayne lamented his rejection by CAMH but is willing to return for another appointment as he does not wish to 'burn any bridges' in the hopes that they may have some services he can access:

> In August I got a letter in the mail that was a result of those assessments that said I didn't qualify for the program but I was free to live in whatever gender I wanted to live in ...I don't like having a psychiatric diagnosis. I have never felt disordered, I have never felt like I have a psychiatric disorder but ... I guess I would love to...get on the path to transition without having a diagnosis but it was sort of doubly frustrating to get the diagnosis and then not get the treatment... I don't want to sort of burn that bridge if they have information or if they have services that they can share with me...I haven't felt very embraced by them. Like you know I was told that I don't qualify for their program so...I don't even, I don't know why they're meeting me again maybe they want to see if I've changed my paperwork.

This quote highlights the extreme gate keeping role that CAMH still has in Ontario. Although CAMH is willing to deem Wayne as transsexual, because he has not as yet changed his identity documents, and as such, does not meet one of the criteria set out in the Real Life Experience portion of the *SOC*, he is not deemed eligible for their program. In spite of this he is still willing to return to CAMH in hopes of somehow getting the services he wants. The discourses that have made CAMH the main site for trans specific health care in Ontario appear to have had a significant impact on Wayne.

Henry was accepted by CAMH as a client and was waiting for his next scheduled appointment. He had these comments:

> I'll be very surprised if they fill out the paper work for me, very surprised. We'll see. I still feel distrustful like I'm not really sure because I wasn't extremely, I didn't bend over backwards for them, at some points I laughed at the questions like I'm sure that you know I seemed smug and pompous and I wonder how that's going to come back. I don't know what's going to happen at this follow up appointment number two.

Henry has not entirely appropriated the discourse of CAMH as *the* site for trans specific health care but he is certainly aware of the power their program wields and he is still willing to do the work, as frustrating and oppressive as it is, in order to access trans specific health care that is publicly funded.

### *Discussion*

The aim of this research project was to make visible the interconnected, often complex forms of work that transsexual males in Ontario do in order to access trans specific health care. The forms of work were made visible beginning from the experiential standpoint of transsexual men. This work was mapped onto the specific sites of health care access and traced up through the discourses and practices that socially and institutionally shape this work. The originating texts of these discourses were spotted. Although beyond the capacity of this project, a further illumination of these texts and the specific institutional sites where they circulate would have supplemented this IE investigation.

Trans men do material and emotional work when they interface with various aspects of the health care system in Ontario. The analysis illuminated how extensive this work is, which begins for these men the moment they decide to access trans specific services for transitioning purposes. This research showed that the family doctor was the initiating site for beginning access to transitioning services. However, what also became clear was the amount of work that occurred leading up to the initial visit with the family doctor. These men attended support groups to gather information on which family doctors were prescribing hormones; they researched the internet to become familiar with the protocols for taking hormones and the effects that taking cross-gender hormones have on the physical and psychic self; and they learned the criteria for meeting eligibility requirements for a GID diagnosis. All this material and emotional work was undertaken to ensure they arrived at the family doctor's office fully 'armed' with the knowledge of what constitutes a credible transsexual and what the common transsexual trajectory is in order to access trans specific health care.

As confirmed by previous research (Namaste, 1995, 2000, Hussey, 2006, Dewey, 2008, Mattee et al, 2009) trans people are well versed in the psycho-medical discourses that have created the credible trans narrative and perpetuated the common trans trajectory. Not every trans person can name the document as the *Standards of Care* nor do they know where and how it originated. They do know, however, that there is a specific text that exists and has circulated to become part of an accepted discourse, and they know that this discourse gives us access to services.

Access however seemed quite variable. Trans men sometimes had to jump through hoops – sometimes for up to two years - before transitioning services were provided: in other cases after one or two appointments trans men would walk out of the doctor's office with a prescription for hormones. And although willing to make and take informed risks, they were concerned about the effects of cross-gender hormones on their bodies. In fact, the trans men in this study reported that they were more familiar with the protocols and the health research on the effects of testosterone than most of their family doctors were. This is similar to the research findings by Namaste (1995). Considering the often central role that hormones have in the transitioning process and the potential for side effects it is imperative that baseline blood work, pelvic, liver and kidney exams are completed and that regular follow –up monitoring occurs (Namaste, 1995). The trans men I interviewed were interested in working with their health care practitioners although they had experienced little consistency in this area, and initiating and monitoring of this health care was in some cases prompted by the men and not their health care practitioner.

Some men were offered virtually no information with respect to administering hormones. According to my research, trans men at times do their own work in regards to figuring out the correct gage and type of needles used for injecting testosterone as well as where to access these needles and the appropriate bodily sites to administer the testosterone. Others, situated in large urban centres such as Toronto, do have access to nursing care to assist with hormone administration.

My research also suggests that the GIC at CAMH is continuing to play a fairly large role in the lives of trans men. In the ten years that SRS was de-listed in Ontario, other sites, particularly in larger urban centres, became available to trans people seeking trans specific health care services. As well, an increase in the number of family doctors willing to work with trans clients occurred. Hormones for transitioning purposes are much more readily available to trans men.

However, SRS such as top and bottom surgery, for many, is still not financially feasible without OHIP coverage. For now at least, CAMH is still the only site in Ontario designated by the Ministry of Health to recommend these surgeries. Completion of the GIC program at CAMH is a necessity before SRS is insured as a benefit under OHIP.

It would appear from my research that the attitudes of the health care practitioners at the GIC as well as their strict interpretations of the *Standards of Care* have not changed since the de-listing of SRS in 1998. Neither has the laborious work that trans men attend to at all stages of the process- from the initial decision to include CAMH as part of their transitioning process, to their lack of control over appointment times, to figuring out the 'right' answers to the intake questionnaire utilized by the GIC as a screening tool, and to their often awkward interactions with the staff during the initial consultation. The trans men I interviewed were cognizant of the fact that 'the world' had changed in the ten years since the de-listing of SRS in Ontario, but CAMH had not. Having to perform a credible transsexual identity, or as Wayne pointed out, having to audition for care, and the work it takes to gain the knowledge of this credible transsexual identity, has not changed. CAMH deploys the same intake process, same intake questionnaire, and same privileging of a specific version of what is deemed a credible transsexual narrative and a common transsexual trajectory.

It would have been quite easy for the focus of this project to be about the often discriminatory and derogatory reactions trans men cope with when attempting to acquire both general health care and trans specific health care. Transphobia can be a debilitating part of everyday existence for trans people, and the trans men I interviewed as well as academic research confirms this. My research suggests, however, that some of what is deemed as a barrier to access that manifests as transphobia may in fact be a consequence of institutional discourses that frame how health care is socially organized for trans people.

Those discourses originate within the texts that have unfortunately functioned to put health care practitioners in a gatekeeping role over access to the resources that are required by trans people to be able to medically, legally and socially transition between genders. "The gatekeeping role which is implicit …has remained in all versions of the *SOC* to date and is something to which many transpeople, and some service providers, vigorously object" (Matte et al, 2009, p.48). When given the sole gatekeeping role for an extended period of time, such as was the case in Ontario with the GIC at CAMH, there is less opportunity to be challenged by those who need this service and more of an opportunity to interpret the text in a very strict way, as the *Standards of Care* have always been viewed as flexible guidelines.

Trans activism in Ontario has concentrated on increasing the number of health care sites that would have the ability to make SRS recommendations to

OHIP with the intent of reducing the gatekeeping role of CAMH. And although this is a useful recommendation for various reasons, especially as a way to create services outside of Toronto, it will not necessarily change the way trans specific health care is discursively organized in Ontario. My research suggests that access and barriers to trans specific health care has more to do with how the *Standards of Care* manifests and mediates social relations between health care providers and trans men, thus, socially and institutionally organizing how access to trans specific health care unfolds in Ontario. Perhaps a move away from the *Standards of Care* as the basis for assessing transsexual identity and conferring access to hormones and SRS, to a set of guidelines that is less focused on restricting access to services and maintaining a narrow definition of what is considered to be a credible trans identity would be helpful. Guidelines that are also culturally and politically relevant in meeting the current needs of the trans community and the needs of health care providers who want to provide knowledgeable trans specific care are also much needed.

### *Directions for Research and Action*

Much of the research undertaken within trans communities has focused on trans women, often to the exclusion of trans men. This research will lessen that gap and contribute towards building further knowledge about the everyday world of trans men. This research also shifted the focus away from the usual public health discourse of trans vulnerabilities and risks that are often increased due to the consequences of barriers to accessing social and health care services. Utilizing an Institutional Ethnographic framework illuminated the health care work that trans men do to meet their transitioning needs and focused on how health care is socially organized in Ontario. Exploring alternates to the *SOC* such as the *Health Law Standards of Care for Transsexualism* that was developed in 1993 in the US or *The Guidelines for Health Organisations Commissioning Treatment Services for Individuals Experiencing Gender Dysphoria and Transsexualism* that came out of England in 2005 could prove valuable in lessening some barriers to accessing trans specific health care.

Individuals from historically marginalized communities are not often asked about their experiences with systems and institutions that often perform gatekeeper roles within their lives. This research has given transsexual males the opportunity to share their experiences and learned abilities in gaining access to the health care system within Ontario that makes their gender transition possible. It also created a picture of the range of practice and activities that transsexual men engage in as part of looking after meeting their healthcare needs.

Exploring the troubles that trans men encounter in the work of getting care will inform service providers in their efforts to improve services to the transsexual male community and will enlighten their ways of thinking about how they support the work that transsexual males do in organizing their access to healthcare. "Institutional ethnography's focus on explicating ruling relations gives this research its potential for being a resource for activism and for transformation of the conditions of people's lives. Learning how people's lives are organized outside their own knowledge and control makes it possible to understand domination and subordination" (Campbell & Gregor, 2002, p.61). This research brings to light the very real social justice work that needs to continue within the Ontario health care system to improve access to resources for transsexual males.

Appendix 1

Bulletin 4480 issued on June 20th 2008 w
and reads as follows

# Bulletin

Bulletin Number **4480** Date June 20, 2008

Distribution Physicians, Hospitals, Clinics and Laboratories Direct inquiries to Ministry of Health and Long-Term Care Processing Sites (address below) Processing Sites

## Subject: Relisting of Sex Reassignment Surgery under OHIP

Effective June 3, 2008, Regulation 552 of the *Health Insurance Act* (HIA) has been amended to add sex reassignment surgery (SRS) as an insured service under the Ontario Health Insurance Plan (OHIP).

Sex-reassignment surgical procedures, including reconstruction of genitalia and mastectomy, are an insured benefit effective June 3, 2008 only if they are performed on patients who have completed the Gender Identity Clinic program operated by the Centre for Addiction and Mental Health and for whom the Clinic has recommended that surgery take place.

Within the foregoing guidelines, reconstruction of genitalia and mastectomy are insured benefits. However, since the hormonal treatments associated with sex-reassignment themselves give rise to breast enlargement, augmentation mammoplasty or breast reconstruction in a male to female conversion is not an insured benefit. Prior approval from the MOHLTC is required.

As the Province moves forward in the delivery of SRS services, we want to ensure that we are adopting the most up to date and efficacious techniques to serve the transgender community. To that end, we have sought the advice of the Centre for Addiction and Mental Health as well as the Sherbourne Health Centre about using the World Professional Association for Transgendered Health (WPATH) standards of care to inform our implementation strategy.

For services proposed to be received at a hospital or health facility outside Canada, prior approval of the General Manager of OHIP is required. See
http://www.health.gov.on.ca/english/public/program/ohip/outcountry_services.html
for the application process and requirements.

Bulletins and the updated version of the Schedule of Benefits are available on the Ministry of Health and Long-Term Care website http://www.health.gov.on.ca/.

This Bulletin is a general summary provided for information purposes only. Physicians, hospitals and other health care providers are directed to review the *Health Insurance Act*, Regulation 552 and the Schedules under that regulation, for the complete text of the provisions. You can access this information on-line at:
www.e-laws.gov.on.ca/. In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulation, the legislation and/or regulation prevail.

**Hamilton** 119 King Street West, 10th Floor P.O. Box 2280, Stn A L8P 4Y7 **Kingston** 1055 Princess Street, Suite 401 P.O. Box 9000 K7L 5A9 **London** 217 York Street, 5th Floor Station A N6A 5P9 **Mississauga** 201 City Centre Drive Suite 300 L5B 2T4 **Oshawa** Executive Tower, Oshawa Centre 419 King Street West P.O. Box 635 L1J 7J2 **Ottawa** Fuller Building 75 Albert Street K1P 5Y9 **Sudbury** 199 Larch Street Suite 801 P3E 5R1 **Toronto** 47 Sheppard Avenue East Suite 505 M2N 7E7

Appendix 2

## Email letter sent out to Rainbow Health Network list serve (RHN@yahoogroups.com) and the trans health lobby group list serve (transhealthlobbyrhn@yahoogroups.com)

**Subject tagline of email**: transsexual males needed for research study

My name is Will Rowe and I am a transsexual male enrolled in the Master of Social Work Program at McMaster University in Hamilton, Ontario. I am currently completing a thesis research project and am interested in interviewing individuals who identify as transsexual males who are 18 years of age and older who would be willing to share their experiences of accessing trans specific health care services in Ontario. These trans specific services would include services provided by family physicians, mental health professionals, endocrinologists and surgeons who perform hysterectomies, top and bottom surgeries. My interest in this research will be focused on how and where transsexual males learn about health care services available to them within Ontario and the work they do to access these services.

There would be one face to face audio taped interview lasting approximately one to two hours. There may also be one or two email correspondence after the interview should any follow-up clarification of the interview data be needed. I am specifically requesting interviews with transsexual males who live within a 100 kilometer radius of the city of Hamilton as I am willing to drive to where you live and meet at a mutually agreeable location.

This research is important as transsexual males rarely have the opportunity to share their lived experiences or provide knowledge in regards to their abilities in learning to negotiate and maneuver through the healthcare system. This research will also shed light on the barriers that transsexual males may face when attempting to access trans specific health care services in Ontario.

If you are interested in participating in this research please contact me at rowerj@mcmaster.ca. Once contacted via email, I will forward a letter of information and consent form as well as the interview guide so that you will be fully informed of the research process.

This research has been approved by the McMaster Research Ethics Review Board.

Thank you very much for your consideration to participate in this research project. Once again, please feel free to contact me if you have any questions or concerns about this project.

Sincerely,

Will Rowe, BA, BSW, MSW (in progress)

## Appendix 3

### Letter of Information and Consent

"Accessibility to Transsexual Specific Healthcare Services in Ontario"

**Principal Investigator**: Will Rowe, Department of Social Work
McMaster University, Hamilton, Ontario, Canada
rowerj@mcmaster.ca

### Purpose of the Study

In this study I want to explore the ways in which transsexual males, eighteen years of age and older learn about trans specific health care services available to them in Ontario and the steps they take and the activities they participate in to gain access to these services.

### Procedures involved in the Research

I will be asking you questions about your experiences in accessing trans specific health care services within Ontario. This one-on-one interview will last from one to two hours and will be audio taped. This interview may be followed up with one or two emails to request clarification of any part of the data collected from your interview. We will meet at a mutually agreed upon time and place within the community (city or town) where you reside.

### Potential Harms, Risks or Discomforts:

You may feel uncomfortable during the interview as some questions may remind you of negative experiences that you have had in the past while attempting to access health care services in Ontario. You do not need to answer questions that make you uncomfortable or that you do not want to answer. I will have available a list of resources that offer support to transsexual men in the community you reside in or nearby communities, for you to contact following the interview if you wish. You are free to withdraw from participating at any point during the research process.

### Potential Benefits

Individuals from historically marginalized communities are not often asked about their experiences with systems and institutions that often perform gatekeeper roles within their lives. This research may give transsexual males the opportunity to share their experiences and learned abilities to gain access to the health care system within Ontario that makes their gender transition possible. This research project will illuminate some of the barriers that are prohibiting members of the trans community from being able to access appropriate services. This information may benefit service providers in their efforts to improve services to the trans community. This research will bring to light the very real social justice work that needs to continue within the Ontario health care system to improve access to resources for transsexual males.

### Confidentiality:

Anything that I find out about you that could identify you will not be published or told to anyone else, unless I get your permission. Your privacy will be respected. I will ask you to choose a pseudonym (false name) that I may use when I quote you in any reports from the project.

All audio tapes used during the interview process will be kept in a locked cabinet and erased as soon as the tapes have been transcribed into word file format onto my personal computer and

password protected. Any hard copies of transc
cabinet other than when I am working on them.

In spite of these steps to protect your confidentiality, the transsexual male population is relatively small and you may be identifiable based on what you say. Please keep this in mind during the interview. I will email you after the interview to get clarity around any data you provided during the interview. I will also include a copy of the transcript of your interview to give you the opportunity to change, add to or delete, any portion of it that you are not comfortable with.

**Participation:**

Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to stop participating, there will be no consequences to you. In cases of withdrawal, any data you have provided to that point will be destroyed, unless you request otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

**Information About the Study Results:**

You may obtain information about the results of the study by contacting me via email in September, 2009 at which point the research project will be complete and a summary of the research findings will be available should you be interested in obtaining a copy.

**Information about Participating as a Study Subject:**

If you have questions or require more information about the study itself, please contact me, Will Rowe at rowerj@mcmaster.ca. If you wish to speak with my supervisor, Dr. Sinding, she can be reached at sinding@mcmaster.ca or 905-525-9140 x22740

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

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**CONSENT**

I have read the information presented in the information letter about a study being conducted by Will Rowe, who is a Master of Social Work student at McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

| | |
|---|---|
| Name of Participant | Date |

## Appendix 4

### Interview Guide

- I would like you to share your experiences of accessing transsexual specific health care services in Ontario. Please take me through the process of it – when did you first have contact with the health care profession about your desire to transition?

- How did you find out about this specific professional and/or organization?

- Who did you talk with, what other sources of information did you need to access?

- How did you know about or have connection to these people or other sources of information?

- What did you need to do to see this health care professional? [clarify the steps taken to access these services once he learned about them]

- What did you do after?

- What did that take? What was that like for you? What did you need to know?

Appendix 5

## DEMOGRAPH

**How do you define your gender identity?** ____________

**How do you define your sexual orientation?** ____________________

**What is your current work status?**

(choose one or two that best apply)

○ Full-time paid employment (30 hours+ per week)

○ Part-time paid employment

○ Unemployed ○ Sick leave

○ Homemaker ○ Retired ○ Student

○ Working without pay (family farm or business)

○ Other: ____________________

**What is/was your usual occupation (if applicable)?**

____________________

How long in this occupation? ________

**Total annual household income (before taxes):**

○ Less than $15,000

○ $15,000 - $20,000

○ $20,000 - $25,000

○ $25,000 - $30,000

○ $30,000 - $35,000

○ $35,000 - $40,000

○ $40,000 - $45,000

○ $45,000 - $50,000

○ $50,000 - $59,000

○ $60,000 - $69,000

○ $70,000 - $79,000

○ $80,000 - $89,000

○ $90,000 - $99,000

○ Over $100,000

**What is the main source of your income?**

○ Paid employment (wages or salary)

○ Self-employment income

○ Employment Insurance

○ Investment income

○ Ontario Disability Support Program

○ Ontario Works

○ Canada Pension Plan

○ Other: ______________________________

**Highest level of education you have completed:**

○ No formal education

○ Completed primary/ elementary school

○ Some high school ○ Completed high school

○ Some college ○ Completed college

○ Registered apprenticeship or trade certificate

○ Some University

○ Completed Bachelor's degree (BA, Hon. BA)

Completed post-graduate degree:

○ MA, MSc, etc ○ PhD

○ Completed professional degree (law, medicine, dentistry, MSW etc)

**How are your prescription drugs paid for?** (check all that apply)

○ Workplace insurance

○ Insurance that you have purchased

○ Pay yourself

○ Ontario Disability Support Program

○ Canada Pension Plan

○ Social Assistance

○ Trillium Drug Program ○ Other: ______________________________

250 College Street
Toronto, Ontario
Canada M5T 1R8
Tel: 416 535-8501

250, rue College
Toronto (Ontario)
Canada M5T 1R8
Tél. : 416 535-8501

www.camh.net

Centre for Addic
Centre de toxicom

Appendix 6

February 10, 2009

Will Rowe
[redacted]
[redacted], Ontario
[redacted]

**D.O.B.: [redacted]**

*A PAHO/WHO Collaborating Centre*
*Centre collaborateur OPS/OMS*

*Affiliated with the University of Toronto*
*Affilié à l'Université de Toronto*

Dear Will:
We have received a medical referral from **Dr. [redacted]** requesting that you attend the Gender Identity Clinic for an evaluation. **Please complete the enclosed questionnaire and return it to us**. Please be as specific as possible. If possible we are requesting a written life story regarding your gender identity issues and two photographs (one cross-dressed, if possible). **The life story and photographs are not compulsory but helpful only the questionnaire.** We require that the above information be forwarded to the clinic prior to arranging for any assessment appointments. We will contact you and apprise you of the next available assessment date, upon receiving your package.

The evaluation requires a one or two day assessment on an **out-patient** basis, as you are interviewed by two psychiatrists, a psychologist, and an endocrinologist, for a complete physical examination, and possibly asked to undergo psychological testing. Approximately four weeks after the initial assessment, a conference is arranged, at which time the clinic makes recommendations regarding your case. A letter outlining the recommendations will be forwarded to your referring physician.

The Gender Identity Clinic sees patient's who are unsure as to whether or not they wish to pursue surgery and want to explore this question with specialists, as well as patients with various types of gender issues, including cross-dressers and transgendered individuals, who are interested in finding a non-surgical solution. We also offer support for family and spouses, provided that we have your consent. In addition, if requested, we can provide consultation to employers. The proper time to come to the clinic is whenever you feel that your gender-related issues require

Appendix 7

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

# GENDER IDENTITY CLINIC

# QUESTIONNAIRE

**Please be advised that all information contained within this questionnaire is completely <u>confidential</u>. It will be kept in your file, intended for the use of the Gender Identity Clinic only. Information, either in whole or in part, will not be released to any other individual or individuals.**

## GENERAl

Date Completed ________________________________

Name on Birth Certificate ________________________________

Sex as on Birth Certificate MALE FEMALE

Name Used ________________________________

Date of Birth ______________ Present Age __________

Current Address and City ________________________________

Province ______________ Postal Code __________

Home Phone No. ( ) ________________________

Business Phone No. ( ) ________________________

Have you ever been seen at the CAMH before
(by any department, not necessarily Gender)? YES NO

## GENDER QUESTIONNAIRE

1. Are you currently employed? ________________________
(Your employer will not be contacted).
   a) Name and address of employer ________________________
   ________________________________________________
   b) Position held ________________________
   c) Length of employment ________________________
2. List jobs you have held for one year or more
________________________________________________
________________________________________________
________________________________________________

## GENDER QUESTIONNAIRE

3. Current annual income from all sou

   a) If other than job, please list source ____________________

4. Are you presently a full-time student? ____________________

   a) Name of university, college, trade school or other ____________________

   ____________________

   b) Address ____________________

   ____________________

5. Are you presently legally married? ____________________

   a) Have you ever been legally married? ____________________

   b) Please give details of marriage, including date of marriage, date of divorce/separation if applicable ____________________

   ____________________

6. Have you ever lived common-law or as if married? ____________________

   a) Please give details ____________________

   ____________________

7. Have you ever been the parent of children? ____________________

   a) Were these your own or adopted? ____________________

   b) Please give details ____________________

   ____________________

8. Have you had desires to be the opposite sex? ____________________

9. At what age did these desires begin? ____________________

10. Have you dressed in clothes of th

    a) At what age did you first crossdress? ____________________

    b) At what age did you begin:

        i. occasional crossdressing ____________________

        ii. frequent crossdressing ____________________

        iii. Continuous crossdressing at home ____________________

        iv. Continuous crossdressing outside home ____________________

        v. Full-time cross-living ____________________

        vi. Which of the above noted categories best describe your present gender role ____________________

        vii. Date when full-time living & working in the opposite gender role began ____________________

        viii. List previous attempts to get medical care for this condition ____________________

        ____________________

11. List any illnesses, operations or accidents (give dates if possible) and indicate hospital or facility where appropriate ____________________

    ____________________

    ____________________

12. Have you ever attempted suicide? ____________________

    a) Please give details for each attempt ____________________

    ____________________

    ____________________

    ____________________

## GENDER QUESTIONNAIRE

13. Aside from any suicide attempts, purpose?

    a) Please give details

14. Have you ever had any psychiatric treatment and/or psychotherapy?

    a) When?

    b) Please give details

15. Who is your present physician?

    a) Current Address and City

    b) Province Postal Code

    c) Telephone Number

16. Have you used alcoholic beverages?

    a) Desribe quantity and circumstances of intake

17. Have you ever taken addictive drugs?

    a) Please give details of drugs used, frequency & duration of use etc.

18. Have you ever taken hormone pills

    a) Please give details of drugs us

19. Prior to any hormones, were your sex organs normal in size, shape and function?

    a) If not, please give details

20. Are you covered by the Ontario Health Insurance Plan (OHIP)?

    a) Please provide your OHIP number

    b) Version code (one or more letters after OHIP number) if applicable

    c) Do you have 3rd party supplementary or alternative medical insurance coverage through your employer

    d) Please provide your policy number

21. Have you ever been arrested?

    a) When, in what city, and on what charges?

22. Are you presently on parole or prot

    a) If you have been incarcerated and released without parole, what was the date of your release from prison? ____________________

    ________________________________________

23. What is the highest level of education you have obtained? ____________

    a) Where? ________________________________

24. Who in your family knows of your crossdressing feelings/behaviours?

    ________________________________________

    ________________________________________

    ________________________________________

25. Who is your next of kin? ____________________

    a) Current Address and City ____________________

    b) Province ____________ Postal Code ____________

    c) Telephone Number ____________________

    d) Please state the relationship ____________________

26. Please provide the following information about your parents:

    a) **Mother**

    Name ________________________________

    Birthplace ____________________ Age ________

    Current Address and City ____________________

    Province ____________ Postal Code ____________

    Marital Status ____________________

b) **Father**

Name ______________________________

Birthplace ______________________ Age __________

Current Address and City ______________________

Province ______________ Postal Code ______________

Marital Status ______________________________

27. List all your brothers and sisters (living or deceased) including step and half siblings

a) Name ______________________ Age __________

Birthplace ______________________ Sex __________

Marital Status ______________________________

b) Name ______________________ Age __________

Birthplace ______________________ Sex __________

Marital Status ______________________________

c) Name ______________________ Age __________

Birthplace ______________________ Sex __________

Marital Status ______________________________

d) Name ______________________ Age __________

Birthplace ______________________ Sex __________

Marital Status ______________________________

e) Name ____________________

Birthplace ______________________________ Sex ____________

Marital Status ______________________________________

f) Name ______________________________ Age ____________

Birthplace ______________________________ Sex ____________

Marital Status ______________________________________

g) Name ______________________________ Age ____________

Birthplace ______________________________ Sex ____________

Marital Status ______________________________________

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