Pathologise/De-Pathologise:
Changing Medical Understandings of Transgender and Gender Non-conforming people in Britain

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In recent years there has been increasing awareness of transgender and gender non-conforming people in the UK, and in turn there have been vastly increasing numbers of people seeking medical treatment for their gender dysphoria. This research paper analyses the past medical literature on transgender and gender non-conforming people in the UK, in combination with an interview with a surgeon working in the field of sex reassignment surgery, to examine the historical trends in medical approaches to gender non-conformity. This investigation into changing medical standards and practices is argued to indicate three major trends, a correlation between wider social norms and medical norms, an increasing de-pathologisation of gender non-conformity and an increasing focus on individualism over society. These trends are then extended forward and used to imagine possible future changes in the medical treatments of transgender and gender non-conforming people in the UK, such as an increasing focus on an informed consent model and a problematising of the boundaries between “transgender” medical procedures and other forms of bodily modifications. This paper aims to contribute to the current body of work in feminist science studies focusing on gendered aspects of medical practices, and also aims to continue the work of Donna Haraway and others in deconstructing rigid bodily categories.
“Transsexualism in many ways typifies this quandary of modern medicine. Is this bizarre behaviour the proper concern of the physician, a disease or disorder within the scope of medicine, or is it a perversion calling for moral sanction or sympathetic tolerance rather than medical inquiry?”

-Sydney Brandon, The British Medical Journal, 1970

Abstract

In recent years there has been increasing awareness of transgender and gender non-conforming people in the UK, and in turn there have been vastly increasing numbers of people seeking medical treatment for their gender dysphoria. This research paper analyses the past medical literature on transgender and gender non-conforming people in the UK, in combination with an interview with a surgeon working in the field of sex reassignment surgery, to examine the historical trends in medical approaches to gender non-conformity. This investigation into changing medical standards and practices is argued to indicate three major trends, a correlation between wider social norms and medical norms, an increasing de-pathologisation of gender non-conformity and an increasing focus on individualism over society. These trends are then extended forward and used to imagine possible future changes in the medical treatments of transgender and gender non-conforming people in the UK, such as an increasing focus on an informed consent model and a problematising of the boundaries between “transgender” medical procedures and other forms of bodily modifications. This paper aims to contribute to the current body of work in feminist science studies focusing on gendered aspects of medical practices, and also aims to continue the work of Donna Haraway and others in deconstructing rigid bodily categories.

Keywords: Transgender, gender non-conforming, medicalisation, pathologisation, de-pathologisation, Britain, NHS, futures
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**Introduction**

In the UK, the numbers of people being referred to specialist services for people identifying as transgender and gender non-conforming has leaped within recent years, with the largest gender identity clinic in London seeing numbers of service users quadruple from 2006 to 2016 (Lyons, 2016). In response to this huge increase a doctor at this GIC stated, “I think the societal change has been really important, society is more tolerant, more accepting and people who are gender-nonconforming are a lot more visible.”. While this is undoubtably true, it is also certainly true that the relationship between wider societal values and medical practice is not a straight forward or one-way relationship. While social change and greater visibility can influence the number of people who identify as transgender, medicine itself has an important impact on creating and maintaining the category of “transgender” and validating, or invalidating, the position of transgender and gender non-conforming people in society. With rapidly increasing numbers of people seeking medical treatment for their gender dysphoria in the UK, research into the evolving relationship between the medical field and non-conforming gendered identities is perhaps more prescient than ever before. Through examining how medical professionals have perceived transgender and gender non-conforming people over time and what changes have occurred in these perceptions, perhaps the connections between medicine, wider societal views and transgender identities will be more greatly illuminated.

This research therefore aims to examine how the attitudes of the medical establishment are changing, what mechanisms are influencing this change, and what this potential change will look like in the future. To conduct this research, I will be analysing medical literature about trans and gender non-conforming people over time, and also conducting an interview with a doctor specialising in the field of gender reassignment. The key research questions are as follows: “What changes have occurred in the attitude of medical practitioners towards transgender and gender non-conforming people? How have new ideas about gender non-conformity spread throughout the medical community? What changes are likely to occur in how gender non-conformity is perceived by the medical field in the future?”. It is this last question which is the most challenging to answer, but also the question which is the most vital and relevant going forward. As increasing numbers of people seek medical treatment for their feelings of gender dysphoria in the UK, the ways that these people
are viewed and categorised by medical professionals is very important to consider. However, considering this last question can only truly occur in relation to the first two questions, since it is only once we see how the medical community has evolved thus far can we imagine how it will evolve in the future. Research into changing medical attitudes to transgender people is not only relevant to transgender people seeking medical treatment but is also important to see the wider influence of the medical field in constructing human experiences, and as a way to gain insight into the links between broader societal changes and the medical industry.

Epistemological and Theoretical Framework

This research into the socially constructed, and potentially bias, aspects of the medical industry fits very well within the larger theoretical field of feminist science studies. The key aim of feminist science studies is to critique and examine the advertised neutrality of natural sciences and bring to light the ways in which these sciences can be influenced by the sexism, racism, classism, etc. which is present within wider society (Nelson and Wiley, 2004). This theoretical understanding encourages greater neutrality in science, through promoting the works of feminist scientists, and urging greater awareness of the ways in which social and political pressures can influence the supposed “neutrality” of science, particularly through endemic sexism (Grebowicz, 2005). The work that feminist science studies has done in the medical field has largely been a critique of the historical and ongoing mistreatment of women and people of colour by medical practitioners, particularly since many historical medical advances have been produced in conjunction with painful experiments on the bodies of low-income women and people of colour (Schiebinger, 2004). Feminist science studies has also critiqued the medical field in regard to its historical understandings of a fundamental biological difference between different categories of people, i.e. a historical medical belief that black people are less susceptible to pain than white people (Owens, 2017). Although this is of course a rather extreme example compared to this research, it is however a good indicator of the ways in which an understanding of feminist science studies reveals the social and political influences on medical understandings. Medical practices are nominally designed to function through neutrality, however as they are produced and conducted by human beings, they are influenced by human traits such as sexism.
The theories of feminist science studies have been very much influenced by Donna Haraway, and her theory of feminist materialist analysis, and so in turn is my research influenced by Haraway. Haraway’s feminist materialist analysis can be seen as a methodology based around deconstruction and reconstruction, in which she considers all aspects of a research question as equally important, even those which could potentially be seen as mundane (Toye, 2012). Not only does this focus on the inter-connectivity of all aspects of culture and society work well for this research, but her focus on “situated knowledges” (Prins, 1995), a focus on including the author as a crucial part within this web of knowledge-making, also works well for my relationship within this subject area as a transgender person with on-going experience of transgender medicine in the UK. Haraway’s theory also focuses not just on the breadth-range of subjects which she considers when conducting research, but also time-range, stating the importance of “an account of radical historical contingency for all knowledge claims and knowing subjects” (Campbell, 2004). This discussion of “radical historical contingency” is one of the reasons why this research project has such a historical bent. This research is conducted with the understanding, as underlined by Haraway’s work, that it is only through understanding the historical knowledge-making processes of the medical industry that we can understand how those knowledge-making processes function today, and how they could potentially function in the future.

The theoretical understandings of feminist science studies and feminist materialist analysis have certainly influenced the direction and scope of this piece of research, however on a more fundamental level, it is important to discuss the underlying theoretical understandings of gender as a whole. Theoretical understandings of gender are vitally important to discuss in tandem with transgender people’s place in medical narratives because these theoretical gender understandings influence how, and what, we read in these medical narratives. However, gender theories have frequently been misused against transgender people, with trans people being seen either as an argument for biological essentialism, through arguments for an “innate” real gender, or otherwise trans people have been used as an example of how gender is essentially performative, as trans people “perform” a gender not assigned to them at birth (Hird, 2002). Issues of biology and a potential “root cause” of gender non-conformity are not discussed in this research, not only because it is not the focus
of this research, but also because ultimately the potentially biological cause of any individual’s gender dysphoria has little impact on how this dysphoria plays out over the course of someone’s life. Therefore, standing in stark opposition to biological essentialism, the understandings of gender in this research is much more influenced by Judith Butler’s ideas of gender performativity (Digeser, 1994). However, while Judith Butler explores in her work how categories such as “man” and “woman” are non-essential, instead created through words, behaviours and actions, in this research the performativity of gender is extended so that categories such as “transgender” or “transsexual” can also be seen as performed and non-essential. To be clear, this is not an argument that these categories are not real and important, but merely an acknowledgement of the ways in which these identity categories are socially created, and self-propagating.

Perhaps alongside general theories of gender overall, it is important to acknowledge and deconstruct some underlying theoretical understandings of “transgender” and transgender identity. Historically, “transgender” and “transsexual” are terms which have been used to define individuals whose gender identity does not match the sex they have been assigned at birth (Wentling et al., 2008). Specifically, the term “transsexual” has often been used to describe an individual who has moved from one concretely defined sex and set of gendered behaviours to another, male to female or female to male. “Transgender” as a term can be defined in its origins as essentially more ambiguous, moving the focus away from a surgical or medical change in sexual characteristics, towards a focus on gendered identities; although in doing so created a new dichotomy between “transsexual” and “transgender” (Lane, 2009). While “transgender” is often presented as a more fluid and ambiguous category, it is still a category predicated on a dichotomous understanding of sex/gender. However, more recent scholarship has aimed to explore and expand categories of understanding through a starting point of transgender theories, for example the “transgenre” theories of Weinstein who writes “I would like to propose transgenre as a new method of analysis that might help us not only step outside of the fray but also produce novel understandings and offer potential for creative theoretical lines hitherto impeded by the sex/gender stalemate” (Weinstein, 2011). In expanding the terminology from “transgender” to “transgenre”, it is not only the sex/gender paradigm which is critiqued, but also the nature/culture, human/animal, self/other paradigms which are explicitly questioned and therefore open for greater exploration.
Moving from these broader theoretical understandings, developing an understanding of the practical ways that transgender identities function in society is also vitally important. One key example of this is the highly influential book “Imagining Transgender: An Ethnography of a Category” by David Valentine. In this work, Valentine conducts an ethnography amongst mostly black and latino assigned male at birth low-income sex workers in New York (Valentine, 2007). Over the course of his ethnographic research, he observes how these people who originally identified as “femme queens” began to instead identify as “transsexual” or “transgender”. This change of identity category did not correspond to any major change in the way that they behaved or their thoughts and desires about their bodies, however, the language of “transgender” did allow them greater access to respect and material resources from doctors, social workers and other welfare-providers, who used the terminology “transgender”. Valentine’s work is hugely influential to this research in two major ways. Firstly, his analysis of the category of “transgender” reveals how it is not within itself an essential category, but instead one coloured by race, class and privilege, and secondly, his work reveals how medical power-structures can influence the identities and lives of transgender and gender non-conforming people. While Valentine aims his focus onto transgender and gender non-conforming people and how they are influenced by structural narratives of gender influenced largely by race and class, in my research I aim to focus on the dialogue between the medical profession and transgender and gender non-conforming people, seeing how the medical profession itself has been influenced.

Valentine’s work is a rare example of a piece of literature which is highly relevant for this specific research, since this research exists in a slightly strange cross-over between the more medical feminist science studies, and the more theoretical literature on transgender people. However, one key area of literature in feminist science studies is the literature related to the construction and consequences of medical power. While this literature is not directly related to transgender people’s experiences with medicine, it is a good starting to place to explore the relationship between medicine and social power. A good example of the importance of this literature around medical power is this quote from a medical article about patient choice, which states, “The patient might then make a ‘choice’ but the whole encounter is located firmly within a conventional bio-medical framework where there is no place for
other frameworks” (Canter, 2001, pg. 414), or another article on the history of medicine in France which states “Modern medicine… established itself by denying legitimacy to competing practitioners and medical cultures” (Ramsey, 1977, pg. 560). These quotes are both revelatory and explicitly critical of the ways in which medical power has been established over time, arguing that medical power has been established by producing and defending a specific set framework, to the exclusion of others. However, this literature then raises an important question, if medical power functions through defending a set framework, how does change function within this framework, and can the overall framework itself be challenged while maintaining medical authority and power?

Some existing literature does exist which approaches changes in medical power, specifically literature which examines historical cases of medicalisation. Medicalisation is the process through which a behaviour or trait begins to be seen as a diagnosable, and treatable, medical condition such as has historically happened with alcoholism and other addictions, which began to be treated as medical rather than moral issues around the beginning of the 20th Century (Bull, 1990). Historically in many societies gender non-conformity has been seen not as a medical problem, but instead as a deviance caused by poor morals or else a normal expression of human variation, and yet over time transgender identities have been medicalised and are now firmly encompassed within the field of medicine in most Western societies (Reis, 2014). There are still contemporary examples of gender non-conforming identities, such as the Hijra in the Indian subcontinent, who are categorised and understood through religious rather than medical typology, however more medicalised “transgender” narratives are becoming increasingly used even among these more diverse gendered identities (Khan et al., 2009). Medicalisation of certain aspects of society can in some ways be attributed to greater advances in medical technologies, which can particularly be seen in the vast wave of medicalisation which occurred in Europe between the mid-16th and the mid-19th Centuries, since this was also a period of vast medical innovations (Loetz, 2010). However, particularly in the case of the medicalisation of gender non-conforming identities, it can be argued that the medical innovations occurred in tandem with evolving medicalised identities, rather than one provoking the other.

Another important facet of this existing literature is the challenging relationship between medicalisation and pathologisation. While medicalisation in itself describes the way
in which a trait or behaviour comes to be seen as treatable through medial practice, pathologisation describes the way that a trait or behaviour becomes seen as abnormal and problematic, and therefore worthy of medical attention (Conrad, 1992). For some theorists, such as Foucault, medicalisation and pathologisation are inherently linked, since Foucault suggests that medicalisation is an essential aspect of the “medical gaze”, through which an individual’s body and personhood are separated, and subjected to the power and influence of medical practitioners (Davenport, 2000). This link between medicalisation and pathologisation can also be seen in more concrete examples, such as increasing pathologisation of menopause from the mid-19th Century to today (Van de Wiel, 2014). The medicalisation aspect of menopause occurs with increasing acknowledgement and focus on menopause from medical practitioners, and increasing medical treatments being available for potentially distressing symptoms associated with menopause. Conversely, the pathologisation of menopause which occurs in association with this medicalisation, is focused on the social and political aspects of menopause, and how menopause has come to be seen as a sign of negative and undesirable aging and lack of reproductive capacity in women. This pathologisation is linked to medicalisation not only because a greater medical gaze was applied to menopause once it started to be pathologised in some segments of society, but medicalisation also increased pathologisation, as menopause became seen as a “curable” issue. As this shows, separating the tangled web of medicalisation and pathologisation is certainly challenging, however it is an important issue to tackle before considering the history of transgender and gender non-conforming people in medicine. While medical treatments do not inherently designate a fixable pathology, the two processes are closely linked.

In describing the conjunction in socio-medical literature between medicalisation and pathologisation, it is also necessary to mention the role that medical practices have played historically in transgender theories and literatures One of the key early pieces of modern transgender theory, “The Empire Strikes Back: A Posttransexual Manifesto” originally published in 1991, argues strongly against the centring of surgical and medical experiences of transgender and transsexual people in transgender literature, arguing that these narratives falsely describe an experience which “passes directly from one pole of sexual experience to the other. If there is any intervening space in the continuum of sexuality, it is invisible.” (Stone, 2006). Stone’s critique is explicitly related to previous narratives of transsexuality, in
which surgical interventions are placed as the omnipotent crux between two social roles, transforming man into woman or woman into man (Sturgis and Raymond, 1979). However, this ongoing project of de-centring medical narratives of transgender and gender non-conforming identities is not a simple proposition. A recent issue of Transgender Studies Quarterly described the subject of transgender medical and surgical procedures as the unspoken issue in much of transgender literature, arguing that it is “talked about mostly to remind people not to talk about it.” (Plemons and Straayer, 2018). This problematised and often contentious placement of medical narratives within transgender narratives means that an overarching historical view of transgender and gender non-conforming people within the medical field could be highly useful in examining the relationship between transgender people and the medical establishment not as a fixed and solid relationship, but instead as one which is fluid, evolving and multivalent.

When considering initial background research and readings, it is also important to contextualise this research, by discussing the specifically British context within which it is conducted. Although in many ways the medical industry can be seen as increasingly globalised, with standard practices and medical innovations being shared readily between many nations, particularly within European and Western countries (Bettcher and Lee, 2002), there are also specific nuances to the British medical context, and the context of transgender people in Britain. Firstly, this British context is important to reference not only because the interview conducted in this research takes place with a British doctor, but much of the medical literature analysed is produced in Britain. As the British Medical Journal itself states “Our Britishness is in the language we use, the assumptions we make, and the proportions of the journal written by British authors and devoted to things British” (Smith, 1999). This focus on “things British” is evident in the analysis of the medical literature, and in detailing the changes that have occurred in the attitude of medical professionals over time, it is clear that certain events in the UK have had a large impact on the medical field. A good example of this is the influence of famous English transgender model April Ashley, who was publicly outed in the 1960s, which had a huge impact on British culture at the time and was also impactful in British medical literature (Rollins, 1982). In addition to specific British transgender cultural references, the British medical framework, in other words the National Health Service, is also fairly unique in the way that it functions. Therefore, although the changes documented and
explained through this research can be mirrored in some ways in the medical systems of other countries, this research is firmly entrenched in British medical understandings.

Another relevant note to make regarding background and foundational literature is a note on the use of terminology and language within this paper. Thus far, this paper has discussed the semantic differences between the historically used terms of “transsexual” and “transgender”, and also briefly explored new possibilities of categories and perceptions, such as “transgenre”, however moving away from the stricter theoretical definitions of these categories, individual people may fit into many or all of these categories at different times (Connell, 2012). In many ways, the use of these terms is more useful in attributing literature and identities to certain time periods, and modes of thought. For example, in much of the medical literature examined from the 1970s-1990s, the term “transgender” is rarely seen and instead the focus is exclusively on “transsexuals” and “transsexualism”, which also coincides with a more binary understanding of trans people’s desires and behaviours (Armstrong, 1980). Alongside this potential ideological baggage attached to terms like “transsexual”, there are also more unconscious issues around the racial and class aspects of this terminology, which can impact on who chooses to, or is able to, identify with certain categories. While “transgender” is often promoted by those working in the field of gender studies as an “umbrella term” which can include many different identities (Weiss, 2009), throughout this paper I have chosen to more generally use the term “transgender and gender non-conforming” in the hopes of including people who have a materially similar set of experiences to people identifying as transgender, but do not themselves identify as transgender. Although this focus on word choice may seem uselessly particular, this paper primarily focuses on the evolution of conceptions of gender non-conformity, and therefore using language which greater enables these evolutions to occur is certainly important.

Methods, Materials and Ethics

Having now discussed the wider theories and theoretical understandings underlying this research, and the previous literature which has had an impact on the direction of the research, it is appropriate to examine the precise methods of the research itself. The methods used to conduct this research will be an analysis of the medical literature on transgender and gender non-conforming people, and an interview with a surgeon specialising in the field of
sex-reassignment surgery, sometimes also known as gender-affirming surgery. This dual-approach choice of methods should allow for both a comprehensive analysis of what has changed through analysis of the literature, and the interview will provide a more focused analysis on why and how these changes have occurred. This choice of methods is not only hopefully comprehensive, but has been influenced by feminist materialist analysis, to create an overall complete methodology. Feminist materialist analysis not only privileges a holistic approach, focusing on all aspects of a research question, but it also emphasises research through critiques and deconstruction (Orr and Lichtenstein, 2004). Using two methods certainly allows for a more holistic approach than a single method, and it also allows for greater deconstruction, as the information gained through one method can be used to verify or query the information gained through the other.

In terms of the literature analysed in this research, as previously mentioned, it is mostly produced in a British context although it is not entirely limited to British medical literature. One of the key sources of literature for this research is the British Medical Journal. The BMJ is a weekly general medical journal which has been publishing weekly since 1840 to the present day and has remained one of the most highly read medical journals in the UK for almost all of that time (BMJ, 2018). Because this journal is so widely read, and also covers a large period of time, it is an excellent resource to examine how perceptions of gender non-conforming people have changed in medical practice over time. Another key literature source is not from the UK, the reports produced by The Hastings Centre based in New York (Hastings Centre, 2018). The Hastings Centre is one of the world’s leading bioethics organisations, which aims to influence ethical medical standards of practice globally. Because the medical treatment of transgender and gender non-conforming people has been frequently seen as a bioethical issue within medicine, reports such as The Hastings Centre’s 2014 special report on LGBT Bioethics are vitally important in gathering information about the wider medical attitude to trans people. The field of medical literature is incredibly wide, and thus ensuring a wholly accurate representation of all medical literature surrounding transgender and gender non-conforming is impossible, however using numerous articles from well-respected papers is perhaps the best way to understand wider consensus in the field.
Although the range of literature which I have examined in this research is quite large, both in terms of the range of literature and the time period that it covers, there are of course some issues with it. One of these issues is the limits of the literature covered, particularly in reference to medical literature covering intersex people (Koyama and Weasel, 2002). Although in many ways the medical establishment’s attitude and treatment of intersex people has mirrored attitudes towards transgender and gender non-conforming people, there are certainly key differences. Among these are the invasive surgeries many intersex people have historically been subjected to shortly after birth, but conversely, intersex conditions have often been perceived as less morally deviant that other gender non-conformity in medical practice, since the narrative of “choice” is removed (Rubin, 2012). While some intersex people would describe themselves as transgender, many would not, and ultimately, I feel as though including medical literature focusing specifically on intersex people within this research would conflate two separate issues. Alongside choosing not to focus on intersex people I have also chosen to focus on British medical literature in this paper, however, it is important to realise the potential damage this focus on a single Western narrative of gender non-conformity can be. A good recent example of this is a campaign by the group Transgender India, called “I am not a Hijra” (Karthikeyan, 2016). In this campaign, the group sought to gain respectability by promoting negative stereotypes about the more traditional gender non-conforming group in India, the Hijra. Instances like this highlight how overtly focusing on a single narrative of western transgender identity can negatively impact on gender non-conforming people worldwide, however for this specific research, including global literature or literature focusing specifically on intersex people has much too wide a scope.

For the interview portion of this methodology, specificity is perhaps expected. The interview I have conducted for this research is with a surgeon who currently specialises in the field of sex reassignment surgery, specifically chest re-construction for transgender men. Through the interview process different information can be gained compared to literature analysis. Interviewing allows for greater input from the researcher to explore precisely why and how certain changes have occurred, compared to broader literature analysis which may only describe what these changes are. I have also chosen to structure the interview as a life history interview, with an emphasis on narrative, to help to bring the changes that have
occurred over time to the fore and help to allow the interviewee to provide reasons for the changes (Goodson and Gill, 2011). An example of this from this interview is the discussion of the interviewee’s first introduction to transgender and gender non-conforming individuals. Through the life-histories format, this begin as the question “In medical school, when were transgender people first mentioned?” which then lead to the interviewee’s experiences with gender non-conformity prior to medical school, and thusly to greater awareness of the concrete interactions between medicine and society. This is another benefit using interviews in this research, in that medical literature only reveals a small amount of knowledge of the total experience of medical professionals. By combining literature analysis and interview, it is possible to reveal this gap between what is stated in the literature, and what occurs in medical practice.

However, there are also so difficulties implicit in the interview portion of this methodology. In particular, conducting an interview with a sole participant is very limiting in the range and validity of information which can be gained. This is particularly the case for this research, since an ideal set of interviews would not only focus on surgeons specialising in sex reassignment surgery, but also psychiatrists and endocrinologists who work with transgender people, and general practitioners, nurses and other medical support staff. In preparation for this research, I had reached out to several medical professionals, specifically a psychiatrist working in a gender identity clinic and a general practitioner, but unfortunately only my eventual interviewee agreed to take part in this research. This is certainly unfortunate, and not an issue limited to master’s students, but an issue faced by many researchers who attempt to conduct research amongst people who have “high-status” professions who are often both challenging to contact and less willing or able to give their time to researchers (Briggs, 2007). Considering the challenges faced in accessing these interviewees, I considered the best route forward to include one personally conducted interview in this research, and to also draw from secondary interviews with medical professionals conducted by other researchers (Mann, 2013). Although this perhaps has not provided as ideal material as multiple first-person interviews, given the material limits of conducting research, this will still hopefully create a more multi-dimensional research piece than merely literature analysis alone.
When considering methodological advantages and disadvantages, ethical issues are also vitally important. While initially there seem to be few ethical challenges inherent in this research, since the research only actively involves one participant who is in a relatively powerful position, yet there are some key ethical points to be made. Firstly, there are the potential considerations that must be made when producing any academic research regarding a frequently disempowered minority (Anthias, 2013). The previously mentioned conflict between Hijra and Transgender communities in India is an example of the issues which can arise in marginalised communities from misdirected academic attention, even when this attention is intended to be positive. Another potential ethical issue with this research into transgender medical narratives, is the ways in which this research itself could be seen in itself as medicalising and reproducing a single medical narrative of trans-ness. However, this paper also seeks to acknowledge and explore the ways in which medical narratives are not merely a single narrative, but instead a collection of constantly evolving and developing narratives, which expand beyond the realm of simple medical power (Horncastle, 2018). When certain narratives of gender, or narratives of gender non-conformity, are given academic prominence over others, this can cause unforeseen issues to marginalised gender non-conforming people. However, while this is certainly an ethical issue to be considered, it is also an ethical question which cannot easily be resolved, except perhaps through its acknowledgement, and the acknowledgement of the inherent fallibility of academic power.

**Positionality**

Thus far in this paper, I have made a brief reference to the fact that I myself am a transgender person, who is currently receiving ongoing medical interventions in Britain. Because of this, my positionality in regard to this research is not straightforwardly simple. One obvious ethical issue is my previous relationship with the surgeon interviewed in this research, who in fact performed surgery on me in early 2017. This could potentially be seen as too close of a connection to allow for unbiased research to be conducted, however there are frequent examples of closer relationships between researchers and participants often producing good research (Driessen, 1998), and this previous aspect to our relationship could be argued as a levelling of power relationships, from patient-surgeon to researcher-participant. However, it is certainly important to acknowledge this connection, and to acknowledge that it could influence this research in ways that I am unable to foresee. In many
ways, my positionality, both in regard to my specific relationship to this medical professional, and my overall relationship as a transgender individual to medical practices, can be seen as a useful and positive aspect of this research. Following Haraway’s theoretical understandings, a truly neutral position is a position which does not exist, and knowledge can only be produced situationally (Haraway, 1981). In other words, there are only two potential positions for a researcher to approach this research from, either having previously received medical treatment for gender non-conformity, or not having received said medical treatment. Neither of these positionalities is inherently more accurate, however the information and location from which the research is approached will certainly be different, and therefore create different knowledges.

Although theoretically speaking writing research papers focusing on topics that one is intimately familiar with is not inherently bias, it is important as a researcher to be able to step back and acknowledge the occasions when potential bias may become more apparent. For example, within this research many historical medical papers focusing on transgender and gender non-conforming people have provoked immediate emotive responses from me, such as one paper entitled “Is Gender Change Unnatural, Therapeutic or Just Poor Medicine?” or another article which argues that trans people “with or without sex reassignment surgery, with or without psychotherapy, can, unhappily, never experience biological or emotional fulfilment” (Hastings Centre Report, 1987) (Rollin, 1982). As a transgender person it can be difficult to detach these historical medical narratives from similarly hurtful experiences faced in my own life, and yet to achieve useful and accurate research goals, it is vitally important to place this medical literature within its historical context and to see it as a stage in the evolution of medical understandings. However, this issue also leads into a wider argument around neutrality and condemnation of historical practices and opinions, particularly when these historical practices and opinions still negatively influence lives today. For example, while seeing medical transphobia as a phase in the co-evolution of medically produced transgender identities, it is also necessary to acknowledge the real harm that this has caused. A study of over 6000 trans and gender non-conforming participants in the US found the prevalence of suicide attempts amongst those whose doctor or health care provider refused to treat them was 60%, much greater than the 41% of the full sample, and also higher than the 57% suicide attempt prevalence of trans people whose family “chose not to speak/spend time
with them” (Haas, Rodgers and Herman, 2014). With an awareness of the real harm that can be caused by medical professionals, it is still necessary to approach these historical narratives through a non-emotive lens, as this is perhaps the best way to lessen contentiousness between the medical field and gender non-conforming communities, and allow for co-production of more positive narratives in future.

Analysis of the Literature

To start the analysis of the medical literature relating to transgender and gender non-conforming people, it is essential to ask: when did this literature begin? In many ways this question is impossible to answer, due to the pervasive nature of gender non-conformity throughout many cultures, however, particularly in European medical history there is one medical professional who played a large part in bringing trans and gender non-conforming people into medical history. Magnus Hirschfeld, who practiced medicine in Germany in the early 1900s, and pioneered early medical treatments for transgender women, particularly through hormones and consensual castration (Sengoopta, 1998). One of his primary reasons for working with gender non-conforming people was due to his own homosexuality, and his desire to promote gay rights through arguing that being gay was not a deviance, but merely a form of inherent biological feminization. While this conflation between gender identity and sexuality is largely no longer found in modern medical literature, gender theorists have frequently revisited the challenging tangle that can exist in the relationship of gender identity and sexuality (Richardson, 2007). However, while Hirschfeld can certainly be said to have originated European medical literature on transgender and gender non-conforming people, it is near impossible to gain access to this literature, since the vast majority of it was destroyed by the Nazi party prior to World War Two, or lost in the immediate aftermath (Tatchell, 2015). However, while it is certainly true that fascism had a devastating impact on Hirschfeld’s research, his work was also considered quite differently in the medical establishment at the time that it is considered today. A clear example of this is a review of his work “Sexual Anomalies” from 1950, which describes it as “a textbook for those whose professional duties render a knowledge of sexual pathology necessary or useful; for instance, criminologists, judges, probation officers” (Miller, 1950).
As this last quote indicates, throughout most of the 20th Century, medical professionals did not see themselves as responsible for resolving gender dysphoria, but instead saw it as a “sexual pathology”, which should be punished, or resolved through the individual conforming to the standards of the sex they were assigned at birth (BMJ, 1966). Once this initial acknowledgement of transgender people had taken place however, this sparked a further acknowledgment of gender non-conforming people in medical literature. This largely took the form of medical articles through the late 1960s and 1970s describing the root psychological causes of gender non-conforming behaviours and identities, believed at the time to be caused through emotional disturbance and poor parental relationships (Ellis, 1968) (Biller, 1971). This era of medical literature is vitally important in two ways, for what it reveals and what it does not reveal. On one hand, it shows an increasing awareness and discussion of transgender people within the medical field, however it also seemingly ignores much of the non-psychoanalytic treatment of trans people that was also occurring at this time. While it is not revealed in the medical literature, references are made to transgender people received hormones and sex reassignment surgery in literature of other fields at this time, such as in sociology and law (Kando, 1972) (Strauss, 1970). During this time, it seems clear that transgender and gender non-conforming people were receiving gender-affirming medical treatments by medical professionals, not limited to psychotherapy, however, as with the work of Magnus Hirschfeld, this work was taboo amongst the wider medical community. A clear example of this is a 1967 article relating to treatment of transsexualism, which describes this area as “a doubtful field of investigation for the respectable physician” (Brandon, 1967).

This debate around the potential respectability of medical interventions for transgender and gender non-conforming people continued into the late 1970s and early 1980s, but during this time the focus shifted away from the medical professionals and towards the patients. The question began to be asked, ‘Is it ethically fair to the patient to conduct medical sex reassignment?’ During this time, wider medical literature had started to acknowledge that sex reassignment procedures were taking place, and even began to acknowledge its usefulness in certain situations. However, this acknowledgement came with strict warnings “that surgery should be considered only for a highly select group of diagnosed gender dysphoric patients” (Rollin, 1982), and that the majority of gender non-conforming people who requested medical interventions should be denied these interventions in preference for
psychological counselling, and a return to their natally assigned gender role. Even for the few people who were considered worthy of receiving sex reassignment treatment at this time, wider medical literature describes these people as unhappy, unsatisfied and often longing to return to their birth genders (HCR, 1987). This depiction of transgender and gender non-conforming people as unlikely to truly benefit from medical interventions was considered as an argument for the poor ethics of medical sex reassignment, however articles also ignore any social factors which could potentially have led to a gender non-conforming person choosing to medically detransition. Medical literature was not completely blind to social factors at this time, but generally socially factors were addressed through an understanding that transgender and gender non-conforming people were detrimental to the societal norm, rather than vice versa. An example of this is several articles discussing the morally detrimental implications of medically transitioned transgender people being able to marry and partake in heterosexual relationships (Toulmin et al., 1981) (Thomson, 1980).

While this medical literature increasingly acknowledges the existence of and potential treatment available for transgender and gender non-conforming people, there are also some absences which are worth noting. The first of these is perhaps the most striking, although also the most complicated to examine, which is the historical focus on transgender women in medical literature (Armstrong, 1980). Although at first the explanation for this could be obvious sexism, as people who are assigned female at birth are perhaps less likely to be in a position to approach medical professionals, and less likely to be considered worthy of medical treatment, as has been found in other medical interventions for cisgender women (Turshen, 1993). However, this disparity in coverage in medical literature also reflects a reality of larger numbers of transgender women seeking medical treatment which continues to this day, for example Bournemouth County in the UK recorded 853 sex reassignment operations took place for transgender women between 2000 and 2009, while only 12 operations for transgender men took place over the same period (Bournemouth, 2017). The reasons for this huge discrepancy are therefore probably much more complex than simply reductive sexism on the part of medical literature, and could involve several other factors, including the less advanced nature of medical interventions available for transgender men, possibly leading to fewer trans men choosing to transition medically. Alongside this absence, there is also a startling absence in the literature of acknowledgement of any racial or class
differences and the impact that these might have on gender non-conformity and access to medical interventions (Skidmore, 2011). However, these differences are apparent in their absence, particularly in the notable absence of any commentary around a court ruling in the 1950s on Ewan Forbes, a transgender man who was the first British person to legally allowed to change the sex on his birth certificate, in order to inherit his hereditary title (Playdon, 1996). This case should have set a precedent and thus enabled more British people to legally change sex, however the details of the case were kept secret in large part due to the very upper-class social position of those involved. This clearly shows the impact that class can have on gender identity within a wider framework of law, and thus the absence of this acknowledgement within the framework of medicine is notable.

With the increased medical awareness and provision of sex reassignment procedures for transgender people, there remained some push-back from some in the medical establishment, who perceived these procedures as unnecessary, or not a high priority. This came to a head in Britain in the 1990s, as health care rationing meant that some parts of the National Health Service were refusing to fund any form of sex reassignment surgery (BMJ, 1996). During the 90s, the NHS was experiencing a great deal of health care rationing, not explicitly to save money but instead to ensure equal access to healthcare provision for people in all areas of the UK, since before this point healthcare options had been vastly different from region to region (New and Klein, 1997). Three transgender individuals who had all been refused access to sex reassignment surgery through the NHS took their case to high court, and ultimately won. The presiding judge ordered that they deserved “proper treatment for a recognised illness” and that the funding authority had acted in a way which was “unlawful and irrational” (Dyer, 1999). This legal decision had a profound impact, firstly an immediate impact on the rights of British transgender and gender non-conforming people to access medical interventions through the NHS, but secondly this also had a knock-on effect in promoting the legal and ethical responsibility of medical professionals to provide treatment for transgender individuals. After this legal decision, wider medical literature no longer considered whether providing medical treatment to transgender patients in general was morally or ethically appropriate, this case firmly implemented treating transgender patients as standard practice, although in doing so also cemented the idea that gender non-conformity is a potentially pathological “recognised illness”.

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However, this was not the last conflict around treatment for British transgender and gender non-conforming people, and another shocking legal case came only seven years later, when one of Britain’s leading experts in gender dysphoria was charged with serious professional misconduct (Dyer, 2006). These charges were bought against Dr Russell Reid by five former patients who later regretted their sex reassignments and returned to living in their originally assigned gender roles. Many of Dr Reid’s colleagues in the medical community supported this charge, arguing that some of his medical decisions, such as prescribing hormones at a first appointment, were not “in line with good practice” (Batty, 2007). This concept of medical professionals as gatekeepers, who must test patients to ensure that they are truly in need of medical treatment for gender dysphoria has been increasingly prominent in the 2000s. Although access to medical treatment for gender dysphoria is now considered a right through the NHS, who is able to access this treatment, and the routes taken to access this treatment are still inexact and changeable. This gate-keeping is certainly found in transgender medical paradigms more than in other medical areas, with some clinicians arguing that access to hormone replacement therapy should be as closely guarded as methadone, while also acknowledging that many patients find this gate-keeping to be “unnecessarily strict, lengthy and humiliating” (Speer and Parsons, 2006). While this gate-keeping is certainly necessary to some degree to prevent patients from causing themselves harm through unnecessary irreversible medical procedures, this level of gatekeeping implies an inherent value judgement about the pain caused to trans and gender non-conforming people denied access to medical treatment compared to the pain caused to falsely-diagnosed cis people receiving unneeded medical treatment (Lane, 2018). While it is reductive to imply that gate-keeping is inherently bad, the level of watershed between treatment and non-treatment is certainly fluid and indicative of wider ideas of harm, bodily autonomy and gendered identity.

These gate-keeping practices can potentially be seen as an extension of the moralising attitude that medical practitioners displayed towards transgender and gender non-conforming people in the 1970s and 1980s, but there are also ways in which medical attitudes, and medical treatment options, are definitely evolving. One example of this is the ethical consideration of new types of treatment for transgender people, such as hormone-blockers for gender non-conforming children (Hruz, Mayer, and McHugh, 2017). This is a clear example of the way in which medical interventions and practices can grow and evolve in sync with
changing ideas of gender identity in wider society, and amongst transgender and gender non-conforming people themselves. In the UK, vastly increasing numbers of children and young people are accessing gender identity clinics to receive help for their gender dysphoria, on one hand this increase is due to a greater cultural awareness of transgender people through transgender activists and celebrities, however these children are then also able to access new medical interventions such as puberty-blockers due to medical innovations (Drescher and Pula, 2014). However, the issues associated with prescribing these medications to children go further than the impact of the medication itself. As one doctor who works in a gender identity clinic treating children writes that this can be “a medicalisation of the complexities of identity and once you have done that, you look only for medical solutions” (Adams, 2016). This can potentially be seen as a shift from gender non-conforming adults self-advocating for medical treatments towards an increased pathologisation of gender non-conformity, since through labelling children as transgender their identities are no longer in question, and the “problem” of potential ambiguity is resolved. However, the line between medicalisation and pathologisation is very thin, and only once larger numbers of young people receive medical treatments can the impact be truly discovered.

While there are certainly many issues with the medicalisation and early classification of gender non-conforming children, the availability of puberty-blockers to people who may benefit from these medical interventions is certainly a positive step. Another positive step in recent medical literature about transgender and gender non-conforming people is a wider range of literature approaching trans healthcare holistically and focusing on other aspects of trans people’s health which can be impacted by their gender identity (Gittner et al., 2015). A key example of this is new research into the higher rates of HIV in transgender communities, particularly for transgender women of colour, and research which argues for specific community-oriented interventions to prevent HIV transmission and encourage good healthcare practices for HIV positive transgender people (Heffelfinger et al., 2008) (Cahill, Valadéz, and Ibarrola, 2013). Other such examples are recent medical consideration of the needs of the ageing transgender population, and transgender veterans coming out of the armed forces (Burda, 2013) (Sharpe and Uchendu, 2014). This medical literature is a positive sign for transgender and gender non-conforming people in society, not only because it provides material benefits for trans people at multiple stages of life, but also because it is
essentially non-pathologising in its demonstration of a greater awareness that trans people have multiple stages of life, and have healthcare needs not merely relegated to their gender dysphoria.

In the wider medical community, recent changes have been introduced overall, which display an awareness of the way transgender and gender non-conforming people have been treated historically and create a statement about how treatment should progress in the future. One clear example of this is a recent change to the US Diagnostic and Statistical Manual for Mental Disorders, in which the category “gender dysphoria” replaced the previous category “gender identity disorder” (Moran, 2013). This change was also intended to be de-pathologising, place the onus of disorder on the negative feelings produced by gender dysphoria, instead of implying that being transgender or gender non-conforming was a disorder as a rule. A similar change also recently occurred in Denmark, in which the identifier of “transgender” was removed from being a medical diagnosis to a code on an individual’s medical record. In speaking of this change, a spokesperson for LGBT Denmark said, “We expect that transgender health care will move more toward informed consent instead of psychiatric evaluations” (Russo, 2017). These changes in the way in which transgender and gender non-conforming people are characterised global will potentially have a huge impact on the medical treatments, and routes to treatments, that trans people can undertake, and therefore a huge impact on people’s lives. While there is still a great amount of gate-keeping in place, the more recent medical literature produced in Britain indicates greater steps towards de-pathologising healthcare for transgender and gender non-conforming people, but changes such as those seen in Denmark do not seem likely in the short-term.

Analysis of the Interview

Before immediate analysis of the contents of the interview there is a small zone of cross-over between the interview and the analysis of available medical literature to be considered, the literature available online informing patients about the specific surgical department that this surgeon works in (NHS, 2018). This website is not only informative as background to the interview, but also provides a different form of medical literature, that aimed at patients rather than at fellow medical practitioners. One interesting facet of this website is its link to the World Professional Association for Transgender Health, who write
“persons must be able to express their gender identity freely, whether or not that identity conforms to the expectations of others” (WPATH, 2018). This is of course a notable and stark difference to earlier medical literature on gender non-conforming people, which placed a huge emphasis on a necessity for trans people to conform to wider societal norms. Another important segment is at the very bottom of the page and entitled “What surgical techniques are available for non-binary individuals?” and goes on to ask patients to “refer to the techniques described in both of the FtM and MtF sections of this website to understand the different techniques available to you, depending on what chest appearance most suits your own gender identity”. Medical literature, and indeed medical practice, focusing on appropriate surgical interventions for non-binary people is in its nascent stages and many non-binary people are advocating for increasing changes in healthcare to address this issue (Horncastle, 2018). However, the inclusion of this segment on potential surgical options for non-binary people on this website, while not necessarily indicative of the reality of said operations, is certainly a positive sign of ongoing change.

One potential reason for this discrepancy between the medical literature published academically, which does not mention non-binary people, and more practical medical information aimed at the public which does, could be based on the differing attitudes within the medical field. The interviewee spoke about these differing attitudes amongst medics arguing, “It does depend a lot on who they are, what area they’re working in… Other surgeons don’t blink, but GPs can be quite conservative, depending where they practice. Older doctors and doctors from more rural areas particularly, they frequently wouldn’t keep up to date with newer medical trends.”. While the majority of articles in medical journals are written by medical professionals who are either working full time as medical writers, or are based within academia, these articles are also specifically peer reviewed by other medical professionals, and letters in response to articles are frequently published in medical journals such as the BMJ (Schülenk, 2013). In addition to this, with greater numbers of journals now being published online, and an increasing push towards open-access journal publications, readership of medical journals amongst practicing medical professionals has increased in recent years (Godlee, 2008). However, this understanding of the medical field as a highly splintered practice is not something I had particularly focused on when analysing medical literature, and this brings into question the relationship between medical literature and the
medical field in general. While medical literature is certainly a reasonable litmus test of the discourses which are occurring in the medical field, it is perhaps not a reliable reading of the wide range of medical beliefs and practices which occur simultaneously within the realm of “standard practice”.

In examining the clear changes which have occurred in medicine over the years with regards to transgender and gender non-conforming people, it is reasonable to question which factors have promoted change, and which factors have hindered it. Alongside the geographical splintering of medical opinions, the interviewee also described the hierarchical structure of medicine as a major barrier to changing ideas about gender in medicine, saying “In medicine ideas take a couple generations at least to come through, and even [then] it’s not mainstream”, although she also stated that the strict hierarchies in medicine are much less prevalent now than they were during her time in medical school in the 90s. This issue of strict hierarchies in medicine is an issue which has been addressed numerous times over the years, however this was particularly focused on in the 1980s, where there was a push to embrace “evidence-based conclusions” over “authority-based opinions” in medical diagnosis and decision making (Davidson and Guzelian, 2012). While evidence-based medicine was first established in the 1980s to promote more neutral knowledge-creation in the medical field, the medical industry is still highly hierarchical, and the opinions and beliefs of older medical professionals are often highly regarded over equally or more valuable insights from younger medical professionals. These strict hierarchies have led to huge amount of inequality, for example, research into healthcare delivery systems in India showed that sexism from the highest medical authorities meant that women and girls received worse medical treatment from all members of the medical team, even from young, female medical professionals (Sen, Iyer and George, 2007). Not only can these hierarchies promote inequality immediately, but they also limit the ability of potential change.

When asked about which factors could be hindering change in opinion about gender non-conformity in the medical field, the interviewee mentioned hierarchies and also strict educational routes which impact on what information young medical professionals are exposed to. However, she also mentioned an underlying fear that many doctors had around gender non-conformity, a fear of accusations of malpractice. In the UK this fear is clearly linked to the infamous case of Dr Reid, as mentioned in the literature analysis, who left the
medical field in disgrace after being accused of malpractice while working in a gender identity clinic, however accusations of medical malpractice have increased in recent years, across many countries. A US medical malpractice lawyer described it thusly “Medical malpractice occurs when a health-care provider deviates from the recognized “standard of care” in the treatment of a patient. The “standard of care” is defined as what a reasonably prudent medical provider would or would not have done under the same or similar circumstances.” (Cheeks, 2013). This is obviously very worrying for anyone attempting to implement changes in the medical field, since any attempt to change the “standard of care” could be seen as deviating from this standard, and therefore would be open to accusations of malpractice. The interviewee had this to say “Probably not many professionals would openly admit that they think about malpractice. But is it a serious issue? Yes. Is it a factor in decision making? Definitely.” These words are backed up by historical research, which has found that in areas where malpractice suits are more common, medical professionals often practice “defensive medicine”, making more conservative and less patient-focused medical decisions, in an effort to prevent malpractice suits (Kessler and McClellan, 1996). The fear created in the medical field around potential malpractice lawsuits could certainly be creating an impediment to ongoing change in the medical field’s treatment of transgender and gender non-conforming patients.

Another limiting factor that the interviewee gave for changes to medical practices came from her positionality as a woman working in medicine, she stated “I think it’s more obvious to me being female, being a female surgeon in particular… There’s a lot of older, white men in medicine, and they can have a lot of prejudices that they don’t realise.”. This of course relates to the potential stratification of medicine, but it is also clearly important to question the gender, class, race, dis/ability etc. composition of the wider medical field, since this could potentially impact on how individual medical professionals approach change, and particularly change relating to gender and gender identity. The interviewee mentions her sometimes challenging positionality as a female surgeon, and it is important to consider that in particular women and people of colour often face prejudices within medicine, and before entering medical school, which has led to representatively fewer women and people of colour working as high-level medical professionals (Gray et al., 2004). Doctors who have not faced disprivilege are of course not inherently opposed to change, however as late as 1994, one
doctor published in a medical journal writing, “Under no circumstances ought homosexuality be regarded as anything other than a destructive habit system” (McColl, 2014), this attitude at this late time demonstrates how one individual’s prejudices can infiltrate wider medical literature and influence the wider medical community, reducing the likelihood of ongoing change.

Alongside these factors which reduce possibilities for change, there are of course many factors encouraging it. One of these obvious factors is the increasing awareness and availability of positive outcomes for transgender and gender non-conforming patients who have received medical interventions, which can work to reassure medical professions firstly that these changes are positive, and secondly that they are working within the realm of good standard practice. The interviewee spoke of the importance of this, and described her work giving guest lectures at medical schools, “I try to focus on the positive outcomes of surgery… a lot of people are able to live more fully after surgery.”. This wider awareness of positive outcomes of surgery, and other medical procedures, for transgender and gender non-conforming people is certainly related to the increasing numbers of these procedures being performed, since with a greater number of outcomes there are naturally more positive outcomes (Faucette, 2014). However, the “positive outcomes” created through medical and surgical procedures cannot be attributed solely to the interventions themselves. The interviewee described greater positive outcomes such as people being more involved in their communities, people able to work who could not before, and people becoming more physically active. While these outcomes are all partially based around increased mental health following medical interventions, there is also a firm social aspect to these outcomes. Therefore, it could be argued that there are now increasingly positive outcomes from medical interventions due to wider social changes meaning that transgender and gender non-conforming people are less likely to be ostracized after receiving medical treatment.

These greater numbers of visible positive outcomes are also working to encourage more young medical professionals to focus on areas relating to transgender and gender non-conforming medicine. The European Professional Association for Transgender Health has only organised conferences since 2015, and yet each conference has grown in size, and there is a large focus on initiatives for medical students (EPATH, 2017). Certainly, one of the reasons for this is the wider acknowledgement of positive outcomes, but it is also potentially
due to many young medical professionals being drawn to a field which they see as new and rapidly evolving. The interviewee spoke of these changing attitudes of medical students in discussing her own experiences in medical school, “I don’t think as a first-year medical student I ever would’ve thought I’d end up where I am now. Not that I would’ve been against it, it just wasn’t something I thought about.”. The growing awareness of transgender and gender non-conforming people in society could be impacting many younger medical professionals to consider this area initially, and the obvious changes which have occurred in the field over the previous 30-40 years could also encourage them to join a field which is observably more dynamic than other specialties. Encouraging young medical professionals to focus on transgender and gender non-conforming healthcare is vitally important for the future of the field, since British medical professionals often face immense challenges changing their specialisms later in life (Brown, 2010). In this way, change within the medical field can be seen as self-perpetuating, change producing change, as the evolutions which take place in this area encourage new and high-potential medical professionals to join, and thereby producing greater change going forward.

Results from Literature and Interview

The analysis of the historical medical literature gave an overview of the changes which have occurred within the medical field, and the interview gave an insight into which factors promote or hinder this change from occurring. The next vital stage is to draw these two analyses together, to try to distinguish some key results. The most obvious result is also perhaps the most ambiguous, which is the ongoing collaboration between the attitudes and actions of the medical establishment and the attitudes and norms of wider society. This is clearly present in the ethical and moral questions raised by historical medical literature throughout the 1960s-1990s wherein much of the medical literature considered medical interventions for the purpose of sex change to be inherently immoral, as the person would then not be able to integrate into the society of the day (BMJ, 1966). This dance between societal norms and medical practice can also be seen in the increasing medical technologies and innovations of practice, such as the new surgical options for non-binary people as mentioned in the interview, or the recent use of hormone-blockers for gender non-conforming children and young people (NHS, 2018) (Adams, 2016). These medical innovations are of course created by medical professionals working within the medical framework, however
these innovations are also created both due to the demands of individuals, and also due to the more liberal social attitude in the UK towards transgender and gender non-conforming people than previously. This unknottable link between the medical field and societal norms could be seen as an ambivalent conclusion, however, it is also an important conclusion to draw: that change within the medical field is predicated on societal change, and in turn societal change is predicated in medicine.

The second conclusion which has become apparent through this research is a more definitive trend over the course of recent medical history, a trend towards increasing de-pathologising of transgender and gender non-conforming behaviours and identities. Initially gender non-conformity was seen as so inherently problematic that medical practitioners worked to prevent patients from identifying or behaving in ways that were incongruent with their sex assigned at birth (Ellis, 1968); following this, medical attitudes evolved, however transsexual identities were still described as “a recognised illness” in Judge’s ruling on implementing treatment for trans people in the late 1990s (Dyer, 1999). However, there has been a strong focus on de-pathologisation in more recent times as the range of treatments available to transgender and gender non-conforming people, and the attitudes of medical professionals in general evolve away from seeing gender non-conforming identities as inherently problematic. A clear example of this is the recent DSM change from “gender identity disorder” to “gender dysphoria”, focusing on the pathology of the discomfort rather than the pathology of the identity itself (Moran, 2013). Even in more recent medical innovations which could be accused of pathologising, such as the use of hormone-blockers for gender non-conforming young people, the issue of pathologisation and the problems that accompany pathologisation are raised and discussed, and this discussion of the pathologisation itself can be seen as a useful tool in preventing this pathologisation from taking root (Hruz, Mayer, and McHugh, 2017). Although it is impossible to truly say that transgender and gender non-conforming identities will remain de-pathologised, at present it seems as though these identities are receiving increasing medicalisation and access to appropriate healthcare, and simultaneously de-pathologisation and thus less stigma.

The third conclusion that can be drawn from the literature analysis and the analysis of the interview is also a change that has occurred in the attitudes of medical practitioners towards gender non-conforming identities, but perhaps a subtler change, a change in focus
from a focus on the rights of society to a focus on the rights of the individual. This change can be seen quite starkly from medical literature of the 1980s which focused on the problems in wider society should transgender people allowed to be wed, and therefore using this as an argument against medical sex reassignments (Thomson, 1980), to the most recent literature which states that transgender and gender non-conforming people should receive medical treatment “whether or not that identity conforms to the expectations of others” (WPATH, 2018). This change from a focus on social norms to a focus on the needs and desires of the individual can perhaps be best observed with recent advances in surgical options for non-binary people, or for people who wish to transition sex medically but not socially (Rachlin, 2018). The combination of body, behaviour and identity created through these newer procedures would certainly be foreign to the social norms of most societies, even societies which are increasingly comfortable with binary-identified transgender people, however these procedures can be seen as a privileging of the individuals’ needs over the needs of society. This movement within the framework of medicine can be seen as a mirroring of a wider overall change, as shown in sociologist Durkheim’s theories that increasing individualisation is an essential component of capitalist modernity (Harms, 1981). However, whether this increasing focus on individual rights within transgender healthcare will continue, has yet to be seen.

Predicting Future Changes

Given the trends that can be drawn from this analysis of the literature and interview, these conclusions serve as a good foundation for predicting the directions that healthcare for transgender and gender non-conforming people may look like in the future. Firstly, since this research is premised on a British healthcare context, it is important to imagine a specifically British medical future for gender non-conforming people. One particular issue that will potentially arise is due to the trend towards de-pathologising transgender and gender non-conforming identities. As mentioned, the legal case which forced NHS medical facilities to provide gender-related healthcare for transgender people was essentially pathologising, based around the conception that gender non-conforming identities were inherently problematic (Dyer, 1999); this is a particular problem which occurs in countries with fully nationalised healthcare systems, wherein de-pathologisation could mean that gender non-conformity could become so de-problematised that it is no longer funded by the NHS. However, this link
wherein de-pathologisation = no longer a severe medical condition = no more nationalised healthcare funding is not necessarily so simple. The NHS treats an incredibly wide variety of medical conditions, including conditions which would not be widely be considered “pathologised”, although the metric used by the NHS to separate who receives treatment and who does not is certainly questionable at times. A good example of this is a case in which a man was refused bariatric surgery through the NHS on the grounds that he did not have a body mass index of over 50, but that in general “those who are less obese may apply and be funded if their case is ‘exceptional’” (Dyer, 2011).

However, examining the connection between de-pathologising and free healthcare for all reveals the dichotomy at the heart of de-pathologisation in nationalised healthcare systems. While the overall desire to change one’s body in certain ways, either through now-common cosmetic procedures or through sex-reassignment procedures, may become de-pathologised, in order to receive healthcare through a nationalised system, individuals must self-pathologise by demonstrating that the severity of their condition means they are eligible for treatment (Owen-Smith et al., 2013). This is due to the potential scarcity implicit in any nationalised resource, which then in turn necessitates gate-keepers to protect the resource from becoming over-used. However, this displays a huge potential contradiction in healthcare for transgender and gender non-conforming people going forward, in which de-pathologisation may increase overall, but this cannot occur within the framework of a nationalised healthcare system which relies on an modus operandi of resolving pathologies (Longley et al., 2000). The other current companion to a nationalised healthcare system is of course a privatised healthcare system, built around treatment not necessarily on the basis of mitigating harm, but instead on financial means. In a way this could be seen as a more beneficial option for gender non-conforming people, since the gate-keeping of self-pathologising is replaced by a gate-keeping of financial resources. However, there are obvious issues with this, as can currently be seen in the largely privatised healthcare in the US, in which transgender and gender non-conforming people of colour and low-income people face much greater social exclusion and experience greater rates of incarceration and poor mental health, in part due to their inability to receive appropriate medical care for their gender dysphoria (Jenness and Fenstermaker, 2014). The current healthcare systems seemingly do not allow for future possibilities in which all gender non-conforming could
receive medical treatment while remaining de-pathologised. It is certainly possible that a radical shift in future medical frameworks could take place to allow both outcomes to occur, but what this shift might be is at present unpredictable.

Moving away from this challenging inherent dichotomy in wider medical frameworks, another potential route forward in trans healthcare is greater moves towards an “informed consent model”, which is already growing in prevalence in many places in the US (Cavanaugh, Hopwood and Lambert, 2016). The informed-consent model only requires patients seeking hormones, and potentially other gender-related treatments, to sign a document stating their awareness of the potential risks and outcomes of the treatment instead of being prescribed these medications following multiple appointments with doctors and therapists. While this model of healthcare certainly provides easier access to patients wishing to acquire hormones this route also means that the medical professional is less at risk for charges of medical malpractice, since the clinical decision-making is enacted by the patient (Schulz, 2017). The informed consent model is also inherently de-pathologising, moving access to trans healthcare away from a more strictly controlled medical environment. The US organisation ICATH, which promotes the informed consent model, argues that “No one should have to go to therapy to prove their true gender, or to get permission to change their bodies.” (ICATH, 2018). The opponents of this model argue that the standard route is in place because it helps to protect individuals seeking these treatments who may later regret this decision, including people with serious mental health problems who have impulse control issues (Urquhart, 2016). However, while informed consent models could certainly increase the likelihood of harm caused to people who ultimately regret their decision, this model only reduces the pathology of bodily autonomy with regards to gender non-conformity to the same level as other semi-permanent decisions of bodily autonomy, such as face tattoos, which do not require medical consent.

The informed consent model of de-pathologisation and increasing bodily autonomy for gender non-conforming individuals could also be seen as linked to another potential future outcome for transgender healthcare, a merging of gender-related medical procedures into the wider field of cosmetic surgeries. Particularly in the US, there is already a merging of these fields, with plastic surgeons frequently using the same or similar feminizing techniques on transgender women as on cisgender women who wish to look younger (Mann, 2013).
Historically many transgender and gender non-conforming people have refuted the associations between gender-related treatments and cosmetic surgeries, arguing that for transgender people these medical interventions are necessary to prevent ongoing suffering, whereas “cosmetic” interventions are optional. However, not only does this argument call for self-pathologisation by transgender people who then must prove the “intense and intrinsic suffering of the trans patient” (Heyes and Latham, 2018), but it also disregards the other forms of non-gender-related dysphoria which can intensely impact on the lives of those seeking cosmetic surgeries. The necessity for this self-pathologisation is increased for transgender and gender non-conforming patients in countries such as the UK with nationalised healthcare systems, since if transgender healthcare is seen as non-essential, it could potentially be removed from the NHS and therefore become inaccessible to wide numbers of people. However, the NHS does in fact provide cosmetic surgeries to certain people, including nose jobs, liposuction, face lifts and breast re-shaping, on the grounds of significant risk to physical or mental health (Perry, 2014). In future, access to hormones or sex reassignment surgery could be seen as analogous to these cosmetic procedures, clinically pathologised in certain circumstances, but overall a free choice of bodily autonomy.

The potential future conflation between “elective” cosmetic procedures and “necessary” transgender healthcare hints at more than just a new medical attitude towards healthcare for gender non-conforming people, but it also hints at wider and more comprehensive beliefs about the positionality of gender and gender non-conformity. These greater possibilities can be seen as linked to Haraway’s ‘A Cyborg Manifesto’, in which she focuses on deconstructing rigid boundaries and categories such as those separating “animal” from “human”, and “human” from “machine” (Haraway, 1991). Although as previously indicated, current debates are preoccupied with even more minute rigid boundaries, such as those between “cosmetic” and “necessary” procedures, between deserving and underserving patients, the destruction of these minute boundaries is an important step forward to ultimately deconstructing larger boundaries. The possibilities for these ideological changes to be provoked by transgender theorising is very real. As Hayward and Weinstein write, it is impossible to “reduce(s) transgender to the suffixial -gender and neglect trans* as prefixal capacitiation for movement. Can we not concede that gender is a socio-political taxonomizing ontologically distinct from, if inextricably entwined with, enfleshed mattering?” (Hayward
and Weinstein, 2015). Potential future bodily interventions available for transgender and gender non-conforming people are not only exciting in the ways in which they could allow greater bodily autonomy for transgender individuals, but also in the way in which they could potentially remove the “gender” from transgender overall and help to further produce greater deconstruction of such categories going forward. If now-gendered bodily modifications in the form of hormones or sex reassignment surgeries became as commonplace in the future as tattoos or other cosmetic surgeries, it is not too implausible to think that ultimately gender could become un-entwined from its currently “enfleshed mattering”.

While it is perhaps drastic to take the conclusions reached from this interview and literature analysis and use it to forecast a category-less future free of rigid boundaries, it is also true that drastic new imaginings of transgender healthcare will be needed in the future, as vastly increasing numbers of people seek to access healthcare for their gender non-conformity. One British psychiatrist speaking of the increasing numbers of people accessing his help through a gender identity clinic said, “It obviously can’t continue like that forever because we’d be treating everyone in the country, but there isn’t any sign of that levelling off.” (Lyons, 2016). Of course, it is ridiculous to suggest that one clinic could treat everyone in the country, but perhaps it is not so ridiculous to suggest that everyone in the country could possess some form of gender non-conformity. While some traditionalist notions are still extant that transgender and gender non-conforming people are inherently biologically different than cisgender people (Bodkin, 2018), these notions have also been applied at various times to people of colour, women, and gay people who have all been labelled as inherently biologically “other” to various extents at various times. This comparison is particularly apt between transgender people and lesbian, gay, and bisexual people, who have often been categorised as an essentialised group, although there are roughly double the percentage of people identifying as LGB under the age of 35 in the UK than over 35, with this number increasing year on year (Siddique, 2017). This clearly shows that traditional normative boundaries of sexuality are increasingly being deconstructed amongst younger generations, as could occur with normative boundaries of gender identity. However, when traditional normative boundaries of gender identity and gendered bodies are deconstructed this produces not only a change in specific behaviours, but also provokes a change in fundamental conceptions of body, self and other.
Conclusion

Overall the results of this research are perhaps multivalent, however taking into account the analysis of the interview and the wider historical medical literature surrounding transgender and gender non-conforming people in the UK, certain clear trends can certainly be identified. Through identifying these trends, of collaboration with societal norms, de-pathologisation and increasing individualization, these tendencies can be extended forward. The result of which is an imagined future which could include a greater focus on the informed consent model, a deconstruction of the barriers between “transgender” healthcare and cosmetic surgery procedures, and ultimately less rigid perceptions of gendered bodies and a further deconstruction of categories of bodily identities; although this future also provokes fundamental questions regarding pathologisation and nationalised/privatised healthcare frameworks. While these futures can be imagined from the trends seen throughout the medical past, this is of course no guarantee for the future. In the UK the medical future is in more disarray than ever before, as the NHS faces an ongoing funding crisis with no end in sight (Puttick, 2018). There are of course also specific dangers for the future healthcare of transgender and gender non-conforming people, which as this research has shown, is closely linked to societal norms. A clear example of this comes from the earliest medical history for transgender and gender non-conforming people, the works of Magnus Hirschfeld, which were ultimately destroyed or lost following the rise of fascism in Germany (Vendrell, 2018). Although this rapid societal change could be predicted in retrospect, at the time it was shocking and completely redirected the trajectory of medicine for transgender and gender non-conforming people. Hopefully such a horrific and violent period in European history will not repeat itself, but the line of history rarely completely follows neat and predictable trends.

The conclusions drawn from this research are solid in themselves, but also certainly hint at the benefits of future research in this area, and unexplored alleyways of connected possibilities. Clear examples of possibilities which could have been explored include the recent innovation of the world’s most extensive penis transplant, which has recently taken place on a member of the US military who had lost his penis due to an injury in Afghanistan (Neergaard, 2018). This could have been used as a starting point to further explore the connections between gender-conforming people and these surgical and medical procedures generally linked to gender non-conforming people; it could also have been used to talk about
bodily “wholeness” and narratives around injury and gendered bodies. Another unexplored direction would be to discuss in more detail other forms of bodily modification, done for experimental and artistic reasons, such as the work of the artist Orlan, and the connection that these incredibly personal and controversial surgical interventions have with ideas of bodily choice and what constitutes as “harm” to one’s body (Jeffries, 2009). These examples widen the frame away from specifically exploring transgender and gender non-conforming people’s medical experiences but would potentially add great depth to our understandings of gendered medical experiences, gender-normative constructions of “harm” and narratives around bodily autonomy. A final more concrete imagined piece of research could take the research lens away from the medical field itself, and instead work with transgender and gender non-conforming people themselves, gathering information about what medical interventions are most important, and what ideal medical futures they would aspire towards. Ultimately, the future of the medical field is not decided by the medical field itself, but instead co-created to respond to the needs and desires of society.
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Interview Guide

Overall Guide Key Research Questions

“What changes have occurred in the attitude of medical practitioners towards transgender and gender non-conforming people? How have new ideas about gender non-conformity spread throughout the medical community? What changes are likely to occur in how gender non-conformity is perceived by the medical field going forward?”

Introductory/Life History Questions

1) What first interested you in pursuing medicine?
2) What was the overall process of training to become a surgeon like?
3) Why did you choose to focus on chest/breast surgery?
4) When did you first learn about transgender people in medical school?
5) How did your friends and family react to your decision to focus on transgender healthcare?

Medical Attitudes towards Transgender People

1) What range of attitudes about transgender people exist in the medical field?
2) What do you think impacts on how medical professionals think about transgender and gender non-conforming people?
3) Do you think attitudes towards transgender and gender non-conforming people have changed since you first entered the medical field?

Factors Influencing Change

1) How do you think attitudes towards transgender people in the medical field have changed over time?
2) What factors do you think help these changes?
3) What factors do you think hinder these changes?
4) How do you think that gender will be perceived in the medical field going forward?