The lived experiences of transgender and gender-diverse people in accessing publicly funded penile-inversion vaginoplasty in Canada

Gianni R. Lorello MD MSc, Aradhana Tewari MPH, Marudan Sivagurunathan PhD, Emery Potter MN NP-PHC, Yonah Krakowsky MD, Janice Du Mont EdD, David R. Urbach MD

Cite as: *CMAJ* 2024 July 2;196:E816-25. doi: 10.1503/cmaj.231250

See related editorial at www.cmaj.ca/lookup/doi/10.1503/cmaj.240878

Abstract

Background: Canada's health care systems underserve people who are transgender and gender diverse (TGD), leading to unique disparities not experienced by other patient groups, such as in accessing gender-affirmation surgery. We sought to explore the experiences of TGD people seeking and accessing gender-affirmation surgery at a publicly funded hospital in Canada to identify opportunities to improve the current system.

Methods: We used hermeneutic phenomenology according to Max van Manen to conduct this qualitative study. Between January and August 2022, we conducted interviews with TGD people who had undergone penile-inversion vaginoplasty at Women's College Hospital, Toronto, Ontario, since June 2019. We conducted interviews via Microsoft Teams and transcribed them verbatim. We coded the transcripts using NVivo version 12. Using inductive analysis, we constructed themes, which we mapped onto van Manen's framework of lived body, lived time, lived space, and lived human relations.

Results: We interviewed 15 participants who had undergone penile-inversion vaginoplasty; they predominantly self-identified as transgender women (n = 13) and White (n = 14). Participants lived in rural (n = 4), suburban (n = 5), or urban (n = 6) locations. Their median age was 32 (range 27–67) years. We identified 11 themes that demonstrated the interconnected nature of TGD peoples' lived experiences over many years leading up to accessing gender-affirmation surgery. These themes emphasized the role of the body in experiencing the world and shaping identity, the lived experience of the body in shaping human connectedness, and participants' intersecting identities and emotional pain (lived body); participants' experiences of the passage of time and progression of events (lived time); environments inducing existential anxiety or fostering affirmation, the role of technology in shaping participants' understanding of the body, and the effect of liminal spaces (lived space); and finally, the role of communication and language, empathy and compassion, and participants' experiences of loss of trust and connection (lived human relations).

Interpretation: Our findings reveal TGD patients' lived experiences as they navigated a lengthy and often difficult journey to penile-inversion vaginoplasty. They suggest a need for improved access to gender-affirmation surgery by reducing wait times, increasing capacity, and improving care experiences.

As a socially marginalized group, people who identify as transgender and gender diverse (TGD) face systemic discrimination across all spheres of life,[1–7] even in jurisdictions where legal safeguards for transgender-related human right protections exist.[8–10] Such discrimination, often referred to as transphobia, denotes an irrational fear of TGD people because they do not adhere to society's expectations and conventions of gender.[11–14]

Health care systems uphold cis-heteronormativity (i.e., an assumption that being cisgender and heterosexual are the norm)[15] and, despite traction to establish more inclusive spaces, systemic barriers continue to impede positive progress.[16,17] Some systemic barriers include omission of TGD people as valued participants within health care systems, absence of inclusive policies, and failure to recognize the importance of such inclusive policies. Factors that shape the health care experiences of TGD people include physicians' inadequate knowledge about care of TGD people,[18–20] a loss of autonomy,[18,21] increased wait times,[20–22] outright discrimination,[3,19–21] and transphobia.[20] A national survey

in Canada found that, although most TGD people had a primary care physician, nearly half were uncomfortable talking to their family physician despite having unmet health care needs.[22]

One reason a person may choose to undergo gender-affirmation surgery is to more closely align their body with their gender identity. Several types of gender-affirmation surgery exist, including both top (e.g., chest masculinization) and bottom (e.g., phalloplasty, penile-inversion vaginoplasty) surgeries. Transgender women report undergoing bottom surgery at rates ranging between 5% and 13%,[23–25] and a 2012–2013 online survey, administered through a transgender education and social networking organization, found that 45% of the 234 transgender women respondents planned to undergo bottom surgery in the future.[24]

In 1903, Dr. J. Riddle Goffe performed the initial inversion vaginoplasty on an intersex female.[26] Following this, Drs. Harold Delf Gillies and David Ralph Milliard developed the first penile-inversion vaginoplasty for a transgender woman in 1951, Roberta Cowell.[27,28] Penile-inversion vaginoplasty is available in private clinics across Canada and has recently become available in a few publicly funded hospitals in Canada. Although 1 in 300 people in Canada self-identify as transgender or gender nonbinary, and nearly two-fifths of TGD people in Canada reside in Toronto, the proportion of people interested in or undergoing penile-inversion vaginoplasty remains unknown.[29]

We sought to gain a better understanding of the lived experiences of TGD people seeking, accessing, and navigating gender-affirmation surgery, specifically penile-inversion vaginoplasty, in Canada.

Methods

Study design

In our qualitative study, we interviewed TGD people who underwent penile-inversion vaginoplasty at Women's College Hospital in Toronto, Canada. We used hermeneutic phenomenology, a methodology used to study how experiences and culture shape everyday experiences,[30] according to a framework informed by van Manen.[31] We conducted participant recruitment and interviews from January to August 2022.

According to van Manen, "Phenomenology aims at gaining a deeper understanding of the nature or meaning of our experiences," rather than theorizing about experiences.[31] He discusses 4 main existentials (herein, we use the term "facet") of lived experience, namely lived body, lived time, lived space, and lived human relations. Lived body situates an individual by depicting them as existing in the world through their body, as well as engaging in relationships with others through their body. Lived time refers to how a person perceives time, as well as how the past, present, and future shape their perception of time (the temporal landscape), rather than solely looking at time as measured by a clock. Lived space refers to how an individual subjectively experiences the spaces they inhabit, coexisting in an interpersonal space with other people, while lived human relations refers to a person's interactions and relationality with others.[31]

We used van Manen's framework because a TGD person's journey navigating penile-inversion vaginoplasty is a transformative process that is complex, intricate, and prolonged. Experiences may vary from interaction to interaction, encompassing multiple aspects of a person's life over many years. According to van Manen, changes in 1 facet affect the way in which the other facets will be experienced. Therefore, this comprehensive framework, which considers the interconnected nature of the 4 facets of lived experience, is helpful to capture the experiences of TGD people navigating penile-inversion vaginoplasty.

We deliberately assembled the research team to reflect a diversity of perspectives and lived experiences (including people who self-identified as gender diverse, queer, cisgender, and persons of colour), as well as social scientists and members of multidisciplinary health care teams. We selected a study methodology that honoured and amplified the voices of the affected community. To ensure that members of the affected community were involved in the study and that the manuscript resonated with their experiences, the roles of 2 participants were extended to include participation in the first trial interviews (conducted by G.R.L.), member checking of the results, and provision of feedback on the draft manuscript, specifically around cultural sensitivity.

We used the Consolidated Criteria for Reporting Qualitative Research to report this study.[32]

Study setting

Women's College Hospital is a publicly funded, outpatient academic hospital that offers a wide range of gender-affirmation surgery, including top (e.g., chest masculinization) and bottom surgeries (e.g., penile-inversion vaginoplasty). The hospital's Transition-Related Surgery program performed its first penile-inversion vaginoplasty in June 2019. Its catchment area for gender-affirmation surgery includes all of Ontario. Before being seen by the Transition-Related Surgery program, a patient must have been approved by the Ontario Ministry of Health, with funding from the Ontario Health Insurance Plan (publicly funded health insurance for residents of Ontario). The approval process requires a nurse practitioner or physician referral and 2 independent assessments (including 1 by a physician or nurse practitioner) to confirm gender dysphoria, 12 months of gender-affirming hormones, and 12 months living as the gender with which the individual identifies.[33] At the time of this study, patients were waiting around 20 (range 11–32) months from consultation to penile-inversion vaginoplasty.

Study participants

We focused on patients who had undergone penile-inversion vaginoplasty at Women's College Hospital as they typically interact with multiple members of the Transition-Related Surgery clinical team (e.g., administrative staff, social worker, pharmacist, nurse practitioner, pelvic floor physiotherapist, preoperative nurse, surgeon, and anesthesiologist), thereby engaging in a more in-depth interaction with the program than TGD patients coming in for other surgeries.

In January 2022, 2 team members (M.S. and E.P.) accessed the hospital's database to identify all TGD patients who had undergone penile-inversion vaginoplasty at Women's College Hospital and who had previously consented to being advised of future opportunities for research participation. The database is updated in real time. The

principal investigator (G.R.L.) and the 2 research assistants (A.T. and a second research assistant) contacted these patients by email, inviting them to participate in the study and to schedule an interview.

Data collection

We collected self-identified demographic data — including gender identity, race, and ethnicity — from each participant before their interview (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.231250/tab-related-content). We developed the semistructured interview guide through a consultative process involving all members of the research team, and subsequently tailored it in an iterative fashion (Appendix 2, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.231250/tab-related-content). Based on general findings from the literature, the interview guide focused on participants' experiences as TGD people within the health care system at large and at Women's College Hospital in particular, exploring their background, their personal journey to gender-affirmation surgery, bureaucracy and forms, interactions, their responses to their experiences, their vision of the future of health care, and their sense of inclusion and well-being in their journey of gender-affirmation surgery.

Before implementation, TGD members of the research team reviewed the interview guide for cultural sensitivity. We pilot tested the guide with a nonparticipant. No changes to the interview guide were made.

After training, the research assistants conducted 1-on-1 virtual interviews using Microsoft Teams. One team member (G.R.L.) performed the first 5 interviews, with the research assistants dividing up the remaining interviews. All interviewers hold postgraduate degrees and have expertise in conducting qualitative research. Each participant underwent a single interview.

Interviews were audio-recorded using Microsoft Teams. We transcribed interviews verbatim. The research assistants verified all transcripts for accuracy and anonymized them; we deleted all audio recordings thereafter. We purchased gift cards ($100 each) from a queer bookstore, which served as honoraria for participation; participants received the honoraria upon interview completion.

Data analysis

Data analysis and interviewing occurred concurrently and iteratively for the first 5 interviews (meaning that an interview was performed, transcribed, and initially analyzed). After a team member read all transcripts in full (G.R.L. read the first 5 transcripts; the research assistants read all transcripts), the anonymized transcripts were uploaded into NVivo version 12 (QSR International) for first-order coding. The research assistants initially coded the data to general codes (e.g., fear, discrimination, anxiety) — a process of phenomenological horizontalization, by which the researchers are receptive to every participant comment and attribute equal value to every comment.[34] We (G.R.L., the research assistants) met 4 times to study and understand the general codes.

Subsequently, we (G.R.L. and A.T.) inductively constructed themes from the data while considering van Manen's 4 facets. One team member (G.R.L.) then mapped each theme directly onto van Manen's framework. The entire research team reviewed the themes and results of mapping.

In qualitative work, saturation is usually an endpoint, when any further data will not provide additional insights.[35] However, data saturation was not a goal for our study as people are incapable of uncovering every meaning of any phenomenon being researched, according to van Manen.[36]

All members of the research team were part of the Transition-Related Surgery program; authors included people with extensive experience using qualitative methodologies.

The researchers reflected on their personal circumstances and social locations as they related to the research question and subject matter when conceptualizing the study, collaborating to code data and construct themes, and interpreting the findings.[37]

We established trustworthiness of the data analysis based on Lincoln and Guba's criteria.[35] We also performed member checking with 2 participants to reflect on whether data accurately depicted participants' experiences and that the research team's assumptions were not ingrained within the results and interpretation; of note, member checking did not result in any changes to the data analysis.

Ethics approval

This study was approved by the Women's College Hospital Research Ethics Board (no. 2021-0130-E). All participants provided informed, written consent for participation.

Results

Of 38 TGD people invited to participate, 15 were interviewed. Most participants (n = 14) self-identified as White and most (n = 14) had gender-affirmation surgery elsewhere before having their penile-inversion vaginoplasty at Women's College Hospital (Table 1). The interviews averaged 71 (range 52–146) minutes in duration. The average time from surgery to study interview was 501 (range 53–977) days.

Our conceptual framework, depicting TGD participants' experiences in accessing and navigating gender-affirming care and surgery, consists of 11 themes that were inductively coded and mapped onto van Manen's framework of lived body, lived time, lived space, and lived human relations (Figure 1). Lived body included the following 4 themes: the role of the body in experiencing the world and shaping identity, the lived experience of the body in shaping human connectedness, intersecting identities, and emotional pain. Lived time had a single theme of the experiential passage of time and progression of events. The 3 themes for lived space were environments inducing existential anxiety or fostering affirmation, the role of technology in shaping the understanding of the body, and liminal spaces (i.e., a place or a state of transition). Lived human relations had the following 3 themes: communication and language, empathy and compassion, and loss of trust and connection.

In the interviews, participants described a broad range of experiences, in some cases, over many years and differing health care systems, in addition to their experiences with the Women's College Hospital program. Representative quotes can be found in Table 2.

Table 1: Participant characteristics

Characteristic	No. (%) of participants* *n* = 15
Age, yr, median (range)	32 (27–67)
Age at time of first coming out as a TGD person, yr, median (range)	24 (4–59)
Age when participants started their GAS journey, yr, median (range)	27 (19–60)
Reported social identities†	
Transgender	8 (53)
Transwoman	13 (87)
Transfeminine	4 (27)
Nonbinary	3 (20)
Woman	1 (7)
Race or ethnicity‡	
White	14 (93)
Mixed	1 (7)
Location of residence	
Rural	4 (27)
Suburban	5 (33)
Urban	6 (40)
Other gender-affirming surgeries undergone	
Bilateral orchidectomy	3 (20)
Revision vaginoplasty	2 (13)
Tracheal shave	1 (7)
Rhinoplasty	1 (7)
Breast augmentation	2 (13)
Facial feminization	1 (7)
Forehead conturing	2 (13)
Voice feminization	1 (7)

Note: GAS, gender-affirmation surgery, TGD = transgender and gender diverse.
*Unless indicated otherwise.
†Social identity categories are not mutually exclusive; gender identity was self-identified based on predetermined categories.
‡Race and ethnicity were self-identified, without predetermined categories.

Lived body

Social situations and environments influenced identity, relationships, and emotions. The lived body facet highlighted how TGD people navigated and experienced their existence within their surroundings. We identified 4 themes that described the heterogeneous, yet unifying, effects of experiences navigating gender-affirmation surgery on the body.

The role of the body in experiencing the world and shaping identity

Some TGD participants discussed the role of identity and the desire to be their authentic selves (quote 1) in deciding to proceed with transitioning (quote 2). Inhabiting the body was intertwined with relationships, where the behaviours of others could influence people's perception of their own experiences of the body; specifically, the lived bodily experience was shaped not only by internal aspects and how people saw themselves but also by external interactions that shaped participants' views of their own bodies (quote 3). External interactions of TGD participants as they navigated gender-affirmation care and surgery emphasized the importance of supportive health care environments that both respect and validate TGD people.

The lived experience of the body in shaping human connectedness

One participant discussed the role of the body in interpersonal relationships, voicing the need for personalized, holistic care that considers the interconnected nature of physical and psychosocial aspects of care, recognizing how her experiences were shaped by both biological and psychosocial factors (quote 4). Given that the human connectedness occurs between the whole patient and the health care provider; the health care provider should recognize that the patient is more than just a physical body.

Intersecting identities

Some TGD participants articulated the importance of intersectionality, that is, the interconnected nature of various intersecting social identities and how the interactions of these social identities shaped their lived experiences (quote 6). Moreover, 1 participant articulated how her transgender identity should not supersede all of her other social identities (quote 7), given experiences in which others wrongfully focused solely on her body's TGD identity. To better understand the individual needs of TGD patients and deliver patient-centred, affirming care, health care providers need to recognize the interconnectedness of intersecting identities.

Emotional pain

Some TGD participants articulated the emotional pain that they endured growing up (quote 8), as well as before surgery (quote 9), finding their experiences quite distressing.

Overall, the lived body facet described how TGD participants experienced their existence through their surroundings, highlighting that they need to be viewed holistically, taking into account how the environment influenced their identity, relationships, and emotions.

Lived time

Wait times, delays in surgery, and overall timelines for accessing gender-affirmation surgery affected participants' lived experiences and their perceptions of time.

Experiential passage of time and progression of events

Some TGD participants noted how they must advocate for themselves when navigating health care systems to ensure that health care providers submitted required forms for surgical approval on time (quote 10). A delay in submitting the proper paperwork could result in prolonging a patient's transition journey (quote 11) or even suicide (quote 12). The perioperative

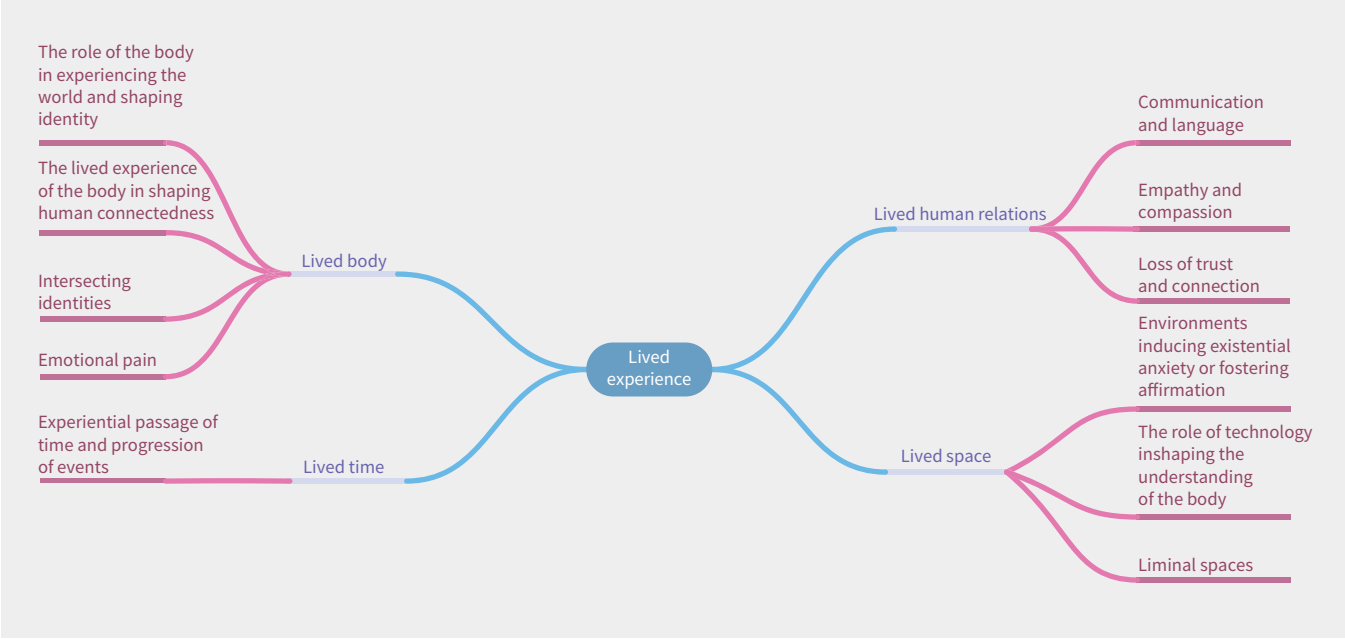

Figure 1: Conceptual framework depicting the 11 interconnected and cross-cutting themes, mapped onto van Manen's framework.

period also played a crucial role in the lived time of TGD participants (quote 13). These temporal aspects of existence shaped their lived experiences as they navigated gender-affirmation surgery.

Lived space

The lived space facet explored how TGD participants experienced and navigated social spaces that they inhabited but also the systems that they have to navigate, including health care systems, legal frameworks, and social institutions. We identified 3 themes.

Environments that induced existential anxiety or fostered affirmation

Transgender and gender-diverse people encountered challenges when seeking gender-affirmation surgery, anticipating limited access, stigmatization, and discrimination. Participants shared how walking into a health care organization could be extremely anxiety-provoking for TGD people (quotes 14 and 16). Participants also highlighted that the postoperative period could be a time of loneliness.

Participants discussed inequities regarding distance and time needed to travel to specific centres that provided gender-affirming care, instilling anxiety from lack of ease of access. They noted how many health care organizations that provide this care are situated in downtown urban centres, so that participants had to commute long distances to access appropriate health services. These inequities resulted in increased expenses and inconvenience, especially within the perioperative period (quote 17), such as costs associated with travel and taking time off work (quote 18). In addition to having to pay for transportation to access health care organizations, a participant discussed needing to pay out of pocket for non-funded gender-affirming procedures.

The role of technology in shaping the understanding of the body

Participants discussed the substantial work they did to gain awareness of their body and anatomy to engage in discussions with their health care providers (quote 18). They had to educate themselves to advocate for themselves. This self-education came at a cost to participants, who noted spending time and money accessing content behind paywalls (e.g., restricted access to content that required a paid subscription). Some participants indicated that they had to connect with others to get support in accessing care and services (quote 19); the support system could be helpful, especially since information can be overwhelming.

Liminal spaces

One participant stated that navigating gender-affirming care was different between Canada and the United States, with Canada being more conservative, resulting in "drift[ing] back in the closet and just kind of, you know, identif[ying] as genderqueer" (quote 20). Participants described being in an uncomfortable liminal state of either having to introduce themselves by their deadname (i.e., a name used before transitioning) or having to highlight their transgender identity when presenting identification (quote 21).

In summary, the lived space facet explored the experiences of TGD people in navigating social spaces that they inhabit, as well as the systems that they have to navigate. These spaces can either be a source of anxiety, gender-affirming spaces, or spaces of uncertainty. Furthermore, technology was a source of education for resourceful people.

Lived human relations

The lived human relations facet focused on the interpersonal dynamics and relationships that TGD participants encountered in their pursuit of gender-affirmation surgery. The 3 themes

Table 2 (part 1 of 2): Participant quotes by theme

Inductive theme	Quote
Lived body	
The role of the body in experiencing the world and shaping identity	*1. "All I could think about was how much I just wanted to be my authentic self, how much I wanted to be a woman." — Participant 12 *2. "I decided that I would live my life as a female for a year and then if it felt like this is truly me, then I would medically transition. So, then that's what led me to the next year at 28 to medically do it." — Participant 14 *3. "I felt like they weren't really clear on those, like minor details... like if I should get electrolysis, if I shouldn't. It just felt like it was not really explained to me thoroughly." — Participant 14
The lived experience of the body in shaping human connectedness	*4. "My general concern about medicine in general, which has kind of led me to distrust it a little bit more, is that it's very physiological and it's very based on aggregate statistics. I don't think that, at least in the hospital context, I don't think psychosomatic elements are taken into account quite well. I think psychology goes ignored. And I feel like a lot of treatment outcomes would improve if we also considered the mental aspect as well." — Participant 8 *5. "And if I was to say that there was 1 issue, it was that there wasn't the emotional, social support, even if it's as simple as just sitting for 5 minutes and talk." — Participant 15
Intersecting identities	*6. "I would say the variety of trans lives. How in depth different trans lives can be." — Participant 9 *7. "This person is a person of colour and trans … . No, this person is trans…as soon as you put the trans in it, it ends the intersectionality. It really does. It makes all the different factors 1 factor and erases the rest." — Participant 15
Emotional pain	*8. "And I used to cry myself to sleep most nights, and I'd have to muffle my sobs and my blankets and stuff, so I shared a bedroom with my 3 older brothers. Didn't want them to hear me crying and I used to pray." — Participant 12 9. "I think that because before I went into my surgery, they told me all these things, I kind of had a little breakdown." — Participant 14
Lived time	
Experiential passage of time and progression of events	*10. "I actually went for the approval for surgery 3 times. One time my doctor forgot to submit it. So that never actually got submitted." — Participant 15 *11. "I was able to convince [Practitioner X] to request ministry approval, shift the approval to [Doctor A], and again it took some convincing to get [Practitioner X] to write them that letter and resubmit. I was basically fully advocating for myself and pushing it along." — Participant 10 *12. "Delaying care leads to suicides." — Participant 6 13. "When I was being put out for my surgery, I used to pray. Please God create this miracle. Let me go to sleep and wake up as a girl. I'm lying there and they're about to put me under and I thought thank you God. You know, I'm gonna go to sleep now. When I wake up, I'll be, as you know, I'll be a girl. But you know, obviously it's cosmetic more than anything. But you know it. It was a dream come true." — Participant 12
Lived space	
Environments inducing existential anxiety or fostering affirmation	*14. "I have anxiety, a little bit. When I walk through doors, what I find myself [doing] is looking at my phone or my chart all the time, and then looking at the doctor looking at the chart. I'm waiting for that 'What?' comment." — Participant 13 15. "I would just say my entire stay at Women's College was so good, like everybody was so good. And I will tell anyone who will listen, I love that hospital. Like every single staff member has been so fantastic. [E]very time I go back for follow-ups … the people at the reception desk are always so nice and so good about names and pronouns and all that. No one made any assumptions about how I identified the whole time I was there … Everyone took really good care of me. I wish that every interaction I had with a person within medicine was as good as my time at Women's College Hospital. Like, it was the best." — Participant 7 *16. "There's always anxiety when you walk in." — Participant 13 *17. "Largely inconvenience, largely not having to go out of the province to be in [City X] as I'm recovering and everything, and have ease of access." — Participant 9
The role of technology in shaping the understanding of the body	*18. "I feel like I've gotten working knowledge that's comprehensive enough to understand what my anatomy is like, what it was like, what surgery did, what its like now, what the various surgical techniques offer in terms of the ability to manipulate where I'm at right now. So, I'm able to have informed conversations with my surgeons. That was a lot of reading. [A] lot of searching for papers using Sci-Hub [a shadow library providing free access to publications] to get through paywalls." — Participant 10 *19. "Within the trans population, like, how do you get access? I mean, people ask each other. That's the main source. So, like either a group or friends or like I'm on a couple of [Province X] … . social media groups there. It's just trans people asking the same questions about services." — Participant 1

Table 2 (part 2 of 2): Participant quotes by theme

Inductive theme	Quote
Liminal spaces	*20. "I knew some things about medical transition, but I could've desperately used a counsellor or some sort of support system at that time. When I moved to Canada, you know, things were a lot more conservative over here than they were in [United States, State X], and so I just kind of slowly drifted back in the closet and just kind of, you know, identified as genderqueer." — Participant 1 *21. "The number of times I was worried that people actually wouldn't believe that my ID was me … and that I would have trouble like, okay, I need to get a blood test … . Great … OK, here's my OHIP card … has a picture of somebody that doesn't really look like me … has a name that I'm not using, so what do I do? Do I go in the office and introduce myself as [Participant 6], that I'm here for a blood test or do I do the horrible mental health thing and go … . Yes, I am deadname or having to out myself to unknown people when I didn't want to … which has a huge mental health impact. It is terrible, but I definitely hit that period in the middle, where I was like I don't know if people are going to believe this is me." — Participant 6
Lived human relations	
Communication and language	*22. "If I get like, misgendered or deadnamed by like, just random strangers, like, that's one thing and I can kind of blow it off. But like when it's health care providers, like, people should [expletive] know better. Honestly. Stuff like that, I tend to avoid. Like any sort of walk-in clinic, I hate going." — Participant 7 *23. "I did have to keep doing talk therapy with him, which again was quite traumatic. His questions were even more invasive, even more inappropriate. At one point, he just flat out asked me if I've ever tried having gay sex and if I did, I might like it enough to not transition." — Participant 2 *24. "When I started having these interactions with people, I am supposed to trust like medical professionals, you know, and a lot of the same stuff is happening, it just kind of reinforces that idea that, you know, the world is dangerous and that I don't fit in and like my identity is something to be ashamed or something to keep hidden." — Participant 2
Empathy and compassion	25. "My overnight nurse who was on call when I was there … I absolutely loved her. I thought she gave me such a good experience there. She made me feel so comfortable, like she would always come in and check on me. And she would give me lots of pillows, make sure I was very comfortable … just, you know, talk to me. Make me feel like not so alone. She would just strike up random conversations about things." — Participant 14 26. "My mom was quite resistant to the whole thing and, in the weeks leading up to my surgery, [there] was a lot of pushback and I was very thankful that [Doctor Y] was willing to book an appointment in a meeting with him and my parents, which, like I'm really, really, really grateful for, because I know he's a very busy guy." — Participant 7 *27. Being visible is a danger, but if we're not visible, then our voice isn't heard. Minds can't be changed, so they keep going with the old adage, the old story, or the fact that there is still people out there that believe it's a mental health condition or, you know, conversion therapy was still around until it was just outlawed. These still exist and people are still subjected to it … . People think we can be cured instead of treated …" — Participant 6 *28. "You have 2 options, either sexually active or not. If I'm active, why wouldn't I want to get tested? Why do I need to justify and have somebody make me feel like I'm doing something wrong for being active?" — Participant 6 *29. "I feel like, you know, when you misgender one of us, you misgender all of us. It hurts. In their hallway conversations, they need to be gendering correctly as well." — Participant 1 *30. "And I am always misgendered over the phone." — Participant 12 *31. "It's just like I got deadnamed from a system and it's just like, you know, really hard because I was there for mental health services. I was getting deadnamed. And I was in crisis." — Participant 1
Loss of trust and connection	*32. "The person who brought me to my room. He kind of was unclear about what my gender was, and that made me feel uncomfortable. And then one of the female nurses [referred] to me as like, a he. And that was a little, like, annoying." — Participant 14 *33. "Yes, I take estrogen. Yes, having estrogen in my body increases my risk of blood clots from a cis male. Yeah, it puts me in the same category as cis females. What's the big deal? That's what I want. I want to have those impacts on my body." — Participant 6

Note: ID = identification, OHIP = Ontario Health Insurance Plan.
*Depicts experiences outside of Women's College Hospital.

considered how interactions with health care providers, family members, friends, and society at large shaped the overall interactions of TGD people.

Communication and language

Some TGD participants articulated anticipating that medical practitioners would lack the knowledge and understanding to avoid misgendering or deadnaming them (quote 22); participants shared that this expectation was a reason they avoided walk-in clinics (quote 24).

Empathy and compassion

Some TGD participants noted that their families were resistant to gender-affirmation surgery and gender-affirming care (quote 26) and they believed health care professionals should play an important role in helping TGD people and their families better understand gender-affirmation surgery. Some participants disclosed family abandonment as a consequence of transition. Some health care providers and some citizens still believe that self-identifying as TGD is a mental health issue (quote 27). Moreover, a participant explained how a physician's inquiry into her sexual history made her feel like she was doing something wrong, whereas she was taking agency in responsibly getting tested for sexually transmitted infections (quote 28). Participants described being misgendered (quote 30) or deadnamed (quote 31), demonstrating a lack of empathy and compassion among health care providers, especially in times of crisis.

Loss of trust and connection

Participants who were misgendered in the health care environment experienced not only frustration, but also discomfort in connecting with other people (quote 32). In general, participants wanted to exercise their agency in gender-affirming care (quote 33).

Generally speaking, the lived human relations facet highlighted how effective communication, empathy, and compassion created positive experiences for TGD people, whereas lack of culturally sensitive communication and empathy resulted in a loss of trust and connection.

Interpretation

We identified some factors that affected TGD peoples' access to health care and gender-affirmation surgery. The findings indicated that TGD people want to be viewed holistically, where lived body, lived time, lived space, and lived human relations are considered together. Environments influenced identity, relationships, and emotions, while delays in obtaining approval, funding, referrals, and subsequent delays in surgery affected TGD patients' overall journeys. Interpersonal interactions, technology, and liminal spaces played crucial roles in shaping their experiences. Positive experiences were described when effective communication, empathy, and compassion were present, while a lack of culturally sensitive communication and empathy led to a loss of trust and connection.

Several studies conducted in the US had similar findings, despite the political, social, legal, cultural, and health care system differences between the US and Canada. Makhoul and colleagues[4] described the perioperative experiences of TGD adults, identifying obstacles such as deficiencies in the education of health care professionals, the need for safer environments, and the necessity for policy changes. Chang and coauthors[5] found a high incidence of misgendering TGD patients within the perioperative period, as well as of TGD patients experiencing triggering moments during that time period.

In Canada, Frohard-Dourlent and coauthors[21] looked at TGD peoples' assessments for surgical readiness, focusing on 3 main themes, namely assessments as gatekeeping (participants' concerns about outdated and discriminatory assessments), assessments as a barrier to care (the bureaucratic, economic, and geographic challenges associated with surgical readiness assessments); and assessments as useful (participants feeling supported and prepared for the subsequent steps in their assessment for surgery). Sansfacon and colleagues[38] investigated the experiences of transgender youth seeking gender-affirming care in Canada. Participants felt satisfied with their overall care, noting improved well-being upon initiating gender-affirming interventions.[38] Their "shared frustrations concerned delays in accessing interventions due to clinic waiting lists or treatment protocols."[38] Some participants discussed adverse effects of the treatments while others described their positive transition journeys; none of the participants expressed regret.[38] Across all studies, common themes included the impact of delays in paperwork submission, wait times for accessing gender-affirming care, and changes in policy, aligning with our study's findings.

The purpose of hermeneutic phenomenology is not generalizability; however, a couple of actionable messages emerged from these data. Improved access to gender-affirmation surgery and reduced wait times for care are urgent needs and can be accomplished by increasing capacity for gender-affirming services in Canada's health care systems. Findings also highlighted the importance of the dynamics of human interaction; care experiences for TGD people could be improved by increasing hospital staff awareness and training, using inclusive language,[39] ensuring a safe and welcoming environment, and not imposing assumptions on TGD people.

Engaging in intentional, community-driven initiatives is essential in transforming health care systems.[40] At a systems level, medical schools across Canada, the Association of Faculties of Medicine of Canada, the Royal College of Physicians and Surgeons of Canada, and the College of Family Physicians of Canada can institute core competencies around TGD people's health and cultural sensitivity. Institutions can thereafter integrate longitudinal curricula to ensure that these core competencies are met before practice.[41]

To increase capacity, advocacy is required to dismantle ongoing barriers to accessing gender-affirming care. Increasing the number of physicians and surgeons who practise gender-affirming care is required, as is assigning funding for procedures not currently covered. Referral processes could be centralized to diminish wait times (noting that wait times are not a unique barrier to gender-affirmation surgery); follow-up costs should be subsidized, especially costs for travel and accommodation.

Increasing capacity, funding more penile-inversion vaginoplasty procedures, and recruiting personnel competent in gender-affirming care and penile-inversion vaginoplasty are priorities. As a response to this study's findings, pronouns for all patients will be placed on the operating room booking list at Women's College Hospital, visible to each member of the health care team. In addition, the Transition-Related Surgery program has increased its capacity by hiring another urologist. We are currently studying ways to increase representation among participants in gender-affirmation surgery studies.

Each TGD person's identity and journey accessing and navigating gender-affirmation surgery is unique. The increasing focus on the biomedical aspects of transitioning may potentially devalue "the affirming power of personal and social transition."[20] Future studies should include voices of TGD people with intersecting social identities and those accessing different aspects of gender-affirming care, including hormones and other gender-affirmation surgery, as this study focused only on participants from Women's College Hospital's program for penile-inversion vaginoplasty.

Limitations

Most of our participants self-identified as transgender women seeking penile-inversion vaginoplasty and as White. All participants had successfully accessed penile-inversion vaginoplasty. Experiences may differ for people unable to access this surgery. All members of the research team were associated with Women's College Hospital and Women's College Research Institute at the time of study; 1 team member (G.R.L.) had provided direct patient care to 2 participants, which may have led these 2 participants to make socially desirable comments; however, we suspect that is not the case given the candid nature of the interviews.

Conclusion

Our research highlighted 11 inductive themes that depict lived experiences of TGD people as they access penile-inversion vaginoplasty gender-affirmation surgery. Honouring and amplifying TGD voices while resisting imposing assumptions of how TGD people should be promotes a patient-centred approach. The results suggest that health care systems need to improve access to gender-affirmation surgery, reduce wait times for care by increasing capacity for gender-affirmation surgery, and improve care experiences.

References

1. Howell JD, Maguire R. Factors associated with experiences of gender-affirming health care: a systematic review. *Transgend Health* 2023;8:22-44.
2. Luvuno Z, Ncama B, Mchunu G. Knowledge, attitudes and practices of health care workers related to treatment and care of transgender patients: a qualitative study in KwaZulu-Natal, South Africa. *Gend Behav* 2017;15:8694-706.
3. Luvuno ZPB, Ncama B, McHunu G. Transgender population's experiences with regard to accessing reproductive health care in Kwazulu-Natal, South Africa: a qualitative study. *Afr J Prim Health Care Fam Med* 2019;11:e1-9.
4. Makhoul AT, Day RT, Walker JC, et al. Perioperative experiences of transgender adults seeking gender-affirming surgery: a qualitative interview study. *Transgend Health* 2023;8:231-7.
5. Chang BL, Sayyed AA, Haffner ZK, et al. Perioperative misgendering experiences in patients undergoing gender-affirming surgery: a call for a gender-inclusive healthcare environment. *Eur J Plast Surg* 2023 Jan. 24 [Epub ahead of print]:1-9. doi: 10.1007/s00238-022-02040-2.
6. Laupacis A. The need to respect a person's identity: experiences of a transgender man. *CMAJ* 2023;195:E1522.
7. Kariyawasam N, Klein J, Sharma M. Safe and equitable inpatient care for transgender, nonbinary and gender-nonconforming patients. *CMAJ* 2023;195:E1511.
8. Cobos DG, Jones J. Moving forward: transgender persons as change agents in health care access and human rights. *J Assoc Nurses AIDS Care* 2009;20:341-7.
9. Kenagy GP. Transgender health: findings from two needs assessment studies in Philadelphia. *Health Soc Work* 2005;30:19-26.
10. Bockting WO, Miner MH, Swinburne Romine RE, et al. Stigma, mental health, and resilience in an online sample of the US transgender population. *Am J Public Health* 2013;103:943-51.
11. Warriner K, Nagoshi CT, Nagoshi JL. Correlates of homophobia, transphobia, and internalized homophobia in gay or lesbian and heterosexual samples. *J Homosex* 2013;60:1297-314.
12. Butler JP. *Gender trouble: feminism and the subversion of identity*. 1st ed. London (UK): Routledge; 2011:1-272.
13. Butler J. *Undoing gender*. London (UK): Routledge; 2004:1-288.
14. Butler J. *Bodies that matter: on the discursive limits of sex*. 1st ed. London (UK): Routledge; 2011:1-256.
15. Hrynyk N, Peel JK, Grace D, et al. Queer(ing) medical spaces: queer theory as a framework for transformative social change in anesthesiology and critical care medicine. *Can J Anaesth* 2023;70:950-62.
16. Bauer GR, Hammond R, Travers R, et al. "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *J Assoc Nurses AIDS Care* 2009;20:348-61.
17. Kcomt L, Gorey KM, Barrett BJ, et al. Healthcare avoidance due to anticipated discrimination among transgender people: a call to create trans-affirmative environments. *SSM Popul Health* 2020;11:100608. doi: 10.1016/j.ssmph.2020.100608.
18. Schaffer L. The lived experience of transgender college-aged students receiving healthcare [thesis]. Burlington (VT): The Faculty of the Graduate College of the University of Vermont; 2015:1-38.
19. Ross K, Fraser S. Minimally invasive procedures in gender-affirming care: the case for public funding across Canada. *CMAJ* 2023;195:E1041-2.
20. Bhatla J, James K, Lamb KAE, et al. The experience of youth on the waitlist for gender-affirming care in Manitoba. *Paediatr Child Health* 2023 Dec. 10 [Epub ahead of print]:pxad087. doi: 10.1093/pch/pxad087.
21. Frohard-Dourlent H, MacAulay M, Shannon M. Experiences of surgery readiness assessments in British Columbia. *Int J Transgend Health* 2020;21:147-62.
22. Scheim AI, Coleman T, Lachowsky N, et al. Health care access among transgender and nonbinary people in Canada, 2019: a cross-sectional survey. *CMAJ Open* 2021;9:E1213-22.
23. Kailas M, Lu HMS, Rothman EF, et al. Prevalence and types of gender-affirming surgery among a sample of transgender endocrinology patients prior to state expansion of insurance coverage. *Endocr Pract* 2017;23:780-6.
24. Sineath RC, Woodyatt C, Sanchez T, et al. Determinants of and barriers to hormonal and surgical treatment receipt among transgender people. *Transgend Health* 2016;1:129-36.
25. Beckwith N, Reisner SL, Zaslow S, et al. Factors associated with gender-affirming surgery and age of hormone therapy initiation among transgender adults. *Transgend Health* 2017;2:156-64.
26. Goffe J. A pseudohermaphrodite, in which the female characteristics predominated; operation for removal of the penis and the utilization of the skin covering it for formation of a vaginal canal. *Am J Obstet Dis Women Child* 1903;48:755-63.
27. Gillies H, Millard R. *The principles and art of plastic surgery*. 1st ed. Boston: Little, Brown and Company; 1957:1-678.
28. Kennedy P. *The first man-made man: the story of two sex changes, one love affair, and a twentieth-century medical revolution*. New York: Bloomsbury Publishing (US); 2007:1-226.
29. Canada is the first country to provide census data on transgender and non-binary people. Ottawa: Statistics Canada; 2022, modified 2023 May 31. Available: https://www150.statcan.gc.ca/n1/daily-quotidien/220427/dq220427b-eng.htm (accessed 2023 Dec. 1).
30. Beck CT. *Introduction to phenomenology: focus on methodology*. Thousand Oaks (CA): SAGE Publications, Inc.; 2021:1-224.
31. van Manen M. *Researching lived experience: human science for an action sensitive pedagogy*. Albany (NY): State University of New York Press; 1990:1-212.
32. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19:349-57.
33. Transition related surgery. Toronto: Women's College Hospital. Available: https://www.womenscollegehospital.ca/care-programs/surgery/transition-related-surgery/ (accessed 2024 Mar. 28).
34. Moustakas C. *Phenomenological research methods*. Thousand Oaks (CA): Sage Publications; 1994:1-208.

35. Lincoln YS, Guba EG. *Naturalistic inquiry*. Thousand Oaks (CA): Sage Publications; 1985:1-416.
36. van Manen M, Higgins I, van der Riet P. A conversation with Max van Manen on phenomenology in its original sense. *Nurs Health Sci* 2016;18:4-7.
37. Olmos-Vega FM, Stalmeijer RE, Varpio L, et al. A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Med Teach* 2022 Apr. 7 [Epub ahead of print]:1-11. doi: 10.1080/0142159X.2022.2057287.
38. Sansfaçon A, Temple-Newhook J, Suerich-Gulick F, et al. The experiences of gender diverse and trans children and youth considering and initiating medical interventions in Canadian gender-affirming speciality clinics. *Int J Transgend* 2019;20:371-87.
39. MacKinnon KR, Lefkowitz A, Lorello GR, et al. Recognizing and renaming in obstetrics: How do we take better care with language? *Obstet Med* 2021; 14:201-3.
40. Kia H, Kenney KA, Abramovich A, et al. "Nowhere else to be found": Drawing on peer support experiences among transgender and gender-diverse people to substantiate community-driven gender-affirming care. *Soc Sci Med* 2023; 339:116406. doi: 10.1016/j.socscimed.2023.116406.
41. MacKinnon KR, Hannah K, Rai N, et al. Integrating trans health knowledge through instructional design: preparing learners for a continent — not an island — of primary care with trans people. *Educ Prim Care* 2021;32:198-201.

Competing interests: Gianni Lorello reports funding from the Canadian Institutes of Health Research (CIHR), Social Sciences and Humanities Research Council, the Royal College of Physician and Surgeons of Canada, and the University of Toronto, as well as remunerated positions for the Royal College of Physicians and Surgeons of Canada as well as the University of Toronto, MD Program. He is a guest editor with the *Canadian Journal of Anesthesia*. Emery Potter reports funding from the CIHR and consulting fees from Rainbow Health Ontario. No other competing interests were declared.

This article has been peer reviewed.

Affiliations: Department of Anesthesia and Pain Management (Lorello), Toronto Western Hospital — University Health Network; Department of Anesthesiology and Pain Medicine (Lorello), University of Toronto; The Wilson Centre (Lorello); Women's College Research Institute (Lorello, Tewari, Sivagurunathan, Du Mont, Urbach); Women's College Hospital (Potter); Division of Urology (Krakowsky), Department of Surgery, and Dalla Lana School of Public Health (Du Mont), and Department of Surgery (Urbach), University of Toronto, Toronto, Ont.

Contributors: All of the authors were involved in the conception of the design of the study. Gianni Lorello and Aradhana Tewari contributed to data acquisition and data analysis. All of the authors contributed to data interpretation. Gianni Lorello drafted the manuscript. All of the authors revised it critically for important intellectual content, gave final approval of the version to be published, and agreed to be accountable for all aspects of the work.

Funding: This study was supported by the Royal College of Physicians and Surgeons of Canada, Medical Education Research Grant (21-MERG-01).

Data sharing: Participants did not provide consent for their data to be shared publicly. Given the sensitive nature of such data, no data will be shared.

Acknowledgements: The authors thank all of the participants for sharing their stories; they would also like to thank the 2 participants who contributed to member checking. They thank Dr. Jad Jaber for their contribution to this study as a research assistant. Gianni Lorello also thanks the Department of Anesthesia and Pain Management at University Health Network – Sinai Health Services for his nonclinical time and support and the Royal College of Physicians and Surgeons of Canada for funding this project.

Accepted: Apr. 2, 2024

Correspondence to: Gianni Lorello, Gianni.Lorello@uhn.ca