

Monopoly and Power Implications for Trans Health Care Specialists Working in a Centralised Setting: A Qualitative Study

Brogan Luke Geurts and Timo O. Nieder¹

Abstract

In the last decade, the range and number of people accessing trans health care has increased at a faster rate than previously. Globally trans health care is commonly used as a requirement for trans people to access legal gender recognition. In Europe, trans health care is often provided within centralised health systems by a limited number of specialist teams placed in monopoly positions. Through a qualitative study, we sought to understand the relationship and role these teams have with legal gender recognition. We conducted in-depth interviews with a team located in Central and Eastern Europe and consulted with local key informants working in trans health advocacy outside the team. After applying qualitative content analysis emerging themes comprised three sections: the team in context; conceptions of trans health care; and beyond the clinic.

Findings indicated that the team conceived trans identities and clinical needs in a medical framework that correlated with the process for legal gender recognition. This followed a similar historical progression across Europe. As the few respected specialists in the country, the team influenced care regulations within the ministry and held a monopoly position. While reform of some regulations was seen as needed, they were met with challenges within the health system and field. These challenges were, however, found to reflect trans health care globally rather than the team itself. Our findings suggest comparisons could be drawn to similar positioned teams throughout Europe regarding decision making, power, and influence. Increased transparency and cooperation between local trans communities and health care providers will be vital.

Keywords

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Health systems, gender identity, transgender, Europe, jurisprudence

Biography

Brogan Geurts is a community based public health specialist and researcher focused on patient-led access to health care, sexual health, harm reduction and human rights. Brogan holds an MSc in International Health and PgDip in International Public Health from Charité University of Medicine Berlin. Brogan has a background in anthropology and has worked in non-governmental organisations and projects in East Africa, the Balkans, Western Europe and the United States. Brogan is an adjunct faculty member in Global and Community Health at the Center on International Educational Exchange (CIEE) Berlin as well as a researcher in the Evidence-based Public Health unit of the Center for International Health Protection (ZIG) at the Robert Koch Institute (RKI), Germany's national public health agency.

Timo Nieder PhD, conducts health services research in the area of transgender health care and sexual medicine/science. Timo is a clinical psychologist, licensed psychotherapist, and sex therapist, both certified through the EFS/ESSSM (ECPS) and the German Society for Sex Research (DGfS). Timo is head of the Outpatient Unit for Sexual Health and Transgender Care at the Institute for Sexual Research, Sexual Medicine and Forensic Psychiatry and 2nd Spokesperson of the Interdisciplinary Transgender Care Center Hamburg, both located at the University Medical Center Hamburg Eppendorf (UKE). Timo is board member of the European Professional Association for Transgender Health (EPATH) as well as principal investigator of www.TransCareCovid-19.com (Measuring the impact of the COVID-19 pandemic on trans health and trans health care) and www.i2TransHealth.de (Interdisciplinary, Web-based Trans Health Care: A Randomized Controlled Trial).

Introduction

Trans people encompass a wide variety of people whose gender identity does not fit society's expectations in relation to the sex and gender roles they were assigned at birth (European Union Agency for Fundamental Rights [FRA] 2014, 14). Trans serves as an umbrella term for a range of historical and emerging terms such as transsexual, transgender, gender non-conforming, genderqueer, non-binary and gender diverse (unless otherwise noted, hereafter trans) (Thorne et al. 2019)². People may identify within the gender binary (male/female), between or outside (Motmans et al. 2019). Some people require a combination of medical services such as taking hormones and having surgeries to change their bodies to more properly fit their gender identity and expression (hereafter trans health care); others may opt for no, little, or only some types of medical services. While some services are considered a medical necessity for some trans people, not all trans people require related medical care (James et al. 2016; Nieder et al. 2019).

Provisions of trans healthcare vary throughout the world (Coleman et al. 2012). In the United States of America, much care is provided in community health centres. In Europe, specialised centres, set in a research setting, tend to provide the majority of care (Deutsch et al. 2015, 2). In other parts of the world, care is either limited, non-existent or provided solely through private clinics (Wylie et al. 2016). In most countries around the world, unregulated and medically unsupervised services are presumed to take place (Mepham et al. 2014; Winter et al. 2016).

Centralised specialist centres in Europe often hold a level of monopolised power over trans healthcare in their respective countries (e.g. Denmark, The Netherlands, Norway, Serbia). These clinics face challenges and criticism in meeting patient demands (Hartline 2019; Krumsvik 2019; Nord 2019; Open Society Foundations 2013; Sharpe 2017; van der Ros 2017). In recent years, the field of trans health, research, visibility and rights has gained momentous traction (Bockting et al. 2016; Motmans et al. 2019; Sweileh 2018). Likewise, the number of trans people seeking and accessing services has been increasing at a faster rate than previously seen, and the recognition of a broader range of trans identities and needs has expanded (Arcelus et al. 2015; Bouman et al. 2016; Eyssel et al. 2017). Discourses

² Under this umbrella term we do not imply a distinction between people with an ICD-indicated gender-related diagnosis and those without.

regarding standards of care and legal reform have simultaneously followed to the forefront.

In several countries, trans health care is used as a benchmark for individuals to legally change their gender and/or name on identification documents (e.g. passport or identification card) (Castro-Peraza et al. 2019). Commonly referred to as legal gender recognition, the process has implications for trans people's ability to maintain healthy livelihoods, in areas such as employment, privacy and adequate health care (Winter et al. 2016). Typically, these benchmarks correspond to somewhere along the classic trans health care trajectory, starting with a mental health diagnosis and moving towards genital surgeries (Wylie et al. 2016). Historically and until now, countries have required medical interventions up to the point of sterilisation, while other countries lack a legal process entirely. Some European countries have started to move away from medical requirements by adopting a self-determination model or relying on a mental health diagnosis alone (Chiam et al. 2016; ILGA-Europe 2016; Transgender Europe [TGEU] 2019; Winter et al. 2016). In all of these cases, health care professionals and specialist teams have played a role through providing and confirming these requirements at some point.

Medical requirements have come under critique for violating human rights and being non-inclusive, with the self-determination model being preferred (Castro-Peraza et al. 2019). The World Professional Association for Transgender Health (WPATH), an interdisciplinary and professional organisation, has opposed surgical requirements since at least 2010. In 2015, they stated: "No particular medical, surgical, or mental health treatment or diagnosis is an adequate marker for anyone's gender identity, so these should not be requirements for legal gender change" (Green and World Professional Association for Transgender Health [WPATH] 2015). In April 2017, the European Court of Human Rights, in the case of *A.P., Garçon and Nicot v. France*, deemed the requirement of sterilisation to be a violation of the Article 8 Right to respect for private and family life under the European Convention on Human Rights (2017). Other medical benchmarks, such as a mental health diagnosis or examinations, were not deemed a violation (European Court of Human Rights [ECHR] 2017).

Criticisms and changes in requirements for legal gender recognition have come with a combined critique of trans health care (66th World Medical Association General Assembly 2015; Basterrechea et al. 2016; Hammarberg 2009; Office of the United

Nations High Commissioner for Human Rights 2015; Open Society Foundations 2014). Access to trans health care in and of itself can be particularly challenging and met with obstacles, including lack of resources, knowledge and quality services across Europe (FRA 2014; Winter et al. 2016; Wylie et al. 2016). Following these expansions and criticisms, the level of impact centralised trans health teams have on provisions of care and legal gender recognition is of interest. The present study aims to explore this relationship and the possible consequences of a centrally located monopoly team in Europe retrospectively. In order to do so, we have chosen a specialist trans health care team located within Central and Eastern Europe as a case example.

The chosen specialist team's operates in a country with a gross national income (GNI) between \$4 126-\$12 745 per capita in 2013 and an unemployment rate of around 20%, that is particularly high among youth (above 40%) (Organisation for Economic Co-operation and Development [OECD]; Blinded reference 1, 2016)³. Structured as a Bismarck model, the country's health system is a centralised health system with a public health insurance fund (Blinded reference 2, 2014). Medical staff are considered to be well trained. However, the health system is underfinanced and corruption has been considered to be wide-spread (Blinded Reference 3, 2017). In the last decade, trans healthcare has been approved to be mostly paid for by the national health insurance (Blinded reference 4, 2012). In 2016, the country was among 23 countries in Europe that required sterilisation for gender recognition. In 2018, they were among 33 countries that require a mental health diagnosis in Europe (TGEU 2016; 2019).

Methods

Methodologic Approach and Study Design

In-depth interviews were conducted with the chosen team of gender specialists in the country described. As the research field is sparse, we chose a qualitative study using in-depth interviews and content analysis in order to inductively build a framework to conceptualise the relationship and "systematically describe the meaning of qualitative data" (Cho and Lee 2014, 170; Schreier 2014). This approach allows for understanding

³ References have been blinded in order to anonymise the study country. A full reference list can be requested from the corresponding author.

the experiences and the relationship from the practitioner's point of view rather than from outside perceptions (Charmaz 2014).

Recruitment and Sampling

All known members of the team were approached for interviews as well as two people known to be working with trans healthcare at the community level (key informants). Team members were identified through their public self-identification with the field, referral from their colleagues or key informants. 88% of the known team participated in an interview and consisted of mental health and surgical care professionals.

Key informants were sought as a means to achieve data triangulation and reflexivity with interview data. This was additionally chosen as means to verify possible participant bias and socially desirable answers. Key informants were selected due to their roles as professionals working with trans healthcare outside the traditional medical system (e.g. international and local trans advocacy non-governmental organisations (NGO), community organisations, within peer-support groups, and researchers) as well as working with trans specific legal reform inside the country and abroad. This has provided a local community and patient perspective as a means of triangulation and reflexivity. Key informants were additionally selected due to previously established rapport with the researcher. Key informants participated in semi-structured and casual conversations (e.g. Skype, email, scheduled meetings, professional events).

Ethical Considerations

Since the specialists discussed in this study are working in a controversial and limited field (such as transgender health care) and are subject to high vulnerability, participants were anonymised. Lack of anonymity would increase the risk of being recognised based on their statements and accordingly receiving negative consequences. This has particularly high importance in an area of health care that faces social-political obstacles and has a limited number of professionals. In order to achieve anonymity, we removed the name of the country, the institution and background information on the political situation and specific legal regulations in this country. Information provided about the country context has been provided broadly.

References that have the potential to identify the participants or the country have been blinded throughout the study as well.

The purpose and design of the study were explained to each interviewee and informant in writing before scheduling interviews. Written and oral informed consent was obtained before each interview, including consent to be identified by profession and to be quoted. Informed consent was sought in the same manner from key informants.

In order to respect participants' right to privacy, confidentiality and anonymity, we have opted to refer to participants as a group rather than as individual pseudonyms or characteristics. We believe pseudonyms or other individualised characteristics, such as speciality, would not suitably achieve anonymity. We have opted for describing participants as a range of professionals as well as presented data without participant numbers in order to further avoid identifying data to specific individuals. We understand that complete anonymisation in any type of qualitative research is difficult and we have strived to ensure confidentiality and anonymity in the best way possible.

Data Collection and Analysis

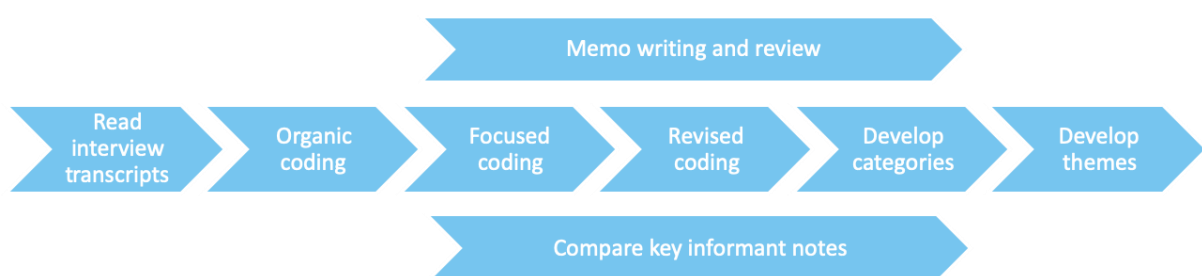
Following background research and a literature review, a general interview guideline was developed in collaboration with both authors and consultation with key informants to ensure local and cultural context. Focused questions were developed for individual specialties (i.e. surgical specifics) and taken into consideration during interviews. Interviews covered four main themes: the history and structure of the team; service provision and patient range; challenges; and future developments.

In-depth semi-structured interviews were conducted in English with 8 members of the team by the first author between 20 February - 11 April 2017. Each interview lasted on average 57.57 minutes (9 min – 97 max, Median = 55, IQR 42 – 85, n = 7). Four interview partners were interviewed in groups of two, based on availability and their working relationship, while the rest were interviewed individually. This variation in interview structure thus impacted both the standardisation of interviews as well as the amount and type of information shared

by each interview partner. Data saturation was considered to be reached when 80% of known members of the team were interviewed. Discussions with key informants took place on-line and in person in the country prior and during the interview period.

Using MAXQDA Plus 12.3 (VERBI GmbH Berlin 2017), an inductive content analysis was applied in order for key themes and concepts to emerge (Elo and Kyngas 2008; Mayring 2010). Each interview was transcribed verbatim and then read once for accuracy and once for content. Transcripts were organically coded by assigning a descriptive term for each relevant passage of text. Summaries of each code were then read, compared for consistency and recoded for any mistakes or duplicates. This process was duplicated in a focused manner for additional continuity and reflection, resulting in a coding scheme. Codes were reviewed by a fellow student and discussed for bias and reflexivity. Memos were additionally attached to blocks of text with either key findings, need for clarification, or direct connection to other participants. Key informant data was utilised as cross-reference data for triangulation, participant bias and a level of community perspective, rather than explicitly as primary source data. Codes were grouped into categories and reflected between researchers and the fellow student. Categories were ultimately organised into overarching themes and discussed. See figure 1.

Figure 1 Overview of data analysis



Findings

As a result of applying qualitative content analysis, a descriptive section was identified followed by four main themes: provisions of care; ensuring and improving

lives; interests of the team; and structural restraints and barriers. Main themes were disaggregated into two main sections (Table 1).

Table 1: Summary of Results

Section	Emerging Themes
I: The Team in Context	
II: Conceptions of Trans Health care	Provisions of Care
	Ensuring and Improving Lives
III: Beyond the Clinic	Interests of the team
	Structural Restraints and Barriers

Section I: The Team and Services in Context

Trans people living in the capital received a referral from a general practitioner or another psychiatrist. Patients outside the capital were referred by a psychiatrist and then approved by a commission prior to referral to the team. Care followed a 3-stage linear path which begun with a psychiatric and psychological assessment lasting a minimum of 1 year. Following the assessment phase, a minimum 1 year of hormone therapy and recommendation letters from approved psychiatrists, the patient was able to undergo gender affirmation surgery. Following the surgery, transition was considered complete and would allow for the possibility to legally change one’s gender marker.

Section II: Conceptions of Trans Health care

Provisions of Care

The team perceived and provided care in a way that was informed by their past clinical experiences. They had a goal to make a consistent and correct diagnosis and promote healthy social functioning. This was seen as a way to prevent trans people from making, what they considered, could be a life altering mistake - thus putting the

team a decision-making role. The team recognised their primary work with individuals they described as transsexual² with a goal to undergo genital surgeries, complete their transition and ultimately allow for legal gender recognition. Key informants expressed that they knew of a number of people who felt they had to alter their narrative to clearly express a desire for lower body surgeries in order to receive some level of care, such as hormones.

“We have to do two things which are a great responsibility, identify transsexualism [and make a diagnosis], if we make a mistake and a person is only transgender and not transsexual then the operation would make him miserable. The other responsibility is his life afterwards, this real-life test, this assessment period is for all of us to see whether after the surgery he would be miserable because he would have lost his family support, supportive friends, had nothing to eat because he had no money, no job so what use could it be?”

“There are some, probably some people [who express not wanting surgery] but we usually deal with patients that want to pass all three [stages], at the form of extreme transsexualism, severe. I mean they are only referring to us or coming to us if they think about an operation.”

Assessments were used as a means to be confident that the person’s identity is what the patient thinks and treatment is necessary. However, practitioners recognised that evaluations and tests were unable to rigorously diagnose a patient and depended on clinical experience.

“Usually I refer them to a psychologist to do some testing, not because these psychological tests will show that they are transsexual because they don’t, until now there is no such refined test that can show us, it’s just clinical experience.”

Doctors had particular concern that patients could either have compounding mental health issues or regret undergoing genital surgery. The team recalled cases of reversal or retransitions surgeries, such as phalloplasty following a vaginoplasty. This type of case provided justification for time bound assessments. At the same time, it was found that the team had a slight variation in their strictness of specific requirements. Key

² Participants have made a distinction between transsexualism and transgender in line with the historical progression of medical classifications. Transsexualism is distinguished from transgender by people who wish to undergo lower-body affirmative surgeries, whereas transgender more generally refers to people who identify as a different gender than assigned at birth (see discussion).

informants referred people to members who they felt had 'updated' and more flexible practices. Some practitioners recognised that patient identities were changing and that they needed additional experience, reflecting on their confidence to diagnose patients. This demonstrated an understanding of their limitations as a team and room for growth.

"Most of our patients are what we called in the past true transsexualism, meaning with an early onset of gender dysphoria. We still don't have that much patients of non-binary, genderqueer and so on. They are just starting to come in this previous year or so. Which is quite a different picture ... I suppose that we have to be prepared and educated for this because we don't have any experience."

Ensuring and Improving lives

The team further emphasised the difficulty of transitioning within the context which was then reflected in some of their practices and intentions. The important role of the family culturally and economically influenced patients, both adolescents and adults, to be open about their identities to their families before transition and led to the team partly questioning patients' autonomy in doing so. Depending on these circumstances, outing oneself could be a requirement to continue care. The team also recognised an informal type of gender recognition documentation used that would later translate into the legal framework. These two examples show reflection upon their influence.

"Many of them come to us and their parents still don't know about the problem they have. So, the first thing is go back and tell your family, if they are not already independent or they live away from the family, I mean how can you go operate yourself and then visit your family and say "I'm a female now" or "I'm a male now"."

"We have one specific [example] in the social context where they start with the hormone treatment. I put on some small paper, some report, that they are diagnosed with transsexualism and they are on endocrinology treatment. I say to them to put that in their wallet and if they go out to some party and suddenly the police make some control or otherwise. They always try to communicate that stuff with the policeman but if they have problems I said "You put this out and show them" and it goes well!"

Key informants confirmed that this informal type of legal gender recognition was useful and accepted as a way to have documentation if legal gender recognition was not available legally.

Section III: Beyond the Clinic

Interests of the team

While the team's reflections on society influenced some of their informal clinical practices, the team had also defined and influenced regulations within the Ministry of Health. Following the adoption of a new health insurance law, regulations determining service provision were set forth by the ministry. According to the team, the regulations were developed by a newly established board within the ministry which consisted of a majority of the team. This concurrently approved the team as the sole providers of trans health care in the public scheme by the Ministry of Health.

"We made some practical guidelines within the Ministry of Health how to explore and how to treat those patients from the very beginning till the end. Our clinic and [names omitted] are the [omitted] clinics that are certified from the Ministry of Health to do the exploration and proposal for treatment, so that's the fact that all people from all [over our country] are coming here and [omitted]."

Key informants noted that only permitting the psychiatrists in the team to provide an initial diagnosis within the national health insurance functionally maintained a monopoly. This further meant that they were the only psychiatrists permitted to write surgery recommendation letters for similarly approved surgical team members. Key informants expressed additional concern that this made it difficult for patients to feel in-control of their transition options because the limited team was the only approved individuals to provide care. They also expressed concern that this affected some patients feeling that participating in research by the team was not in-fact voluntary. This was further influenced by long waiting periods and team members also working in private practice. Both the team and the key informants recognised that there are other surgeon(s) working privately outside the team; however, they had lost professional contact and believed they were primarily attending to patients from abroad.

Almost every member recognised that they were working in both public and private practice. Key informants expressed additional concern that patients can feel pressured to go to private practice in order to receive more flexible and timely care. This was similarly recognised by at least one practitioner and influenced their response and understanding of their role. Others recognised the dual role in a way that encouraged them to work in public and private care.

“I was part of a team involved in both places, professional team and in health insurance, we were supposed to see whether transsexual clients have all sufficient conditions to go for surgical treatment. So I thought it was a conflict of interest if I was in private practice, I mean there is no rule but I know my clients might think that I am there so they have to go to my private practice in order to get a signature from me, so now I am completely in private practice.”

“[Colleague] was insisting in doing the surgeries in public hospital for these people because if you look at economical way for me it is much better to work in private hospital where I will get paid for the surgery. My interest, is not to work without specific salaries as so I have private patient who is paying, I am getting a percentage.”

Despite their role in private or public practice, their role within decision making and the ministry gave them a respectable level of medical authority and authenticity for disseminating socially acceptable knowledge.

“The other thing that is pretty important is that the ministry of health have accepted and certified us, it gives the opportunity that we can speak about these phenomena ... for our country it's extremely important if someone will listen to you and accept what you are talking about.”

This approval provided the team with a level of validation and showed an understanding of the importance of their role.

Structural Restraints and Barriers

Structural restraints and barriers had a potential impact on the team's ability to further change regulations within the ministry. There was a need to fight for prioritisation of the issue within a strained system and against other professionals. However, despite challenges that were unique to the context, practitioners recognised that the field is challenging and widely misunderstood globally, highlighting that this was not unique to their country and therefore made their role increasingly important.

"Well we always have challenges because this is a quite edgy team and controversial team and controversial country where we live. When you have all the paradoxes here, you have storming's and fightings and everything ... We all have the controversies why should we do some financial to this thing, so you have to explain that again and again, why it's useful, why it's good you know ... General practitioners of psychiatry [within our country], do not know anything about this and how to explore thoughts."

"First our colleagues not only in [our country] but I mean all over the world really don't understand the small differences between the terms [gender dysphoria, gender identity disorder, homosexual, transsexualism] so this is why we need to make [ourselves as a team] more approachable to the community."

The team and key informants recognised that providing trans healthcare had improved since there had been insurance coverage of services. However, they mentioned a number of persisting challenges, predominantly due to the structure of the health system and regulations set forth. Resources were a key challenge in terms of services that were covered, as well as a need for more individuals approved to provide care, highlighting their strain as a monopoly.

"As the number of patients are growing we will have to do something in the future but we have to cover a lot of technicalities relating to other parts of work that we do. ... To have more time and more persons involved would be great, that is most important, the time we need and the persons involved that's the main thing and it's a challenge how to accomplish this."

The team identified that as trans healthcare has evolved the regulations have become limiting and may have been not solely determined by the team. Some participants identified how the lack of formal legal gender recognition policies along with informal sterilisation requirements limited flexibility in options for their patients and also violated their rights. They further stated that changing this law could be beneficial to

patients and the transition process but needed to be strategic and timely to be successful.

“You also have certain percentage of patients that stop after doing the top surgery, they don’t wish to have genital surgery and it is not something that they have to do, but according to the law in [our country] they won’t be able to change their legal documents. For example, they can change the name to take a unisex name but they would stay female because they still have female reproductive organs... First it has to be legally changed, first because now they cannot get the new documents without completing all steps, like psychiatrist, endocrinologist and complete surgery, not to have anymore any signs of the previous gender. So, if that changed then the patient has more possibilities to choose ... The law needs to give the possibility to for example not remove the uterus and the ovaries if they want because if they want to preserve their fertility even according to all laws everybody has the right to be parents.”

“This [assessment time frame] is regulated by the ministry to be one year, that is the period of time ... The challenge is that we have an urge for mastectomy in patients before [hormone] therapy, they have that need, but we don’t have the guidelines, the ministry didn’t allow that for them at this moment.... We have to work on trying to change that in future, but we have to do slowly step by step if we want to be accepted. For example, there are some this these activist’s organisations they want to fast and now alarming and screaming for that but it’s not smart to do it like this.”

Key informants expressed that the team supported a new bill on legal gender recognition drafted by NGOs but also felt they were not transparent enough about their role within making regulations and policy recommendations. Both the team and the key informants expressed that they felt they did not always understand each other, especially regarding priorities. They did however cooperate and have a positive working relationship.

“Our cooperation with NGO’s in some things we do, we cannot find agreement, and I feel we do not maybe understand each other. This depathologising trend is something ... it has to be a kind of something if you need treatment for it you know.”

“A couple of months ago one of the leaders of one of the LGBT associations from [our country] ... they were trying to remove the word disorder or remove actually transsexualism from the ICD at all, like to remove it because it is not considered as a disease, it is a state but not a disease ... so I mean okay if you remove all of that from everywhere so it is not a disease, it is not a disorder, it's not anything. What are we treating then?”

This discrepancy can illustrate how NGO's and people outside the clinical field influence their opinions but also reflects their role within trans health care and the influence they have.

Discussion

This study explored the relationship between a monopolised trans health service in a centralised health system and their impact on provisions of care and legal gender recognition. Our findings suggest a correlation between how the team conceived trans identities and clinical needs with the process for recognition. The team stated that as the respected specialist in the country they had an influential role, particularly in creating recommendations and regulations. Reform of some regulations was seen as needed but met with challenges and kept within a medical context.

While some patients began to express a desire to not receive surgery, the team saw their work primarily with patients they described as transsexual. Participants made a distinction between 'transsexuals' who wish for a number of surgeries and 'transgender' people that may not have a strong or initial desire for surgeries. This distinction informed the prescribed transition path and how care was provided by some of the team and could limit access to care and legal recognition for people who do not identify as transsexual (Motmans et al. 2019; Thorne et al. 2019; van der Ros 2017). This understanding of gender identity can be reflected in the changes in the International Classification of Diseases (ICD) from 'Gender identity disorders' (F64) and 'transsexualism' (F64.0) in *Chapter V: Mental and behavioural disorders* in the ICD-10 to 'Gender Incongruence of adolescence or adulthood' in *Chapter 17 of Conditions related to Sexual Health* in the ICD-11 (World Health Organization 2016; 2018).

The team recognised trans people as needing medical care to treat and cure a diagnosis through long-lasting medical changes; otherwise, they did not understand the purpose of providing clinical care. Thus, putting gender identity into a medical framework excluded people who do not require medical care. This was highlighted through the understanding of their role and responsibility in making a correct diagnosis. However, they stated that there is no test to diagnose being trans and therefore it requires first-hand clinical knowledge and experience. This finding was emphasised through the practice and regulation of conducting an assessment for a minimum of one year before beginning hormone treatment. This practice has been criticised for delaying care as hormones are a common motivator and entry point for trans people to seek care (Deutsch 2016, 201).

Although seen as assisting patients in navigating transition in a challenging context, benchmarks and encouragement of coming-out has been noted as paternalistic and a way to question patient autonomy. These practices are known to influence a patient-provider dynamic in which patient narratives are “likely to lead to very schematic presentation of people’s personalities” (Nieder and Richter-Appelt 2011, 232). This was a matter of concern for key informants regarding patient decision making and the level of gatekeeping power the team holds. As Fraser (2015 abstract) stated, trans health care has evolved from “a binary to a spectrum approach of gender and the corresponding change from a sex-change and one-size-fits-all model of medical treatment to the currently broader and individualised approaches to health care”. Thus, this understanding of confirming trans identities through linear medical-related benchmarks can be viewed as outdated.

Participants recognised changes in the field and the need for more flexibility in the regulations, such as mastectomy before hormones or an easing of which surgical procedures allow for legal gender recognition. However, these provisions of care appeared to directly correlate with the regulations that guided the team. It became evident that a number of the team were the individuals approved by the Ministry of Health to provide care, made up the board within the ministry, and had an initial influence on the regulations. The finding that one participant felt a conflict of interest as a board member developing regulations while also working in public practice pointed to the extent of self-regulation and justification. Interestingly, the self-influenced regulations of medical-related benchmarks additionally correlated to the same benchmarks used for approving legal gender recognition.

Key informants showed concern that this dual approval essentially made the team a monopoly. This was illuminated through their sole approval to provide care including writing recommendation letters for surgery. Their relationship with NGOs expressed a power relationship and varying opinions in regards to timing, priorities and the necessity of changes.

The use of an informal gender recognition method through providing documentation once hormones were begun showed that the team recognised their influence and the immediate ways that they can act. This type of documentation could be correlated with changes across Europe allowing for legal gender without or before surgery (Chiam et al. 2016; ILGA-Europe 2016; TGEU 2019; Winter et al. 2016).

This finding of monopoly and power drew attention when a consortium of NGOs released a press statement prior to the amendment of the law kindly asking for a meeting with the relevant ministries and the board. They cited concern that the process had been secretive and non-inclusive as well as arguing that proposed gender recognition required surgery and sterilisation, legally mandating that team members must provide the services (Blinded reference 5, 2018). Thus, it reinforced the monopoly and restricted care to the team's location.

The country has since removed sterilisation and surgery as the sole benchmark for legal gender recognition – an improvement in accordance with the ruling in *A.P., Garçon and Nicot v. France* and human rights (2017). However, as of 2018, they were among 33 countries in Europe that require a health-related benchmark of a mental health diagnosis which was deemed an inadequate marker of gender identity by WPATH in 2015 (Green and WPATH 2015; TGEU 2019). According to one report from a consortium of NGOs published after the research, care is more accessible to a wider range of patients and identities in 2018 (Blinded reference 6, 2018).

This study was unable to conclude the direct role the team had in formulating legal gender recognition laws; however, their position and historical influence suggests that some involvement is likely. We believe that interviews with the team coupled with perspectives from key informants have provided a perspective that is unique in understanding how trans health specialist and care provisions can correlate with legal gender recognition processes.

Limitations

As the field of trans health care has continued to rapidly evolve, the study would benefit from follow-up interviews. Inclusion of lawmakers and members of the government would have provided an additional perspective on the influence of the team. Direct inclusion of patients would have been beneficial to gain first-hand accounts of receiving care and applying for legal gender recognition. Inclusion of key informants was, however, used as a data proxy. Interviews varied in the number of people and the interview guide was adapted to each speciality, therefore interviews became non-standardised affecting the amount and type of data from each interview. Similarly, consultations with key informants took place offline and online and were non-standardised, limiting the data collection. Such means of data collection, sample selection and qualitative study design, therefore, can bring into question the direct comparison to other centralised trans health care teams.

Conclusion

Our findings suggest a comparison to other European countries in which trans health care is often directly connected to legal gender recognition (TGEU et al. 2017). The team provided care and conceived trans identities in a medical framework similar to the historical progression of trans health care and legal gender recognition found across Europe (Wylie et al. 2016). The concern that doctors not only in their country but all over the world do not understand trans health care illustrates that these challenges are not unique. All participants expressed a need for more resources that were beyond the team's control (e.g. time, people and money), which is emblematic of obstacles and access to trans health care found across Europe (FRA 2014). Other trans health care teams positioned as monopolies within the health care system are also noted to face similar criticism and challenges (Nord 2019; Sharpe 2017). The single team in Norway for example similarly, "extends its monopoly in three directions: with regards to patients, other doctors, and the public authorities" (van der Ros 2017).

Across Europe and globally trans health care continues to evolve along-side legal gender recognition to follow patient-led and self-determination models, separating legal gender recognition from medical benchmarks. Despite this separation, trans health care providers will continue to play a vital role for many trans people who need related health care. With this separation, changing models of care,

continued increase in people seeking care and broader recognition of trans identities, further research into the impact trans health care specialist have on legal processes will be needed. The process for appropriate clinical reform and human rights implementation will require increased transparency and cooperation between local trans communities and health care providers that can prove to be mutually beneficial.

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