A Fight for Health: My Transgender Journey for Care

A thesis submitted to the School of Graduate Studies
in partial fulfillment of the requirements of the degree of

Master of Science in Medicine, Applied Health Services Research
Division of Community Health and Humanities, Faculty of Medicine
Memorial University

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July 2020

Abstract

This critical autoethnographic study chronicles my personal journey accessing health care as a transgender person. Access to health care is a current issue for transgender people in Canada, particularly in Canada's smallest province, Prince Edward Island. This research addresses geographical and methodological gaps in the current literature by providing a rich and detailed description of my health care journey as a member of Prince Edward Island's transgender community. This insider account intends to improve understanding, increase awareness, and facilitate meaningful health system and societal change. Personal memory data, self-observation/self-reflection data, and external data sets including my medical records, surgery denial forms, Facebook conversations, and personal emails were collected. Thematic analysis was conducted using a queer theory lens and revealed four major themes: ill health and personal transformation, privacy and safety, barriers and facilitators to care, and an ideal system and hope for the future. Four recommendations were generated: the need for a gender-affirming health care policy, better pathways to access medical transition related health care services, education and training for Prince Edward Island health care professionals, and an online information hub.

Keywords: transgender, autoethnography, health care access, queer theory, Prince Edward Island, Canada

Dedication

This thesis is dedicated to the transgender community of Prince Edward Island.

Acknowledgements

This thesis would not have been possible without the continuous support of my thesis supervisor and committee members, master's program instructors and peers, as well as my family and friends. First and foremost, I wish to express my sincere gratitude to Dr. Diana Gustafson for her support and guidance through every step of my thesis journey. Your dedication to my success and constructive feedback have been greatly appreciated. Thank you for seeing value in my story and making me a better writer. I would also like to extend thanks to Dr. Kate Tilleczek and Dr. Ailsa Craig. You have both been invaluable resources of knowledge throughout this process. I am truly grateful for all of your encouragement and support. To my master's program instructors and peers, thank you for creating an environment in which I felt safe and comfortable to share my truth and experiences. This was crucial in my development as a master's student. Finally, I would like to thank my family, partner, and friends for their support, patience, and acceptance. Thank you for being there through it all, believing in me, and helping in my journey to finding and becoming my authentic self.

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Chapter 1: Introduction

I want you to close your eyes for a moment. I am making the assumption that most people reading this are cisgender, meaning that you identify with the gender you were assigned at birth. Imagine having the brain you have now, and simply swapping out your genitals and secondary sex characteristics with those of the opposite sex, a sensation of literally feeling trapped in the wrong body. Now, at first this may seem exciting to you if you've ever wanted to spend a day understanding how it feels to be the opposite sex, but imagine living your entire life feeling this disorientation and incompleteness, unable to truly express yourself and enjoy your body like the rest of the world seems to do. Imagine having to keep these feelings a secret, because you've heard jokes about people like you, and you just want to fit in. Imagine actually figuring out there is a biological basis for what you're feeling and that there is help for people like you. But again, you've heard stories of others like you, being disowned by their family and friends, and at this point you would rather deal with this pain than lose them. Imagine finally hitting a point where you just can't take it anymore. So, you go to your family physician and they are unable to help you, have no idea how to help you, or perhaps worse, they refuse to help you. Now open your eyes. This is an example of what it feels like to be transgender, and without access to adequate health care services.

This critical autoethnography explores my personal story of accessing health care as a transgender person in the Canadian provinces of Prince Edward Island (PEI) and British Columbia (BC) and making sense of the story in the larger context of Canada's publicly funded and administered health care system. Transgender people are a marginalized and oppressed community that face many barriers when accessing health care services and navigating the health care system. As such, we are unable to access crucial services that significantly contribute to our well-being and overall health. The purpose of this study is to provide a rich and detailed description of my lived experiences as a transgender person navigating the health care system to improve understanding and embody “the change I seek in myself and in the world” (Holman Jones, 2016, p. 235).

According to Milne et al. (2017), patient stories are re-shaping health care. This research intends to offer insight into a heretofore unexplored local experience to create meaningful change on PEI and contribute to the broader scholarly conversation. By introducing an insider perspective, readers will be able to better understand some of the kinds of experiences a transgender person can have seeking health care services. This insider perspective has the potential to change the way the public, health care professionals, and policy makers understand the transgender community and their needs. In addition, this research has the potential to impact policy, programs, services, and practices relating to transgender health care on PEI and contribute to the national conversation. Autoethnographies have been conducted on the experience of being trans and accessing health care services (MacDonald, 2013; Nealy, 2014; Nealy, 2017; Stewart, 2017). However, these have not focussed exclusively on health care accessibility.

Research Questions

The research questions that guided this critical autoethnographic study were:

1. How do I make meaning of my lived experiences accessing health care as a transgender person?
2. How accessible are transgender health care services on Prince Edward Island?
3. What are the barriers and facilitators to accessing health care services for transgender people on Prince Edward Island?

In this chapter, I provide background information relating to being transgender and explain transgender health care services. This includes a description of the PEI context and PEI transgender health care services, as well as the comparatively better transgender health care services available in BC. Although my journey for care took me to four Canadian provinces, I restricted my attention to BC and PEI where I lived and was able to access publicly funded health care services. I also introduce queer theory – the framework that I used to make sense of my story.

Key Concepts

These are answers to some of the common questions I am asked about being transgender: What does it mean to be transgender? A transgender person is an individual whose gender identity does not coincide with the gender identity they were assigned at birth. When a baby is born, they are assigned the gender that is culturally associated with their genitalia. If they continue to identify with the gender they are assigned at birth, they are described as being cisgender. In other words, their sexual presentation aligns with their gender identity. The World Professional Association for Transgender Health (WPATH) (2012) describes gender identity as "a person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (p.96). Gender role or expression includes "characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role)" (p. 96). When a person's gender identity does not match their physical presentation, they can experience gender dysphoria. Gender dysphoria is described as "distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (p. 96). There are different ways in which a transgender person can identify. Some people may identify as female or male, while others identify with neither gender, in other words, a non-binary or gender nonconforming identification (WPATH, 2012).

Why are people transgender? There are several theories as to why some people are transgender, with some theories gaining more support than others. Currently, the most supported theory suggests that being transgender is biological and that the brains of transgender individuals are structurally similar to cisgender individuals that share their same gender identity. In 1995, Dick Frans Swaab led a study to discover structural differences between male and female brains. Post-mortem brain tissue of transgender individuals revealed that male-to-female subjects had clusters of cells that resembled those of a cisgender female brain (Trotta, 2017). More recent brain scan research found that the brains of transgender men have a weakened connection between the area that processes self-perception and the area that processes one's own body (Burke et al., 2017). The cause of these differences in transgender people is not fully understood, but it is thought that being transgender could be the result of insufficient or excess prenatal androgen exposure (Trotta, 2017).

What is transitioning? To more closely match their gender identity, some transgender people choose to undergo the process of transitioning. This includes changing their appearance to align with their gender identity. Depending on the person and their gender identity, their transitional needs may vary greatly. The process of transitioning may include a combination of legal, social, and medical transitions. Legally transitioning may include changing one's gender marker and name on legal identification (Health PEI, 2018). Social transitioning may include *coming out* (disclosing to others that you are transgender (Klein et al., 2014) and the outward expression of one's gender identity such as choice of clothing and hair style (Health PEI, 2018).

Medical transition includes a range of health care services, which is the focus of the next section. All transgender people are different and thus, their desires, needs, and levels of transition may differ (WPATH, 2012).

Transgender Health Care Needs and Services

Health is a human right (World Health Organization [WHO], 2017). The World Health Organization (WHO) (2017) explains that there are no racial, religious, political, economic, or social distinctions to this fundamental right. As with cisgender people, transgender people require access to general health care services, which should be gender-affirming. Gender affirmation is “the social process of being recognized, or affirmed in one’s gender identity, expression, and/or role” (Reisner et al, 2016, para. 6). This may result in gender euphoria; the positive feelings when one’s gender is confirmed (Benestad, 2010). Some health care services are specific to this population. A wide variety of services from counselling sessions to more invasive surgical interventions fall under transgender health care services. A transgender person who wishes to medically transition may decide to pursue counselling, hormone therapy treatment, and/or gender-affirming surgeries.

Hormone therapy for transgender individuals is a medical treatment that supresses and/or adds to a body’s natural hormones. This results in the alteration of secondary sex characteristics. This may include estrogen, anti-androgens, and progestins, with the desired effect being to feminize the body. Alternatively, it may include testosterone, with the aim of masculinizing the body. There is also an option of using puberty blockers in order to delay puberty in children and youth. Transgender people receiving hormone therapy should optimally be well supported by endocrinologists and other health care professionals as there can be adverse effects to these treatments. Possible adverse effects of hormone therapy may include heart disease, high cholesterol, secondary polycythemia, and depression. There are notable gaps in scientific knowledge about the long-term effects of hormone treatments (WPATH, 2012).

Gender-affirming surgeries, also known as gender reassignment surgeries, can be pursued either before or after an individual begins hormone therapy treatments. Transgender people may choose a combination of or varying degrees of these procedures. These surgical interventions include the removal of internal and/or external organs that are culturally associated with gender, the reconstruction of internal and/or external characteristics, along with procedures that enhance the appearance of patients in order to more closely coincide with expectations for their gender identity (Health PEI, 2018). Surgical procedures may include mastectomy (removal of the breasts) with chest reconstruction/masculinization, breast augmentation (construction of the breasts), oophorectomy (removal of the ovaries), hysterectomy (removal of the uterus), vaginectomy (removal of the vagina), penectomy (removal of the penis), orchidectomy (removal of the testicles), scrotoplasty (construction of the scrotum), metoidioplasty and phalloplasty (two procedures for constructing the penis), and vaginoplasty (construction of the vagina) (WPATH, 2012).

The process of medically transitioning usually begins after a mental and physical assessment is carried out by a health care professional. If desired, this is followed by hormone therapy and gender-affirming surgeries (Health PEI, 2018). WPATH (2012) states that these treatments are medically necessary. The eligibility criteria for medical transition are listed by the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. These criteria include persistent and documented gender dysphoria, the capacity to make a fully informed decision and consent to treatment, being of the age of majority in a given country, and if present, have medical and mental health concerns reasonably well-controlled (WPATH, 2012).

To undergo any type of gender-affirming surgery, there are additional criteria which include 12 months of hormone therapy as well as 12 months of living in the gender role of their gender identity (WPATH, 2012). In certain circumstances, people can avoid the hormone therapy requirement if there is a medical condition that prevents them from taking this treatment. To have these treatments covered by a provincial health plan, transgender people must meet the governments criteria for *medically necessary*. However, it is possible for transgender people to skip the WPATH eligibility requirements when paying *out-of-pocket* for their surgeries. In these cases, informed consent may be the only requirement (WPATH, 2012).

Access to medical transition-related and general health care services for this minority population are crucial. Transgender individuals are at a significantly higher risk for mental health issues, violence, abuse, and discrimination when compared to the general public (AIDS PEI & PEI Transgender Network, 2017). Of the transgender Ontarians surveyed, 43% had attempted suicide and 77% seriously considered taking their own life (Scanlon et al., 2010). Trans Pulse (2011) describes that this rate and associated issues are dramatically decreased when transgender people have access to proper health care services (Betts, 2017). The positive effects of medically transitioning include living authentically and overall satisfaction, as well as a significant decrease in depression (Alegria, 2011).

Transgender people who require but cannot access appropriate health care services may suffer from mental health concerns and social consequences. One study reports that in Europe, Canada, and the United States 22-43% of transgender people have a history of suicide attempts. Social support, having personal identification documents changed to the appropriate sex designation, reduced transphobia, and most relevantly, medical transition is associated with lower suicide risk (Bauer et al., 2015). Of the transgender people surveyed, 66% of female to male transgender individuals and 61% of male to female transgender individuals had symptoms of depression. Another study reports that the estimated prevalence of heavy episodic drinking among transgender individuals living in Ontario is 1.5 times greater than the age-standardized population in Ontario (Scheim et al., 2016).

As is true for all people, family support is important for the mental health and well-being of transgender people. Trans youth with strong parental support report higher self-esteem, higher life satisfaction, better mental health, and appropriate housing compared to trans youth without strong family support (Travers et al., 2012). Parental support is also associated with a reduction in suicidal ideation among trans youth (Bauer et al., 2015). The majority of transgender people who are parents report that their gender identity has embarrassed or hurt their family. Older trans adults experience significant worry about growing old alone or being socially marginalized because they are trans. Many are turned down for or fired from jobs, beaten up, harassed by police, or move because they were trans. Additionally, there are reports of some trans individuals losing complete or partial custody of their children because they are transgender (Pyne et al., 2015).

Transgender Experience in Canada

Transgender health care coverage and accessibility vary across Canada (Bauer et al., 2015). Depending on where an individual resides, there may be limited or an abundance of resources that they can access (AIDS PEI & PEI Transgender Network, 2017). In Canada, there is federal legislation for publicly funded health care insurance under The Canada Health Act. This Act states that the primary objective of Canadian health care policy is “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Health Canada, 2017, para. 2). There are criteria and conditions established by the Act that provinces and territories must adhere to in order to receive the full federal cash contribution for insured health services and extended health care services.

The specific aim of the Canada Health Act is "to ensure that all eligible residents of Canadian provinces and territories have reasonable access to medically necessary hospital and physician services on a prepaid basis, without charges related to the provision of insured health services" (Health Canada, 2017, para. 4). Section 12 of the Act includes an accessibility criterion, which explains that "residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting 'where' the services are provided and 'as' the services are available in that setting" (Health Canada, 2014, p. 4). All provinces and territories in Canada carry the responsibility of providing medically necessary services through the publicly funded, universal, health insurance program (Giblon & Bauer, 2017). On PEI, the Department of Health and Wellness of Prince Edward Island holds the responsibility for providing policy, as well as strategic and fiscal leadership for the province's health care system (Health Canada, 2017).

PEI is an Atlantic Canadian province; the smallest province in Canada. It has a population of just over 152,000 people (Government of Prince Edward Island, 2018). Giblon and Bauer (2017) suggest that as many as 1 in 200 people may be transgender meaning that there are potentially 760 transgender individuals living on PEI. Considering that many transgender people live a stealth (not openly transgender) life, this also means that many people living in the province have not had any known exposure to transgender people.

The social environment of PEI is constantly improving for the transgender community. In 2017, Tyler Murnaghan, former chair of Pride PEI, states that “the Island’s inclusiveness has come a long way in the last few years” (Fraser, 2017). However, Russell Louder, a non-binary PEI resident, states that “there aren’t really safe spaces” (Fraser, 2017) on PEI for the LGBT (Lesbian, Gay, Bisexual, and Transgender) community. Additionally, Louder explains that “PEI isn’t always welcoming to LGBT people” (Fraser, 2017), discussing a lack of nightlife and transgender-accessible bathrooms. Louder also states that they and their friends have been harassed at bars, as well as disrespected in professional settings (Fraser, 2017). Since PEI is currently in the process of extending health care services to their transgender community (Neatby, 2018), this is an important and current human rights issue in the province.

Prince Edward Island Transgender Health Services

Health PEI holds the responsibility for coordinating transgender health care services in the province. PEI was the last Canadian province to publicly fund appropriate gender-affirming surgeries, only recently including hormone therapies for transgender people in the PEI Pharmacare (CBC NEWS, 2015). Many people, including myself, have had to take health care into our own hands. This has meant paying for these services *out-of-pocket* to protect our own health and well-being. Health care services for transgender people are not adequate on PEI and should be significantly improved and expanded. The province has stated it is currently working on improving current policies and creating new policies in order to better serve their transgender community, but progress has been frustratingly slow (Neatby, 2018).

Family physicians, nurse practitioners, and community mental health providers are described as the first contact for transgender patients pursuing medical transition on PEI. Patients and providers may also seek help from the provincial patient navigator (Health PEI, 2018). While some health professionals may experience difficulties in accessing services for their patients, others are completely unaware of the process of transitioning (AIDS PEI & PEI Transgender Network, 2017). To access medical transition health services, a mental health professional must carry out an assessment to determine a person’s readiness for these treatments (Health PEI, 2018). Currently, there is only one health care professional conducting these assessments on PEI and individuals may wait up to three years for an appointment (AIDS PEI & PEI Transgender Network, 2017). Moreover, there are no endocrinology services for those seeking to transition and Health PEI lacks clearly defined pathways for accessing specialized care services that are not performed within the province (AIDS PEI & PEI Transgender Network, 2017).

Gender-confirming surgeries were publicly funded on PEI in 2018, ten years after BC publicly funded these services in 2008. On PEI as elsewhere, a person must meet certain eligibility criteria to access gender-confirming surgeries. Clinical eligibility is assessed using WPATH’s criteria, which is required by the Canadian jurisdictions that insure these surgeries. After receiving recommendation from a family physician and approval by PEI Medicare, Health PEI requires that a medical team develop a surgical plan. The procedures covered by PEI Medicare are clitoral release, erectile/testicular implant, hysterectomy, mastectomy with chest masculinization, metoidioplasty, oophorectomy, phalloplasty, scrotoplasty, vaginectomy, clitoroplasty, labiaplasty, orchiectomy, penectomy, and vaginoplasty. All surgeries are performed out-of-province with the exception of hysterectomies, mastectomies (without chest masculinization), oophorectomies, orchiectomies, and penectomies (Health PEI, 2018).

British Columbia Transgender Health Services

What might good transgender health services look like? In BC, the Provincial Health Services Authority is responsible for coordinating transgender services. To facilitate navigating the health care system, the province created a BC-wide information service and research hub, Trans Care BC. This hub provides information and educational resources for transgender people, their families, and health care professionals. BC provides their transgender residents with care and support including peer support, mental health and wellness support, as well as support resources for their family, friends, and significant others. The information hub also explains the process of medical transitioning in the province, such as accessing hormone therapy and/or surgeries. Primary care providers are able to prescribe hormone therapy to their patients if they feel comfortable. In cases where a provider feels this is outside of their scope of practice, they may refer a patient to another provider or suggest a readiness assessment. A patient's primary care provider also monitors hormone treatments.

Waitlists for publicly funded gender-affirming surgeries in BC have been rumored to average 2-4 years (McCarty, 2016). The typical process for surgical treatments includes a readiness assessment by a primary care provider, a referral to a surgeon, and consultation(s) with a surgeon. If a patient is undergoing an upper body surgery, it will be completed in the province. If the patient is undergoing lower body surgery, the surgery will be completed out-of-province (Trans Care BC, 2019).

Theoretical Framework: Queer Theory

According to Adams and Holman Jones (2008), "autoethnography is queer" (p. 377). Queer theory is the interpretive framework that guides this study, as it shows "the 'critical' in critical autoethnography by putting theory into action" (Holman Jones, 2016, p. 231). Queer theory challenges the gender binary and deconstructs the idea of normal (Holman Jones & Adams, 2010). Emerging in the 1990s from social constructivism with a particular emphasis on lived experiences (Gamson, 2000), queer theory focuses on how bodies "constitute and are constituted by systems of power as well as how bodies might serve as sites of social change" (Holman Jones & Adams, 2010, p. 201). Queer theorists believe that our identities are fluid, therefore our identities are constantly changing and situated in a specific context and time (Wilchins, 2004). Society has constructed this idea of finding yourself, suggesting that this is an objective experience to which there is an end (Wilchins, 2004). However, as post-structuralist Foucault (1998b) explains, the self is subjective and is a response to our context.

Judith Butler is a feminist and a central figure in queer theory. She explains that there is no ontological truth to being male or female. Furthermore, there is no correct male or female body, just an ideal that is highly unattainable. In her book, *Gender Trouble* (1990), Butler breaks down the traditional, binary views of gender, suggesting instead that gender is a performance or construct. Butler's text and her ideas influenced the formation of queer studies and revolutionized the ways in which we approach and understand gender. In addition to facilitating the emergence of transgender theory, Butler creates a positive relationship between transgender people and feminism (Connell, 2012).

Judith Butler emphasizes that transgender people are engaged in the process of attaining a sex, much like the rest of society, but they have to work much harder to unbecome their birth sex (Johnson, 2005). For Butler, gender is not something we are or have, gender is doing, and we are compelled to do gender in order to be recognized as human in a binary way that is consistent with our biological bodies. Transgender bodies are excluded from binary constructions. The demands of heteronormativity dictate that our bodies only count when our gender, sex, and desires connect (Butler, 2004). Butler states that queer theory is tasked with determining “how to create a world in which those who understand their gender and their desire to be non-normative can live and thrive not only without the threat of violence from the outside but without the pervasive sense of their own unreality, which can lead to suicide or suicidal life” (2004, p. 219).

Queer is not a term that I use personally, but it has been used by some to describe gender identities that fall outside binary gender categories. Initially, I found this terminology to be quite dysphoria-inducing, but upon further investigation I realized this theory was the best fit for my study. As this research serves to promote social and systematic change by studying the life of a transgender man, specifically the experiences of accessing health care as a transgender man, queer theory is congruent as it shifts the focus from a transgender man’s life to the practices and systems of society (Seidman, 1996). Indeed, this theory is congruent with the philosophical assumptions stated above, as I believe that identities are subjective, fluid, and ever-changing.

My study examined a non-normative expression of gender, a gender identity that was not typically mainstream (University of Illinois at Urbana-Champaign, 2018) and thus, queer theory is satisfactory in framing the issues of this research. Using this interpretive framework has enhanced the understanding of my experiences within the social, institutional and cultural contexts where they’ve occurred. Queer theory was used to interpret my experiences by exploring how non-normative gender identities navigate a health care system full of barriers in comparison to normative gender identities. The use of this lens facilitated my exploration of how my body is constituted by systems of power and how it may serve as a site for change.

Chapter Summary

Transgender health care is a timely issue as this marginalized population experiences higher mental and physical health issues. Transgender health care needs and services include general health care and medical transition related care. Current transgender health services on PEI are inadequate, but BC services are comparatively better. My critical autoethnography was concerned with making meaning of my experiences as a transgender person accessing health care services on PEI in the context of Canada’s publicly funded and administered health care system. Queer theory was the analytical framework that helped me make meaning of my experiences.

My thesis is divided into six chapters, followed by references and appendices. In the second chapter I describe the literature review that provides the context for this thesis. This points to the methodological and geographical gaps in current research. The third chapter provides a description of critical autoethnography and the methods I employed. The fourth chapter chronicles my personal story as a transgender person accessing health care. The fifth chapter uses the lens of queer theory to discuss the research findings in relation to current literature. In the sixth chapter, I discuss my learnings about my patient experience, the limitations of my research, potential future research, and recommendations for policy and social change.

Chapter 2: Literature Review

Introduction

This literature review was conducted to gain an improved understanding of transgender peoples' experiences accessing health care. For the purpose of this literature review, health care includes gender transition related care and general care. This review provided background information relating to transgender health care accessibility and pointed to the methodological and geographical gaps in knowledge. Identifying gaps in the literature justified the use of autoethnography, as well as the research questions that guided this study: how do I make meaning of my lived experiences accessing health care as a transgender person; how accessible are transgender health care services on PEI; and what are the barriers to accessing health care services for transgender people?

In this chapter, I describe my search strategy, which included peer-reviewed and grey literature searches. The findings are organized thematically and include: experiences with providers; the health care system; finances and travel; general health care services; transition-related health care services; experiences in health care settings; social support; and self-advocacy. This chapter concludes with a discussion of the geographic and methodological gaps in the selected literature.

Search Strategy

The databases CINAHL, PubMed, and PsycINFO were searched for English language, peer-reviewed journal articles in which the full-text was available. The search was limited to the Canadian context because my experiences existed in this context where access to a universal, publicly funded health care system is assured to all Canadian residents. To justify the use of an autoethnographic methodology, "autoethnography" was searched against the terms "transgender," "health care," and "access." In searching PubMed, the MeSH terms "transgender persons" and "delivery of health care" were included. This search resulted in zero results for all databases.

To expand the scope of my search to non-autoethnographic studies, the terms "transgender," "health care," "access," and "Canada" were used to search the same databases. Again, the MeSH terms "transgender persons" and "delivery of health care" were included in searching PubMed. Searching these databases resulted in 76 findings. Duplicates were removed, and the titles and abstracts of findings were screened based on inclusion criteria. Inclusion criteria included literature in which transgender patients were a population of interest and health care accessibility was a topic of interest. No dates were excluded and literature involving both transgender youth and adults was included. This was due to the limited availability of publications on this topic. Fifty-one of the findings were identified as not relevant.

A full-text review of the remaining twenty-five articles was conducted. The reference lists of these articles were hand searched. Hand searching reference lists resulted in two additional findings from the *TransPulse Project* and two additional findings from the University of British Columbia that also met the inclusion criteria. A PRISMA diagram (see Appendix A) details the results of my search. Ten peer-reviewed articles and two peer reviewed reports were included in this review. To analyze the content of the included literature, I created a concept map for each piece of literature and conducted thematic analysis across concept maps.

A grey literature search of media was also conducted (Mckenzie, n.d.). This was limited to mainstream news media as these sources are created for cisgender audiences and hold cultural authority. Although all Canadian provinces provide publicly funded transition-related care

(Canadian Professional Association for Transgender Health, 2018), this search was limited to PEI and BC, as these were the provinces where I've accessed public health care as a transgender person. Specifically, CBC News Prince Edward Island, CTV News, and The Guardian newspaper were searched to explore the experiences of transgender Prince Edward Islanders. The Vancouver Sun, CBC News British Columbia, and HuffPost were searched to examine the experiences of transgender British Columbians. Articles published prior to 2015 were excluded from the BC search, as it was during this time that BC's provincial government improved their transgender health services (CBC News, 2014). Additionally, this was the time frame in which I accessed medical transition services, top surgery and hormone therapy.

The search features of each newspaper's website were used to identify articles. To filter through articles, variations of the search terms "transgender," "transgender health," and "Prince Edward Island," or "British Columbia" were used. The titles of the findings were then screened based on inclusion criteria. Inclusion criteria included studies in which transgender people were a population of interest and health care accessibility was a topic discussed. A PRISMA diagram (see Appendix A) details the results of my search. Five PEI related articles and one BC related article were included in this review. Concept maps were created for each of these articles and thematic analysis was conducted across concept maps. A comparative analysis of PEI and BC was then conducted.

Transgender Health Care Access in Canada

Each selected document, the type of source, study design, barriers to care, and facilitators to care are displayed in a chart (see Appendix B). Eight major themes emerged from the analysis of the selected literature: experiences with providers, the health care system, finances and travel, general health care services, transition-related health care services, experiences in health care settings, social support, and self-advocacy.

Experiences with health care providers

Transgender people report discomfort with their family physicians. Of the 83% of surveyed transgender Ontarians with a family physician, half report discomfort when discussing transgender related health issues with their family physician (Giblon et al., 2017). Discomfort discussing their transgender specific health concerns is the main reason transgender people do not access care when needed (Bauer et al., 2015). Only 15% of surveyed transgender Canadian youth report feeling “very comfortable” discussing their transgender status and health concerns with their family physician. More than one third of these youth report feeling “very uncomfortable” discussing their transgender status and health concerns at walk-in clinics (Veale et al., 2015, p. 32). This discomfort can be due to the uncertainty of a family physician’s level of trans-friendliness (Gahagan & Subirana-Malaret, 2018) and can lead transgender people to avoid seeking care (Clark et al., 2017). A negative correlation exists between going without mental health care and comfort with family physician in Canadian transgender adolescents. (Clark et al., 2017).

Transgender people also report that they experience barriers such as provider refusal to provide care and the required disclosure of transgender and genital status (Scheim & Travers, 2017). Additionally, transgender people report that they are more likely to experience resistance from providers when they do not conform to the “dominant understandings of gender identity or expression” (Taylor, 2013, p. 113). This can result in the denial of care, (Taylor, 2013) which may include being denied prescription refills by physicians unfamiliar with gender-affirming care (Clark et al., 2017).

Transgender people report that they experience a lack of provider competence, providers lacking the information they need (Taylor, 2013), and not obtaining enough information from providers to make informed decisions regarding their care (Frohard-Dourlent et al., 2017). They also report that they are uncertain of their provider's knowledge in trans specific health care issues, as well as cultural competency in LGBTQ issues (Gahagan & Subirana-Malaret, 2018). Transgender people are uncomfortable and frustrated by their experiences with physicians who are uninformed regarding their health care needs (Clark et al., 2017). When transgender Canadian youth are concerned that a physician is uneducated in transgender issues, they tend to avoid seeking care (Clark et al., 2017). Avoiding care is also due to medical mistrust. These claims are valid. For instance, transgender people report that they have been discouraged by providers from getting HIV testing. This is due to the provider's mistaken perception that the transgender person's risk is lower than someone who identifies as cisgender (Scheim & Travers, 2017).

A patient's comfort with their family physician facilitates their access to health care. In particular, this relates to discussions regarding their gender identity and sharing their specific health care needs. Higher levels of mental health accompany those who are more comfortable discussing their needs with physicians and better health is reported by transgender people whose family physician is aware of their transgender status. Furthermore, both family physician comfort and family physician knowledge of a patient's transgender status are positively correlated in Canadian transgender youth (Clark et al., 2017).

The health care system

Transgender people report barriers to health care access relating to the health care system. A systematic barrier is the binary division of health care services based on normative genders;

male and female. This division of services can cause discomfort in transgender people because of their identification as a non-normative gender. This exclusionary system built on a gender binary includes the health care system's failure to implement inclusive practices. These practices include intake form practices, waiting room practices, and examination room practices (Scheim & Travers, 2017). The uncertainty of the health care system's inclusiveness of transgender people (Gahagan & Subirana-Malaret, 2018), health system policies (Taylor, 2013) and not knowing where to go to access care (Veale et al., 2015) also reflect the institutionalization of gender binaries that leads to exclusion.

Finances and travel

Transgender people face financial and travel barriers in accessing health care for gender-affirming surgery and hormone therapy. These barriers can lead to transgender people missing needed care (Clark et al., 2017) and may contribute to self-performed surgeries and nonprescribed hormone use in transgender people (Rotondi et al., 2013). Transgender people also report travelling "long distances at their own expense to access competent care" (Taylor, 2013, p. 111). Travel for care also introduces an increase in complication rates. Those required to travel two or more hours to access surgical care report a complication rate of 44%, while those required to travel less than two hours report a 34% complication rate. This is significant as 60% of surveyed transgender Canadians report travelling two or more hours in order to access surgical appointments relating to gender-affirming surgery (Frohard-Dourlent et al., 2017). In addition, geographical location poses the barrier of access to trans-friendly resources. In transgender people with a history of undergoing HIV testing, residing in a city with limited trans-friendly resources leads to interruptions in testing history (Scheim & Travers, 2017).

Travel to access care is a key barrier for transgender people on PEI. This province, with the smallest population in Canada, lacks appropriate services meaning that most transgender people must travel out-of-province to access these services. In particular, an 11-year old resident of PEI was required to travel out-of-province in order to discuss hormone therapy options with an endocrinologist. This out-of-province travel will be required for any future medical services relating to their medical gender transition (Jenkins, 2017). BC, by contrast, has one of the largest provincial populations and one of the largest Canadian metropolitan centres. There are no published articles claiming that transgender people in BC must travel out-of-province to access these transition services.[1]

General health care services

A lack of access to health care for transgender people goes beyond gender-affirming services. These include general health needs. Transgender people report that their health needs are unmet. A survey of transgender Ontarians reports that 44% have unmet health care needs and a higher percentage of trans men than cisgender men report they did not receive health care when needed (Giblon & Bauer, 2017). Compared to cisgender heterosexual women, transgender people are 2.4 times more likely to report unmet mental health care needs. These differences do not exist after adjusting for social context factors, including discrimination and social support (Steele et al., 2017). Of the surveyed transgender Ontarians with a self-reported Emergency Department health care need, only 71% were able to obtain care (Bauer et al., 2014). Additionally, transgender Canadian youth report that they do not receive the physical health care they need (Veale et al., 2015).

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[1] Although individuals in BC may not be required to travel out of province to access certain health care services, those living in rural areas of BC may experience the same travel barriers as those living on PEI.

Transition-related health care services

Transgender people lack access to transition related services. Of the transgender Canadians surveyed, 40% report challenges in finding an assessor for transition-related care (Frohard-Dourlent, 2017). An assessor is a health care professional who conducts an assessment evaluating a person's readiness for transition-related care (Trans Care BC, 2020). Transgender people perceive this challenging process of finding an assessor as a gate-keeping mechanism (Frohard-Dourlent, 2017). Transgender men report that psychotherapy, surgery and hormone therapy are difficult to access, all of which facilitate the social and emotional components of transition (Taylor, 2013).

Transgender Prince Edward Islanders are unable to access health care services and supports in a timely manner, if at all. In particular, transgender people experience difficulties accessing supports for their hormone therapy. A news article describes the barriers Ash Arsenault faced accessing bi-weekly hormone therapy (MacDonald, 2014). He revealed that it is most difficult to find someone to administer his testosterone injections every two weeks, explaining that he waits two or more hours at a clinic for a 30-second injection.

Accessing assessments for hormone therapy and surgeries also serves as a barrier to care on PEI. Cadence O'Keefe explains that she was on a waiting list for a medical assessment for five years. This waitlist prevented O'Keefe from beginning medically necessary hormone therapy (Neatby, 2018). The executive director of PEI's PEERS Alliance explains that "accessing those assessments here on the Island is virtually impossible. People are going off-Island to get those assessments" (Neatby, 2018). This barrier was not found to be experienced by transgender British Columbians. James Gardner, a transgender man, shares his experiences accessing hormone therapy in BC. Gardner explains that this process was "fairly easy" for him in his province (McCarty, 2016).

Transgender Prince Edward Islanders also experience difficulties accessing proper gender-affirming surgeries. In particular, this relates to public funding for these procedures, as well as a pathway to safely access proper surgical procedures. Jay Gallant was shocked upon learning in 2016 that PEI was the only province in Canada that did not publicly fund any gender-affirming surgeries (Martel, 2018). Gallant was left disfigured when his only option for transitional health care services in the province included a mastectomy without chest reconstruction. Gallant explains that it is now too late for reconstructive surgery (Martel, 2018). In another case, James Gardner was not pleased with his experiences pursuing surgical intervention, despite having reported relative ease accessing hormone therapy. Although gender-affirming surgeries are publicly funded in BC, Gardner was met with excessive waitlists for a mastectomy, a wait that was rumored to be two-years long (McCarty, 2016).[2]

Access to health care services relates to a person's access to necessary assessments through the referral process, as well as their access to gender-affirming surgeries. Indeed, 60% of surveyed transgender British Columbians describe their referral to an assessor as easy and almost two-thirds report receiving provincial government funding for their gender-affirming surgery.[3] This experience is further facilitated by a patient's ability to choose the surgeon performing their gender-affirming surgery and access to provider contact information in case of questions or complications. One survey reports that 57% of transgender British Columbians

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[2] It is difficult to compare wait times of gender transition-related mastectomies and mastectomies for cancer treatment as the approaches to surgery are different (i.e. masculinization of the chest).

[3] Although one-third of surveyed transgender British Columbians report not receiving government funding, this is a positive statistic when compared to the historic lack of public funding on PEI.

were able to choose their preferred surgeon to perform their gender-affirming surgery. Reasonable wait times for accessing health care services is also a facilitator. These wait times can vary greatly (Frohard-Dourlent et al., 2017). In order to avoid the long waitlist for a mastectomy in BC, James Gardner used his own savings to pay for his $7000 surgery in Florida. Paying out-of-pocket facilitated his access to care (McCarty, 2016).

Experiences in health care settings

Transgender people experience barriers to health care access relating to negative experiences in health care settings. These include both fear of negative experiences and previous negative experiences. One transgender man reports that previous negative experiences led to missing needed care. These negative experiences may include problems with clinical documentation, provider cisnormative and heteronormative assumptions, and refusal of services to transgender patients (Clark et al., 2017). Of transgender Nova Scotians surveyed, 56% report at least one negative experience with the health care system (Gahagan & Subirana-Malaret, 2018) and these previous negative experiences can lead to transgender people avoiding care (Scheim & Travers, 2017). Furthermore, 52% of identifiably transgender emergency department users experienced trans-specific negative experiences, and 21% report they avoid care because of the perception that their transgender identity will negatively affect their experience (Bauer et al., 2014).

Negative experiences in health care settings are a barrier to care for transgender Prince Edward Islanders. Jay Gallant recounts a negative experience when meeting with a therapist on PEI regarding his gender identity. Gallant explains that the therapist “was really uncomfortable with the situation and just kind of said, 'This is part of your mental illness. This will pass.'" (Martel, 2018). Ash Arsenault’s experience supports this finding. He states that he “shouldn’t have more negative reactions from people in the medical field than just from everyday people" (MacDonald, 2014). These negative experiences may include physicians' and health care providers' lack of knowledge in transgender health care. Cybelle Reiber states that on PEI "there is a lack of family doctors who have knowledge and comfort around working with trans-people and trans-bodies" (Neatby, 2018). No articles were discovered discussing negative experiences in health care settings by British Columbians.

Transgender Prince Edward Islanders have negatively described their experiences in accessing health care services. Gallant explains that medically transitioning on PEI is frustrating (Mulholland, 2018). He states that he was forced to make the difficult choice between an unsatisfactory surgical procedure or continuing to live with significant psychological pain. Jay explains, "For me, knowing I couldn't afford to have the proper surgery done nor could I just move to another province, I was placed in a very difficult position" (Mulholland, 2018). The transgender community of PEI has also struggled for medical acceptance. Ash Arsenault describes his experience with PEI's health care system and the province's medical professionals as "one hoop to jump through after another" (MacDonald, 2014). Alternatively, James Gardner was pleased with the care he was receiving in BC. This was the case until he pursued surgical intervention (McCarty, 2016).

Facilitators to accessing health care as a transgender person include previous positive experiences and perceptions of a safe space care environment. Of the transgender Nova Scotians consulted, 69% report at least one positive experience with the health care system (Gahagan & Subirana-Malaret, 2018). Positive experiences with assisted reproduction service providers and clinics include trans-friendly clinic environments as well as the use of gender-neutral terminology (James-Abra et al., 2015). Additional facilitators to care are related to a patient's perceived safety in their care environment. This may relate to the creation of safe spaces for transgender patients. For instance, 83% of surgeons and 89% of clinic staff created safe spaces for transgender British Columbians (Frohard-Dourlent et al., 2017). Key facilitators to undergoing HIV testing include the provision of gender-affirming primary care and access to test administrators that are trusted by transgender people (Scheim & Travers, 2017).

Social support

Social support is a facilitator to health care access for transgender people. This includes available post-operative support, family support, and peer support. Transgender people are facilitated by their available post-operative support. Following a gender-affirming surgery, surveyed transgender British Columbians ranked their post-surgery social support an average of 7/10 points. (Frohard-Dourlent et al., 2017). Family support is also a facilitator to care for transgender people. High levels of parental support and family connectedness facilitate the health of transgender populations as transgender Canadian youth report better health when these levels are high (Veale et al., 2015). Furthermore, peer support is a facilitator to care for transgender people. Transgender men employ peer networking strategies to identify health care that is culturally competent. Asking other transgender men about their experiences with providers was shared as a primary method in identifying health care providers. An additional method includes consulting with transgender peers for information, leadership, knowledge, and validation when it becomes difficult and problematic to access and receive health care services (Taylor, 2013).

Self-advocacy

Self-advocacy is a facilitator to health care access for transgender people. Transgender men perform extra work in their attempts to access care, such as networking with other transgender men, advocating for themselves with health care providers, and being health literate. This includes being armed with the information that providers will need such as lab results, medication dosages, and pain records. This is information that one would expect a health care provider to be responsible for. Transgender men feel they must self-advocate in their access to care, specifically when they are challenged by providers. Navigating their access to care requires strategic knowledge of health care policies and practices (Taylor, 2013). Transgender men also report using strategies to navigate transphobia and cissexism in the health care system. This includes their ability to avoid confrontation with providers (James-Abra et al., 2015). Additionally, a high level of health literacy is an important component of self-advocacy for transgender men accessing health care (Taylor, 2013).

Gaps in Selected Literature

The selected literature is geographically limited. Much of the published research on transgender people's experiences accessing health care was conducted in Ontario and British Columbia. There has been limited research in the Atlantic region and no published research conducted on Prince Edward Island. The contexts of other Canadian provinces, with an emphasis on Ontario and British Columbia in this case, are much different than that of Prince Edward Island. Therefore, the selected peer-reviewed literature is limited in its transferability to Prince Edward Island because transgender people living in provinces with larger and more urban populations may experience health care access differently.

The selected literature also demonstrates methodological limitations. The majority of studies collected their data through survey methods. This method of data collection has limited the exploration of transgender people's lived experiences accessing health care. The literature is also limited in that no autoethnographic studies focus specifically on a transgender person's journey accessing health care. Therefore, the selected literature lacks a rich and detailed exploration of a transgender person's journey with accessing health care, particularly by a researcher with an insider perspective.

Chapter Summary

This review of peer-reviewed and grey literature provided background information relating to transgender health care accessibility. The geographic and methodological gaps in current literature justify my use of autoethnography in the PEI context. Eight major themes emerged from analysis of the literature review findings: experiences with providers, the health care system, finances and travel, general health care services, transition-related health care services, experiences in health care settings, social support, and self-advocacy. These findings reveal that good configurations at the systems level can result in positive experiences and facilitators, while poor configurations can result in negative experiences and barriers to access. In the next chapter, I describe my autoethnographic approach to addressing my research question.

Chapter 3: Methodology and Methods

Introduction

This chapter describes and justifies my approach to addressing my research questions. I explain autoethnographic research and my chosen methodology, critical autoethnography. This includes a detailed discussion of data collection and analysis methods, and methodological congruence and rigour. This chapter begins with a description of the ontological, epistemological, and axiological beliefs that guided my research.

Philosophical Assumptions of Qualitative Research

Creswell and Poth (2017) state that “whether we are aware of it or not, we always bring certain beliefs and philosophical assumptions to our research” (p. 15). Four philosophical assumptions guide qualitative research: ontological, epistemological, axiological, and methodological beliefs. Ontological assumptions concern the nature of reality. I believe there are multiple realities and therefore my experience is not representative of all transgender people. Epistemological assumptions are focused on how the researcher knows what they know. My epistemic stance is one of being an insider to the transgender community. Axiological assumptions include the role of values in research which, in this case, involved the manner in which I made my values and biases known. I actively reported the value-laden nature of the information and data that was gathered. Methodology refers to the rules that guide the research process (Creswell & Poth, 2017). The rules of autoethnography guided my inductive and emergent approach to collecting and analyzing my lived experience. As an autoethnographer, it was important for me to declare the philosophical assumptions I brought to my research. My personal ontological, epistemological, axiological, and methodological assumptions are explained in the sections that follow.

Ontology

Creswell and Poth (2017) define ontology as “a researcher’s view of reality” (p. 18). For this thesis, I assumed a postmodernist and relativist ontological stance. According to postmodernism, knowledge depends on the conditions of today’s world and the multiple perspectives involved. These multiple perspectives may include gender, race, and class, among others (Creswell & Poth, 2017). Relativism rejects the idea of an independent reality, favoring multiple and equally relevant realities (Andrews, 2016). This stance supports my analysis as I believe that knowledge must be set in the context of today’s world and in concert with the possibility for multiple perspectives to come to bear on a singular issue. Moreover, I believe that there are multiple realities and these multiple realities must be understood and embraced. For example, I believe that not all experiences are the same as my own, and that each transgender person living on PEI may have a unique experience with the province’s health care system due to a number of variables (family physician, timing, family support, genetic factors) (Health PEI, 2018). Therefore, my perspective of PEI’s health care system may be quite different than that of other transgender people. For example, I believe transgender health care services are almost completely inaccessible on PEI. However, there may be transgender people living in the province who deem services to be easily accessible and this is dependent on their specific experiences and contexts. Although this research focusses on my perspectives and experiences, it must be noted that the experiences of transgender Islanders could be quite diverse.

Epistemology

My epistemic stance refers to how I’ve come to know what I know with respect to transgender health care accessibility. I am an insider to the research problem. I have lived experience as a transgender person and have spoken with and listened to other transgender people as authorities of knowledge. As a PEI resident, I have sought both regular and medical transition related health care services within the province of PEI. I have also sought health care services in other Canadian provinces, specifically BC, Ontario, and Nova Scotia. I have experienced PEI's health care system firsthand, as well as the harrowing pursuit of medical gender transition. I am a member of the P.E.I. Transgender Network and have allies and contacts in the transgender community. This allowed me to get as close as possible to other transgender people living on PEI, resulting in a partial understanding of their experiences. I am currently also the community representative Co-Chair of Health PEI's provincial Transgender Steering Committee.

Axiology

Axiology is a researcher's stance on the value of the research (Creswell & Poth, 2017). I hold a specific axiological stance and have made my values known throughout this thesis. Because this is an autoethnography, I am telling my own story. Therefore, I practiced reflexivity throughout the research process in order to maintain rigour (Farrell, 2015). The values that I hold informed the way that I approached this research (Creswell & Poth, 2017): all people living on PEI deserve respect and equal treatment; health care should be accessible to all people without risk of discrimination or abuse; and all procedures and treatments deemed medically necessary should be accessible.

I value autoethnographic research. I believe that transgender people are the authorities of knowledge of our own experiences. In the transgender community, community-based knowledge is the most turned-to source for information. Mainstream sources of knowledge, however, are not inclusive of these forms of knowledge in understanding how to best serve transgender people. This research is valuable because it focuses exclusively on the health care journey of a transgender person. According to Milne et al. (2017), patient stories are re-shaping health care. The Canadian Institute for Health Research states that "a patient's experience provides valuable insight" (2018, para. 1) Health care professionals are the gatekeepers to the health care resources and services that transgender people need. This autoethnography demonstrates that we (transgender people) are authorities of our own experiences and truths. The knowledge may educate health care professionals and decision makers about needed change.

This research is valuable in providing an insider perspective and improving understanding of transgender people and their health care needs in the country. As this is the first study that has been conducted in the province of PEI that includes a transgender Prince Edward Islander, it is valuable source of information for my province. This study is value-driven in that it acknowledges the existence of PEI's transgender community and their need for adequate provincial health care services. Finally, this research contributes to the emerging global conversation about transgender health as an important and emerging area of research.

Methodology

A critical autoethnographic approach aligns with my ontological, epistemological, and axiological assumptions. I chose a critical autoethnographic approach to addressing my research questions. This narrative methodology allowed me to develop a rich and detailed description of the research problem, as well as my situated truth of transgender health care accessibility as a transgender individual seeking health care services on PEI. In doing so, I was engaged in processes of becoming, and because of this I showed ways of embodying change (Holman Jones, 2016). An inductive and emerging process shaped both the collection and analysis of data (Creswell & Poth, 2017). In the following sections, I discuss autoethnographic research, the use of autoethnography in health research, and critical autoethnography.

Autoethnography

Autoethnography is a type of narrative inquiry that uses the researcher's personal story and experiences as the primary form of data. This data is used to conduct a sociocultural analysis and interpretation of the meaning of these experiences (Chang, 2016). As such, an autoethnography is an autobiography that "self-consciously explores the interplay of the introspective, personally engaged self with cultural descriptions mediated through language, history, and ethnography explanation" (Ellis & Bochner, 2000, p. 742). Through participating in this critical form of self-study, the researcher views their personal experiences actively, scientifically, and systematically. This is in relation to the cultural groups that the researcher identifies as similar to themselves (Hughes et al., 2012). In my case, my cultural groups are residents of PEI and the transgender community.

Autoethnographic researchers aspire to connect the personal and the social through their research, and in turn, make the connection between their personal experiences and the experiences of others (Chang, 2016). In order to make this connection, autoethnographic researchers collect a variety of data using a variety of methods (Chang, 2008). These methods may include personal recall, introspection, and personal reflections, among others. Data may also be collected through interviews, or by other means, with others who have had experiences that are similar to and/or different than the researcher's own experiences. Those who have witnessed the researcher's experiences may also be chosen to be interviewed, such as family members (Chang, 2016). This type of research embraces personal assumptions and reflections within the research. The strength of this type of research came from the incorporation of reflexivity in positioning myself within my own research (Chang, 2016).

Autoethnography in Health Research.

In 1995, Carolyn Ellis, an ethnographically trained sociologist, published an autoethnography titled *Final Negotiations*. Through chronicling her experiences with caring for her husband while he was dying of cancer, Ellis' autoethnography revealed the emotional and learning potential of health-related narratives. There is great diversity in health-related autoethnographies as they have been found to cover a wide variety of topics. Furthermore, health-related autoethnographies are not limited to patients, as they have been produced by family members, caregivers, nurses, therapists, and educators, to name a few. Although several health professionals have published autoethnographies, the unique nature of autoethnography has facilitated the passage of non-health professionals into the health research field (Chang, 2016).

The motivation to conduct a health-related autoethnography, and therefore expose very personal life details and health information has been questioned and must be seriously considered. In an attempt to explain this motivation and popularity of method, Chang (2016) notes the appeals of using autoethnography. These include generating the knowledge of marginalized subjects, building camaraderie through shared experiences, and/or achieving healing, empathy, and transformation through autoethnographic storytelling. Oftentimes, these stories have been silenced through oppression and should be "brought out to the light so that others gain a new understanding about human experience" (Chang, 2016, p. 446). Generating the knowledge of marginalized subjects, in my case a transgender person living on PEI, allowed me to tell a unique story previously untold or unknown outside the trans community.

According to Chang (2016), building "camaraderie through sharing often stigmatized stories so that those who quietly suffer from them could find their voices in the published works" is the motivation behind conducting a health-related autoethnography (p. 446). An autoethnography allows for a silenced voice to be heard by others who feel they have been silenced. In producing this autoethnography my voice has been heard, and although my intended audience is cisgender people, it is my hope that my story can resonate with other transgender people.

Chang (2016) claims that conducting and publishing autoethnographies have a healing component for their authors. Ellis (2010) also explains how writing an autoethnography can be therapeutic for both the researcher and their readers. Writing an autoethnography enables the researcher to gain understanding of their experiences and self. This process has allowed me to purge my burdens and question ideal stories, while validating my pain (Ellis, 2010). Autoethnographies can also be therapeutic for readers in that narratives validate the pain they have experienced. It is my hope that reading this autoethnography may allow trans readers to feel an increased ability to cope with and change their situation as well (Ellis, 2010).

It should be noted, however, that health-related autoethnographies have been predominantly narration-heavy, and many autoethnographies “are published with little interpretation of illness as a sociocultural phenomenon” (Chang, 2016, p. 447). Therefore, my emphasis has been on both the auto and ethno components of this autoethnography (Chang, 2016). The cultural interpretation of a narrative is important (Ellis, 2010) in making “characteristics of a culture familiar for insiders and outsiders” (Ellis, 2010, para. 9).

Autoethnographies are critiqued when findings are not theoretically framed, when data analysis is not detailed, and when designs are not rigorous. Criticism concerns insufficient field work, observation of cultural members, and time spent with others (Ellis, 2010). In a later section on methodological rigour I show how I addressed these critiques.

Critical autoethnography

Critical autoethnography is an intimate methodology that studies and critiques culture through the lens of the self and one's personal experiences (Harris, Holman Jones, & Pruyn, 2018). The methodology of autoethnography merges writing one's own story or narrative (autobiography) and the study of and writing about collective beliefs, values, language, behaviours and actions of a culture-sharing group (ethnography). While this provides complex and specific insights into human lived experiences and relationships, critical autoethnography goes a step further as it investigates how cultures are created and compromised through relations of power, including social, political, interpersonal, and institutional relations. Within cultures, our experiences may be enlarged and/or constrained by relationships of power, and this is a focus of critical autoethnography. The critical in critical autoethnography serves to reveal and unearth the underlying mechanisms that reinforce oppression (Harris, Holman Jones, & Pruyn, 2018).

In conducting a critical autoethnography I viewed my work as a means of pointing out the politics of my positioning, while explicitly acknowledging the privileges and marginalization I have and will continue to experience in my life. Additionally, I acknowledge my responsibility for addressing these unfair and unjust processes within my lived domain, which includes research practices. This was done by creating accounts of intersectionality which brought attention to "how oppressive institutions, attitudes, and actions in cultures…do not function independently but instead are connected and mutually influencing" (Harris, Holman Jones, & Pruyn, 2018, p. 5). The goal of these accounts of intersectionality was to capture the "complexities of intersecting power relations that produce multiple identities and distinctive perspectives on social phenomena" (Harris, Holman Jones, & Pruyn, 2018, p. 5). To do so, I was critical of my own intersectional positionings within cultures. Throughout the research process and in writing this thesis, I interrogated these positionings (Harris, Holman Jones, & Pruyn, 2018).

I chose a critical autoethnographic approach for this research mainly because of its evocative potential (Chang, 2008). In taking readers on my journey, they are provided with a sense of what accessing health care as a transgender person feels like and gain an understanding of the complexities of being transgender, including the oppression and marginalization that I have experienced. By providing a rich, detailed description of my experiences within my cultural context I have the potential to connect with readers on an emotional level. Using critical autoethnography resulted in rich and evocative stories, allowing for the voice of a non-normative gender identity to be heard and exist, rather than silenced. My goal with using critical autoethnography was to disrupt structural and societal inequities faced by this marginalized and oppressed group. This introduces transgender people as agents of authorized knowledge relating to health care, disrupting the inequities of the health care system as well as the objectification of transgender people that occurs through cisnormative knowledge authorization. The questions that guided this study were:

1. How do I make meaning of my lived experiences accessing health care as a transgender person?
2. How accessible are transgender health care services on PEI?
3. What are the barriers to accessing health care services for transgender people?

Data Collection

Data collection began in April 2018 and was completed in December 2018. April 2018 was chosen as the data collection start date as it was during this time that I made the decision to conduct a critical autoethnography. December 2018 was the end date for data collection as I felt

I had had adequate time to gather personal memory data, self-observation and self-reflection data and external data sets. External data sets included my medical records, surgery denial forms, Facebook conversations, and personal emails.

Data collection began with the collection of self-observation data/self-reflection data. At the time of this research, I was still in the process of pursuing transitional health care services. Therefore, I was able to observe my experiences as they were happening and reflect upon them (Creswell & Poth, 2017). Through the processes of introspection and self-analysis, I documented my emotions and personal thoughts using a smartphone to record the data. These data were organized in a password protected Microsoft Word document. I reviewed and refined these data throughout the research process.

There were challenges to collecting self-observations. These included disruptions in the recording of data and limitations relating to my memory. At times, my thoughts were disrupted while collecting self-reflection and self-observation data. These interruptions were due to the public health care settings where I documented my experiences. Collecting self-reflection data was also limited because of the fallible nature of my memory. Autoethnographers recognize that events are not recalled exactly as they were experienced. However, Ellis (2010) explains that "autoethnographers value narrative truth based on what a story of experience does" (para. 32). I addressed these challenges by having my phone available in all health settings, collecting self-observations as they were occurring or as soon as possible after the experience, and collecting these data in private and quiet areas when possible.

Another source of data was external data sets. These included my personal medical records, surgery denial forms, as well as Facebook and email conversations I had with surgeons and health care staff and people within and outside of the transgender community. These data were essential as they served to “preserve thoughts, emotions, and perspectives at the time of recording, and remain untainted by the present research agenda” (Chang, 2008, p. 107). External data created from January 2011 to December 2018 were included because 2011 was the year I began to vocalize my feeling about my gender identity. Only the components of my medical record that were relevant to my medical transition were included. Only excerpts from emails and Facebook conversations discussing my experiences with medical transition were collected. For ethical reasons, I only collected my own words from Facebook conversations. Other data sources were used to provide contextual support. These data were organized in a password protected Microsoft Word document. This document was reviewed and refined throughout the research process.

The final step in the data collection process was the collection of personal memory data. This included data collected from a personal journal/autobiography that I wrote in March and April 2017. My journal captured the emotions and experiences I had during my coming out experience and transition. Only excerpts that were relevant to my medical transition and/or social context were excerpted for analysis. This type of data was collected and written as text in a password protected Microsoft Word document.

Another source of personal memory data was from a personal journal written for the purpose of this thesis. I kept this journal from April 2018 to December 2018 to ensure that I reflected on my past over several months. Through personal memory recall, I have chronicled my past experiences that were related to my medical transition and accessing health care services as a transgender person. These past experiences included my experiences in accessing mental health services, family physicians, hormone therapy and endocrinology services, as well as surgeons and gender-affirming surgical procedures. In addition, the personal memory data chronicled my experiences in health care settings and my experiences growing up on PEI as a transgender person. These data were reviewed and refined throughout the research process.

There are limitations to personal memory data. As previously discussed, it is possible that my memory has shaped or distorted the past. Ellis (2000) explains that memory, like life, does not function linearly. As such, we interpret our past experiences from our current position. Restructuring the past can be a challenge, however, there is value in this practice (Ellis, 2000). Ellis (2000) states that there is “value in trying to disentangle now from then, as long as you realize it’s not a project you’ll ever complete or get completely right; instead you strive... to get it ‘differently contoured and nuanced’ in a meaningful way” (p. 118).

Furthermore, the emotional involvement in the study can be viewed as a disadvantage in that it makes it difficult to be on the outside and perform a cultural analysis (Ellis, 2000). This moving in and moving out process described by Ellis (2010) is necessary in producing an authentic autoethnography. The use of multiple data sources ensured that I conducted a sound and rigorous autoethnography.

Data Analysis

Narrative analysis was conducted to analyze the data. This strategy also allowed me to view the similarities and differences across the collected data and reveal the meaning of the data I generated (Creswell & Poth, 2017). Data analysis began with the creation of primary organization labels. These labels provided initial data information, such as the collection method and data source. Data were then organized according to their source and collection method. Secondary labels were then created which served to report data content, such as key players, location, and dates. Separated by headings, each data source was then organized in chronological order. I have used a data log to track these labels which is stored in a password protected Microsoft Word document. Data that were collected for this study were reviewed and refined several times. This process was used to limit redundant data (Chang, 2008).

Chang (2008) suggests that data analysis in autoethnographic research should be interpretive in explaining how one's experiences are both culturally and personally meaningful. Through this process of analysis and interpretation I searched for and explored the interactions of social and external factors with my internal experiences (Chang, 2008). I analyzed the intersecting relationship between my *self* and the societal/institutional contexts I interacted with and existed within. To ensure methodological congruence with critical autoethnography, I created a chronology of events that pointed to epiphanies and turning points in my story.

Methodological Congruence

Methodological congruence is the interconnectedness between the purpose of the research, the research questions, and the methods employed throughout the research process. Methodological congruence ensures that a research study is cohesive, rather than isolated into potential incompatible parts. To ensure that my research was methodologically congruent, each choice that I made was consistent with my philosophical assumptions and methodological rules for conducting a critical autoethnography. I identified a problem that needed to be investigated, advanced my study's primary purpose, and specified the questions that served to guide my study's design. These steps provided foundation for the decisions I made relating to my study's research methods, such as data collection and analysis (Creswell & Poth, 2017). I also built in rigour using elements that were consistent with narrative research.

Methodological Rigour

Autoethnographic studies can be challenged by those who doubt this method of inquiry, and the autoethnographers may also have questions of their own relating to the methodology.

Attempts have been made by scholars to “provide guidelines to situate this powerful, but unique, research method of autoethnography within the existing framework of good human research” (Chang, 2016, p. 447). Chang (2016) proposed five standards for maintaining a high level of methodological rigour in autoethnographic studies. These are authentic and trustworthy data, accountable research process, ethics toward other and self, sociocultural analysis and interpretation, and scholarly contribution.

Authentic and trustworthy data

Autoethnographies generate knowledge from data collected and analyzed by the author-researcher. Therefore, personal memories are a significant source of data in this type of research. The collection of authentic and trustworthy data is central to establishing rigour in autoethnographic research. The notion of authenticity is at odds with queer theory, which questions the existence of authenticity. Although the truth is not necessarily authentic, my truth creates meaning.

Chang poses an interesting question: “When autoethnographers draw data from their personal memories and possessions that no one but the researcher can access, how can the readers trust that the data are real and authentic?” (2016, p. 447). He goes on to say that “memory can wane and become distorted over time” (p. 448). To address this critique, I collected data from a variety of data sources over a long time frame. This increased the probability of collecting rich data that is both authentic and trustworthy (Chang, 2016).

Chang (2016) argues that in addition to utilizing various authentic and trustworthy data, autoethnographers must reveal these sources of data in order for autoethnography to develop as a method in health research. Using a variety of data sources was a form of triangulation, an element that increases the credibility of findings (Chang, 2008). Moreover, I do not believe that describing the research process would disrupt the research process, and therefore I have chosen to provide a detailed description of the process, further strengthening the rigour of this study.

Accountable research process

"When autoethnographers whistle and dance all by themselves behind the closed door, how can the audience keep these autoethnographers accountable for their research process?" (Chang, 2016, p. 447). According to Chang (2016), an accountable research process is one in which the researcher is transparent and practices self-reflexivity. Autoethnography provides the researcher with the authority to design and execute their research process, allowing for the utmost creativity (Chang, 2016). To ensure an accountable research process and an impressive autoethnography in health research, Chang recommends that the researcher provide a detailed description of the research process and explicit reflections on the research process (Chang, 2016).

Because readers cannot assume the use of specific and standard processes, I made explicit the research process I used. I provided explicit descriptions of the research process and my reflections on it. This supports my efforts in ensuring an accountable research process. As with all approaches to qualitative research in which declaring philosophical assumptions is expected, declaring my standpoint as both researcher and research subject as well as engaging in reflexivity throughout the autoethnographic process was essential. The strength and veracity of this study came from my personal standpoint and the way that I positioned myself in my story (Creswell, 2017). I detailed my connections to this field of study in both personal and professional contexts. Through my experiences as a transgender person, and someone who is connected to others in the transgender community of PEI, I shared my understanding of transgender health care accessibility and the provincial health care system.

Ethics toward others and self

Chang (2016) offers a third standard for autoethnographic research in health research; ethics toward others and self. Just as researchers using other methodologies are expected to obtain consent in research involving human subjects, autoethnographers should be required to do the same for those who are included in autoethnographic stories (Chang, 2008; Tolich, 2010). In terms of obtaining retrospective consent, Tolich (2010) declares a particular disproval for this approach, stating that "seeking informed consent after writing an article is problematic and potentially coercive, placing undue obligation on research 'subjects' to volunteer" (p. 1600).

Anticipatory ethics are desirable but complex to achieve in practice (Chang, 2016). Autoethnographers must demonstrate their attempt to adhere to ethical standards in order for the quality of a health-related autoethnography to be considered good. Therefore, autoethnographic researchers should consult with the ethical review boards of their institutions and strive to achieve the utmost of protection for others and their rights. Researchers must also consider the potential personal impacts that publishing their autoethnography may have. For instance, the researcher may be exposed to emotional and/or physical pain as a direct result of the deep reflections required in conducting this type of research. Additionally, the researcher is placed in a position of vulnerability as they expose their feelings and lives to others. The researcher must also be aware of and reminded that they can withdraw from their own study at any time. This warrants serious consideration as the researcher must also ensure that their own rights are protected (Chang, 2016).

I reviewed the requirements for ethical approval and was advised by my university's Research Ethics Board (REB) that ethical approval was not required for an autoethnographic study. I was concerned by this, as it was clear that conducting this type of research was not without the potential of harm or risk to me, my loved ones, and other key players in my experiences. Webber and Brunger (2018) argue that "the production and enactment of risk guidelines should be limited to the pedagogical relationships within the educational institution, or to institutional requirements for workplace safety, not REBs" because risk assessment is subjective (para. 29). Nevertheless, the institutional ethics board's decision left me feeling unprotected. I felt that the potential harm to me caused by conducting an autoethnographic study was not recognized and that my health, safety, and well-being as a researcher were not valued or important. By not offering to me the same protections as researchers and participants engaged in non-autoethnographic studies, I felt the REB failed to protect me.

Gustafson and Brunger (2014) explain that Research Ethics Boards serve to protect vulnerable populations. This might reasonably extend to the transgender community. Therefore, the lack of an ethical approval process for autoethnographic research must be critically considered. In this thesis, I critically reflected on the power of institutionalized practices at play. This illuminated the power relations involved in the ethical approval process and identified the clear power imbalance that exists between researchers and Research Ethics Boards. Gustafson and Brunger describe that vulnerable populations have difficulty "getting through the door" (2014, p. 1001) of ethics approval. However, in my case of conducting autoethnographic research, this door is non-existent. This may pose an obstacle to other vulnerable populations conducting this type of research.

Although ethical approval was not required, I made efforts to protect myself and others from risk and harm when reflecting on past experiences that were painful and or potentially harmful. I attended to the three principles of TCPS2 which include respect for persons, concern for welfare, and justice (Canadian Institutes of Health Research, Natural Sciences and

Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010). I made efforts to maintain my mental health when necessary, and scheduled sufficient time for relaxation (Priddis, 2015). I had conversations with members of my supervisory committee to check in on issues relating to respect, welfare, and harm.

Confidentiality was maintained to protect myself and others from the potential harm/risks associated with autoethnographic research. Official names were not used in this thesis, to ensure the protection of loved ones and health care providers. In the case of using Facebook conversations, full names and other identifying information were removed. Although the key players in my health care journey were not consulted or informed about this research, I removed all identifying information from my data. The specific names of health care providers and other key players were not used. I also opted to use generic location titles. This practice was maintained throughout the research process, including data collection, data analysis, and in writing my story in this thesis.

I exposed several of my truths throughout this thesis, however, there are specific aspects of my life that I excluded as a way of protecting my privacy. Anonymity was not possible as my name can be found on the title page of this thesis. This was a difficult decision for me as I tend to live an anonymous or stealth life in regard to my transgender identity. However, I felt that by removing my identification and therefore silencing myself, I would be colluding with a system that marginalizes transgender people. I consider being transgender to be a part of my medical history rather than my social identity. Therefore, I have forgone the protection of my privacy for the purpose of this research and to further the movement for improved transgender health.

Memorial University of Newfoundland (n.d., para. 1) describes informed consent as an on-going process that “provides participants with enough information about the study to allow them to make informed decisions about whether to participate, and whether to continue to participate." The informed consent process begins at the first point of contact between researcher and participant, and it extends to study completion and/or withdrawal of participants. As the researcher is the study participant in an autoethnographic study, this can prove to be challenging. Although ethics approval, and therefore informed consent, were not required to conduct this research, I felt the need to provide a form of self-informed consent. The document used for the informed consent process can be found in Appendix C.

The information collected for the purpose of this thesis were stored on my personal password protected laptop computer. All data files collected for this study were stored as password protected Microsoft Word documents on my laptop. These documents will be stored for the 5 years that follow the submission of my thesis.

Sociocultural analysis and interpretation

The fourth standard for conducting autoethnography in health research is sociocultural analysis and interpretation (Chang 2016). This component is applicable to the ethno feature of autoethnographic studies. According to Chang (2016) "the fundamental purpose of autoethnography as a social science inquiry is to answer the question about the sociocultural meanings of human experiences" (p. 449). The methodology of autoethnography serves to connect the self with the social and examine the relationship between the two. Our personal experiences (the auto component of autoethnography) are shaped by the sociocultural contexts in which they exist and are created. Therefore, it is important that the personal experiences of the autoethnographer are interpreted in their specific sociocultural context. Researchers must also explain the meaning of their experiences in comparison to the experiences of others. As such, they must describe their specific sociocultural values and explain how society has reacted to their personal experiences (Chang, 2016).

Chang argues that "autoethnography in health research must go beyond the mere narration of personal experiences by providing an in-depth analysis and interpretation of sociocultural meanings of the autoethnographers' personal experiences" (2016, p. 449). To achieve this standard, I analyzed and interpreted the data using my sociocultural contextual lens. I also compared my experiences to the experiences of others. This included searching for cultural themes in the data as well as analyzing my relationship with the societal and institutional contexts I interacted with.

Scholarly contribution

The fifth standard for autoethnographies in health research is scholarly contribution. Under this standard, researchers are challenged to "make their studies relevant and transferable to the wide community of researchers and research consumers" (Chang, 2016, p. 449). Autoethnographies hold evocative potential, but they must be more than the personal stories of the researcher-author. Autoethnographers in health research must ensure that they provide a scholarly contribution that is not limited to their personal stories. To ensure a scholarly contribution that is not limited in scope, researchers must connect their autoethnographies to the current literature and "make serious efforts to speak to what their personal issues should mean to the broader health research community" (Chang, 2016, p. 449). I have framed using queer theory and grounded my research findings in the current relevant literature.

Reliability, generalizability, validity, and transferability

Autoethnographers may face opposition to their study's reliability, generalizability, validity, and transferability. These are other tools for building rigour in autoethnographic research. Reliability is defined by the researcher's credibility. The reliability of this research may be challenged due to the personal nature of the data that I have collected. However, readers test the story and its ability to speak to them in autoethnographies. As such, a defensible autoethnography must speak to the reader in regard to the researcher's experiences and/or the experiences and lives of others (Ellis, 2010). My supervisory committee has reviewed this thesis and challenged me to examine and address how my personal story is communicated and may be received by the cisgender and the transgender reader.

Ellis (2010) states that generalizability "is determined by whether the (specific) autoethnographer is able to illuminate (general) unfamiliar cultural processes" (para. 35). The generalizability of this study may be questioned as the data were generated by one subject (me). Therefore, it may not hold true to all cultural processes (Lapan et al., 2012). Due to this study's qualitative nature, the findings from this study are not generalizable to all transgender people as mine is only one story among many. However, there may be similarities in my experiences accessing hormone therapy and gender-affirming surgery to other transgender men. Many experiences described, such as those surrounding the use of proper pronouns and names, may be similar for other transgender people.

A valid autoethnography is one that exists as a coherent story, as well as one that connects the reader and writer. Ellis (2010) states that validity "evokes in readers a feeling that the experience described is lifelike, believable, and possible, a feeling that what has been represented could be true" (para. 34). I have ensured a valid autoethnography by transporting readers into my world and telling a story that has improved my life and may be useful in improving the lives of transgender readers. I have also ensured validity in supporting communication between readers and those who differ from them (Ellis et al., 2010).

Chang (2016) asks, “When the experiences are personal to one autoethnographer, how can this single person’s story be transferred to the understanding of others?” (Chang, 2016, p.447). The transferability of an autoethnographic study may be challenged due to its subjective nature. Riordan explains that transferability is “achieved when readers feel as though the story of the research overlaps with their own situation and they intuitively transfer the research to their own action” (2014, p. 10). Additionally, it is the ability to transfer the findings of a research study to different contexts with other subjects and may be explained as the “interpretive equivalent of generalizability” (Anney, 2014, p. 277). I have made serious efforts to support the transferability of this study through thick description (Geertz, 2008).

Although I am the sole participant in this study, it may be useful to provide a description of myself and elaborate on my rationale for studying myself. I am a 26-year-old transgender man residing in the province of PEI. Assigned female at birth, I began social and medical transitioning to male at 17 years old. My pursuit of medical transition services included health care services such as hormone therapy and gender-affirming surgeries. At the time of this writing, my medical transitioning is ongoing. I lived on PEI during a time in which transgender surgeries were not a publicly funded service, but I have been fortunate to undergo surgical treatments out-of-province during this time. I have also been fortunate that my family physicians have been accepting and supportive of my transition. Furthermore, my mother is a Registered Nurse and acts as my family caregiver. Being in a position of great privilege and still experiencing great health care difficulties, provided the rationale needed to study myself. A strength of this is that it will reveal hidden personal experiences in accessing health care as a transgender person.

Chapter Summary

This chapter explained and justified my choice of critical autoethnography to address my research questions. I began with a description of my personal ontological, epistemological, and axiological stances as a post-modernist who believes that knowledge depends on the conditions of the world and the involved multiple perspectives. Critical autoethnography is congruent with these philosophical assumptions. To ensure methodological rigour, data were collected using external data sets, self-reflection and self-observation data, as well as personal memory data. Narrative analysis created a chronological story characterized by epiphanies and turning points that appears in the next chapter.

This chapter also identified some of the challenges of conducting critical autoethnography and how I addressed these challenges by following Chang (2016)'s criteria for maintaining a high level of methodological rigour. These included the criteria of authentic and trustworthy data, accountable research process, ethics toward other and self, sociocultural analysis and interpretation, as well as scholarly contribution.

Chapter 4: My Story

“How do you move from hiding your life to telling your life story?”

-Carolyn Ellis, 2004, p. 109

Introduction

This chapter is a chronological presentation of my earliest memories as a 5-year-old trying to make sense of my gender expression to my current age of 26 and the 21 intervening years trying to access health care as a transgender person. I provide descriptive explanations of my personal experiences and relevant background information to facilitate the understanding of my journey. For a visual timeline of my journey see Appendix D. Specifically, I examine relevant experiences from my childhood/pre-coming out years, my coming out experience, my experiences accessing health care services, and my health care advocacy. These include social relations with my family and friends, health care professionals and staff, as well as the general public. I explain my experiences accessing both transgender specific and general health care on PEI, in Canada, and in the United States. I narrate my story by presenting my experiences and feelings, followed by statements revisiting these through my present-day lens.

My Childhood Years and Finding Myself

Growing up, I did not label myself as transgender as I did not possess the language to describe what I was feeling at the time. The historical and regional contexts in which I grew up did not expose me to transgender role models to facilitate the understanding of my feelings. One thing was certain, I knew from age five (1998) that there was something just not right about me being a girl. I tried my best to fit in and do what other girls did, but always found myself wishing I could be a boy and do what boys did. These desires were not limited to traditional male stereotypes such as independence. They also included my desire to express my masculinity. I longed to wear the same clothes as the boys at my school, have a male hairstyle, and be called by masculine pronouns.

In retrospect, I understand that these were signs that I was transgender. However, this epiphany occurred after my childhood years. I suppressed many of my desires in an attempt to fit society's mold of an acceptable, normal girl in the gender-expression context. Every day, I took on an acting role so that the most prominent signs of my true gender identity remained a secret. I lacked the language for what I was experiencing and labelled myself a tomboy. Presenting myself as a tomboy was a logical alternative because a lot of girls that I knew did the same. Based on my inauthentic exterior female presentation, nothing seemed out of the ordinary to my family, peers, or the general public.

Inside was an entirely different story. My mind and body were at odds, and I felt confused and unfulfilled with my life: past, present, and future. I would automatically imagine myself as the father of my children, rather than the mother. Each time I would shake my head and remind myself that I was not right in my thinking, as I had been born a girl. This was paired with an unexplainable wariness for my future. I would attempt to express my gender identity by dressing as a boy for Halloween costumes. This made me feel genuine happiness, as I could look, walk, and talk the way I wanted in public without any ramifications. Additionally, I would assume male roles when the opportunity arose, such as singing male verses of songs and playing male characters in my childhood.

Assuming a male role felt automatic and natural to me. I felt my authentic self when expressing my masculinity. However comfortable I felt being a boy, I never told anyone about what I was feeling out of fear originating from an experience I had at seven years old. While shopping for clothes with my mother, I requested boys' clothes. My mother supported my request without question; however, I was met with criticism from a family friend when wearing these clothes. To avoid future criticism, I fearfully hid the clothes away in my closet and it became my mission to suppress my masculinity and fit in. I felt I had done something wrong by wearing these clothes although I did not understand why it was wrong. As a child I was not capable of understanding the broader gender norms at play. In using my adult lens, it is clear that in wearing boys' clothes I was challenging societal gender norms.

As I grew older, my journey was further impacted by social relations. I gained a clearer sense of society's gender norms through interactions with my peers in junior high and high school (2005-2011). The historical social context was changing, and the awareness of gender norms became more apparent to me. I felt pressure to conform in the ways I acted, dressed, and expressed myself. I was told to wax my eyebrows and change the way I sat because I appeared too masculine. Internally it felt good to be called masculine, but I knew I had to change in order to present as normal as possible and avoid ridicule. I also styled my long hair and bought women's clothing, both of which I had no interest in. This served to camouflage my true gender identity at school and social events. Upon returning home from public outings, I would quickly change into gender neutral clothing. I experienced great ambivalence as I tirelessly fought opposing internal forces, presenting as my inauthentic self and the relief of avoiding criticism.

My hidden identity and this suppression of my truth lead to debilitating anxiety and depression. During my final year of high school, I was consumed by health issues (disordered eating, depression, anxiety). At the time, I thought this was completely isolated from the internal conflict between my mind and body. In retrospect, I realize it was related to being transgender as I attempted to control my body and the changes resulting from puberty. I dissociated from my body to survive each day, separating my masculine mind from the feminine body it inhabited.

It was becoming unfathomable to continue the act I had kept up for years, however, I did manage to continue. Upon speaking with my family physician about my health issues I was referred to a counsellor. At that time, I did not share any feelings relating to my gender identity with my family physician out of fear, confusion, and my limited language to describe what I was experiencing. For the same reason I did not share these feelings with my counsellor for many months. Throughout the year that I attended counselling, being transgender was not investigated as a potential factor in my deteriorating health.

In 2011, I was at an all-time low and my health status began to impact every aspect of my life, including my university courses. To focus on my health, I withdrew from my courses and began a deep dive into what I was feeling. This independent and self-driven investigation began with searching the internet for answers to the questions I had over the years, questions relating to my gender identity.

In my search I came across a transgender man's YouTube channel describing his process of transitioning. As the historical and regional contexts in which I existed had negatively exposed me to transgender people, watching these videos was the first time I was positively exposed to a transgender person. After watching one video, I was overwhelmed with relief and hope. Finally, I had the vocabulary to describe what I was experiencing, and I no longer felt alone in my experiences. Learning that medical transition health care services were possible and available for people like me was an incredible discovery, and for the first time in my life I was excited for my future. This was a key turning point in my journey.

Finding who I was and learning who I could be was both beautiful and terrifying. It was beautiful in that I learned there was legitimacy to and treatment for how I had felt all these years; it was terrifying in that I knew my journey would not be easy, medically or socially. Medical transition would be difficult as PEI did not fund or perform gender-affirming surgeries. Socially transitioning in this regional context would be difficult due to the province's small population and limited diversity.

I knew what I could potentially expect from people on PEI because of the cultural context I grew up in. Throughout my childhood and teenage years transgender people were always the punchline of jokes. It was implied that transgender people were not normal and as such, I had never heard a positive comment about a transgender person. My only known examples of transgender people living on PEI were allegedly working in the sex trade and/or were bullied, socially outcast, or marginalized. Additionally, PEI had a reputation for being a place that you leave if you're different, and being transgender meant that I was.

Coming Out as Transgender

In 2016, I began journaling to gather my thoughts and preserve my gender transition experiences. My journal explains that "coming out as transgender was not an easy thing. Many people ask me how I did it, and my answer is simply that I had to." After carefully considering my health and safety, I decided to share what I was feeling with my counsellor in 2011. Fortunately, I was met with her support, however, she did share that she lacked specific training in working with transgender people. Although I had to educate her on trans issues and the process of transitioning, she was willing to facilitate my transition by talking through my feelings with me and providing referrals and letters of support for gender transition related health care. She facilitated my access to a psychiatrist. An excerpt of my counsellor's email to a psychiatrist read: "Aly is identifying that she feels male… Aly has been doing research online about transgender and wants to know what the process is for sexual reassignment surgery, etc. She requested I tell you her 'news.'"

Unfortunately, upon meeting with this psychiatrist and sharing my feelings, he responded, “I don’t know what to do with this.” This response left me feeling frustrated with the health care system and confused as to where to turn. My confidence in the health system that was built by my counsellor’s support was destroyed in a matter of seconds. My personal journal states that I felt “trapped” and “at a dead end.” I knew that it was possible that the psychiatrist would not know how to help me, but I did not expect that he would be unwilling to try.

In the 2011 context, gender identity disorder was the term used by the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) to describe my symptoms. I embraced the medicalization of my gender identity as I believed it was a medical condition. At age 18, I came out to my family and friends. I first confided in my mother due to previous positive experiences with her unconditional loving demeanor, empathy, and position as a health care professional. This was followed by telling my father, brother, and sister, respectively, sharing that I believed I had gender identity disorder and felt I was supposed to have been born a boy. I did not feel that being transgender was the fault of social gender norms, but more of a birth defect for which I could seek medical treatment. By using medical language to explain what I was feeling, I thought my claim was more legitimate. According to my personal journal, “I remember that I worded it as gender identity disorder, so as to explain that it was out of my control and purely biological.” In retrospect, I understand that I believed using this terminology in my coming out would lead to a higher likelihood of acceptance for my gender transition.

Social relations impacted my coming out experience. I did not know what to expect from my family and friends. I hoped for their support, but the variety of coming out horror stories I had read online instilled me with worry and fear. These included instances of transgender people being disowned by their families and isolated by their friends. Although the possibility that this could happen to me was frightening, I knew that I needed to come out. My personal journal states, “Quite honestly, I didn’t care who I would lose at that point because I was going to lose myself if I continued living the way I was.” It was something I needed to do to survive emotionally and socially, whether I had their support or not.

I was fortunate. My family and friends reacted kindly to my coming out. My news was met with love and for some, a desire for increased knowledge on the topic. I began telling people one by one, with each positive reaction increasing my confidence, courage, and strength. The more people that supported me, the easier it became to share with others. Although I did not feel people understood exactly what I was feeling or what being transgender meant, I was reassured that I would not be disowned or cast out by my family or friends due to my declared gender identification. I knew that the beginning of my transition would be uncomfortable as people got used to my new appearance. However, I had felt so uncomfortable in my own body for years that I knew this was something I could and needed to cope with.

In reflecting upon that time, I now realize that I tried to carry the burden of my transition alone. After coming out, I took steps to ease other peoples’ adjustment to my gender transition. Initially, I told people that I only wanted to change my clothes, cut my hair, and potentially have top surgery. I also explained that they did not have to call me by a different name or use different pronouns when speaking to or about me. The only time I requested the use of male pronouns was to ensure my safety and privacy in public places. I was so focused on how other people would deal with my transition and making them feel comfortable, that I forgot to focus on what I needed. For example, instead of asking to be called by male pronouns like I needed, I remained silent on the issue because I felt I had already asked my family and friends for so much in accepting me as transgender. This is evidenced by my counsellor’s note, “Does not want to put any stress on her family.”

An Appointment with My Family Physician

After realizing that I had the support of my family and friends, I built up the courage to discuss my feelings with my family physician in 2011. Through online sources, I had read of transgender peoples’ negative experiences coming out to their family physicians. This led to fear for my safety and ability to access health care. I knew that I was putting myself at risk by disclosing my truth to my family physician, as I was not legally protected from discrimination or abuse on the grounds of gender identity at that time. Alternatively, I was desperate for answers, resources, and access to medical transition health services that I felt my survival depended on.

When the date of my appointment arrived, I was paralyzed by anxiety. My personal journal states that “I was so nervous to tell my doctor I was trans” as I did not know what to expect. Taking my mother’s advice, I prepared thoroughly for my appointment. I educated myself through online resources to ensure that I presented my truth both accurately and professionally, and I rehearsed responses to any possible negative reactions. Unbeknownst to me, sitting in the waiting room that day would be the first of many times I would feel incredible angst for my privacy, and fear for my health and safety in a health care setting. This angst and fear were due to my gender identity.

I was asked to discuss the nature of my appointment with my family physician’s receptionist/assistant. In an attempt to calm my nerves, I took a deep breath and accepted my fate. I was nervous to disclose the issue at hand, but I had known the receptionist/assistant for my entire life and felt adequately prepared for this moment of truth. Fearfully, I shared that my appointment was to discuss gender identity disorder. I was privileged in that she reacted with the same kindness as previous health concerns. Furthermore, her reaction led me to believe that I was not the first transgender patient she had experience with. In retrospect, I understand this experience was key in facilitating the discussion of my gender with my family physician because I felt more comfortable and safer knowing I had her acceptance.

Shortly after, my family physician entered the room and inquired as to the nature of my appointment. In the most nerve-wracking experience of my life I belted out that I believed I had gender identity disorder. In this moment of vulnerability, I was overwhelmed with relief by my family physician’s response as she stated, “no one knows you better than you.” The compassion, integrity, and respect she showed me diminished my fears. Furthermore, she shared that I was not her first transgender patient, which provided me with reassurance and increased my confidence in my future care. In retrospect, I understand that this experience reinstated my confidence in the health system and hope for the future. I experienced an epiphany that I now had support from a medical professional.

By contrast, I was disappointed to learn that transgender resources and health care services were especially limited on PEI. My family physician explained that the majority of people leave PEI to seek medical treatment. As such, she provided me with a referral to an out-of-province gender clinic. I weighed the costs of receiving treatment out-of-province. This included the financial costs of travelling out of province such as transportation and accommodations, as well as the costs associated with the time away from school and work. I made the difficult decision not to pursue this referral beyond a phone consultation at the time.

My Social Transition: PEI and BC

Socially transitioning was going to be quite difficult in the PEI context because of the small population and reputation that “everyone knows everyone.” I knew that any time I was in public I would likely know someone, and they would notice my change in appearance (short haircut and men's clothes). Consequently, I avoided public spaces. Indeed, something that I had never been afraid of before became something that I dreaded. To avoid awkward situations, I strategically planned entire outings. Oftentimes, this included planning which bathroom I could/would use and when I would have the safest opportunity to do so. Although avoiding people became a common practice, the more people I explained being transgender to, the more confident and comfortable I became in public. This was facilitated by positive reactions.

I did not want to move away from PEI but knew it would facilitate my transition experience. Early in my social transition my partner was attending the University of Victoria. After gaining acceptance to the university, I decided to move to across the country at age 19 (2012). Socially transitioning in the BC context would be superior to socially transitioning on PEI due to the larger population, increased diversity, and my ability to be mostly anonymous in BC. I took this opportunity to develop, grow, and learn how to be who I wanted to be in the comfort of a more socially progressive province. Indeed, my personal journal states that "this allowed me to be away from my small hometown and blend into society as a male."

I noticed differences between the PEI and BC contexts immediately. For example, the University of Victoria had gender neutral bathrooms in 2012 while the University of PEI did not incorporate gender neutral washrooms for another six years. In addition, the BC government publicly funded gender-affirming surgeries, some of which were performed in the province. I felt more accepted and less abnormal in this context, as my gender identity was recognized and supported by the provincial government. This resulted in my increased comfort in BC's health care settings and confidence in their health system.

Other than when providing legal identification was required, no one knew me as female. I was able to assert my male identity in BC as I could walk, talk, and act the way I had always wanted to. Furthermore, I was able to learn how to be a man through my observations and connections with others without the same fear I experienced at home. I felt safer using the men's bathroom in BC. This was because of the greater acceptance of transgender people in this context and because the larger population meant a decreased likelihood of seeing people who knew me. Moreover, I did not have to worry about people outing me through the use of female pronouns, as I commonly experienced on PEI, because I presented as a normal guy in BC.

In 2013, after one year at the University of Victoria, I returned to PEI. Returning home was an adjustment, however, I felt stronger and more confident than ever with the insights I had gained in BC. At 20 years old, I wanted to join my friends in going to local bars. This idea caused internal distress; however, I was determined to live the life of a normal 20-year-old. On PEI with its limited bar scene, I knew that going out on a Saturday night would feel like I was back in high school. Indeed, showing up to the bar with a men's haircut and clothing would be like coming out as transgender to my entire graduating class. I had few negative experiences, most of which were limited to awkward stares and questions from acquaintances. I was fortunate in that I easily passed as male to people I did not know due to my body size, naturally masculine voice, and ability to purchase binders to masculinize my chest.

Pursuing Top Surgery

My pursuit of top surgery (2013-2016) was tedious. I was determined to undergo a double mastectomy once I learned that masculinization of my chest was possible. Unfortunately, at the time, the PEI government did not fund or perform gender-affirming surgeries. As such, I would be required to privately fund my surgery and travel out-of-province to access these services. Although I faced these barriers, I was privileged in my pursuit. Three factors facilitated my pursuit of top surgery: being young; being small breasted; and having family support. Because I was young, I had a lower risk of complications and an improved recovery rate. Being small breasted meant I was a candidate for a minimal scarring procedure called keyhole surgery. Additionally, I received medical and financial support from my family. This included post-operative care from my mother as well as financial support in privately funding my top surgery and related expenses.

The process of pursuing top surgery involved researching various clinics to determine which procedures they performed and the related costs. I assumed the role of principal navigator of my surgical care and began my pursuit by searching for clinics that performed my preferred keyhole and/or peri-areolar procedures. The majority of contact was through email. I emailed clinics in Halifax, the United States, Quebec, and Ontario. In choosing the clinic to perform my surgery, I considered travel, receiving health care outside of Canada, regional social contexts, my comfort with the surgeon and staff, the provision of gender-affirming care, requirements to undergo surgery, safety and privacy, and my candidacy for my preferred procedure. Although I learned much about these clinics through the online transgender community, I have many lived experiences with these clinics.

The Halifax clinic was favorable due to its location. However, I experienced discomfort due to their lack of gender-affirming care. This included discomfort and worry for my safety and privacy when stating my name in their waiting room, not being asked what name or pronouns I used, and their lack of knowledge in transgender health. These institutional factors made me feel that information that could identify that me as a transgender person was not private or confidential, and this could put me at risk for violence or harassment from staff or the public who do not accept transgender people. The surgeon recommended that I undergo further treatment in Halifax leaving me feeling frustrated as the surgeon did not see how this redundant treatment, travel, and time away from school and work could be harmful to me. This is an excerpt from an email with the receptionist at this clinic:

> I do not have the time or the money to go through the program he [the surgeon] wants me to. I felt the appointment was a step backwards for me, so I am looking into other surgeons such as one in [place] who only requires my consent and is much cheaper.

After my experience with this clinic, I felt hopeless for two reasons: one, that I would never be able to have surgery and move forward with my life and two, that I would have to continue proving I was *transgender enough* to cisgender people. This experience also left me feeling different than other patients – different in that I was seeking medically necessary health care services while those who were seeking privately funded breast augmentation for cosmetic reasons were not required to undergo further treatment in determining their eligibility.

I also contacted clinics in the United States after learning online of their reputation for providing gender-affirming care. However, I was hesitant for two reasons: one, I had no previous experience receiving health care in the US; and two, I did not know how transgender people were treated and thought of in these regional contexts. Although one of these surgeons was considered to be the best at the peri-areolar procedure, I had to make the difficult choice between my health and safety and the chest I desired. My health and safety were prioritized.

Clinics I contacted in Quebec and Ontario were desirable as they were located in Canada. I was required to send photos to these clinics to determine my eligibility for my preferred procedure. The Quebec clinic informed me that I would not be eligible which left me feeling confused and frustrated. I felt confused because other clinics had stated I was eligible, and I felt frustrated because I was paying for the surgery and thought I should have some control over the decision. The Ontario clinic specialized in top surgery and had a website catering to the procedure. The online transgender community shared their positive experiences with the clinic's provision of gender-affirming care. I received a free consultation with their surgeon and felt comfortable with him and the clinic. This was because they asked what name and pronouns I used. I was also confident in the care I would receive due to their experience with transgender patients. Additionally, I was only required to provide informed consent to undergo the procedure, leaving me in control of decisions relating to my care. I felt that the gates built up by other clinics to keep me out were broken down by this clinic and therefore, I chose to schedule my top surgery with that clinic.

A New Family Physician

My lifelong family physician retired in 2015 when I was 22 years old leaving me, my health and the future of my transition in the care of a new family physician. I was worried that I would lose confidence in the care that my previous physician had built and fearful that my new physician may not support my transition or accept my gender identity. It was during this time that I began connecting with transgender people on PEI through social media due to their public advocacy work. My fears relating to a new physician were based in part on the negative experiences described by my transgender peers, which included a lack of acceptance, discrimination, abuse, and lack of knowledge in transgender health. My peers also shared that they experienced significant barriers to their care because of their physician relationships and the PEI context.

My fears were allayed the first time I met my new physician, as she was trans-friendly and supportive of my gender transition. I quickly felt comfortable discussing transgender related health issues with her because she accepted my gender identity and was willing to facilitate my transition. This comfort has continued since then, and I have never refrained from discussing any aspect of my transition with her out of fear or shame. Below is an excerpt from my medical records from my first appointment with my current family physician: "Prefers to be called "Aly" name change…transsexual who identifies as male"

Undergoing Top Surgery

After months of fear-induced procrastination I scheduled my top surgery for February 2016. I was 22. My medical records state that I was "nervous but looking forward to getting it done." To be eligible for surgery I was required to undergo the standard testing procedures required for general anesthesia. This included necessary blood work, an electrocardiogram, and being deemed physically and mentally fit to undergo surgery. Fortunately, my family physician was able to conduct these tests and happily obliged by sending an electrocardiogram referral. After arriving at the hospital for my electrocardiogram appointment, I was somewhat relieved to see that the admissions receptionist was a family friend. Although I recognize that this may be very unnerving for some transgender people, I felt more comfort than discomfort. I felt comfort in knowing that this person would know that my name matched my face. However, I felt discomforted by the possibility that they would use female pronouns and out me as transgender in the very public admitting area. I was relieved when that did not happen.

In the waiting room I sat next to a man who perceived me as a young boy. I knew this by the way he spoke to me. I became worried about what may happen if the man heard my name when I was called in to the testing room. Fortunately, he was called in for testing before I was. The technician who conducted my test appeared confused by my name and appearance, however, she showed me to my room and provided me with instructions. I felt uncomfortable with a test being conducted on my chest since I had not yet undergone top surgery. This was escalated with the technician's visible discomfort (no eye contact, short responses) in trying to make me comfortable while not offending me.

I was deemed physically and mentally fit to undergo surgery, my electrocardiogram was unremarkable making me eligible to undergo surgery. Undergoing surgery meant that I was required to travel to Ontario. My chosen clinic had experience with patients travelling from out-of-province and had a suggested system in place. Specifically, the clinic scheduled my pre-operation appointment the day prior to my surgery and asked that I remain in the area for at least seven days following surgery to recover and have my surgical drains removed. Additionally, the clinic was attached to a hotel and it was suggested that I stay at that location to ease my access to the clinic. I felt comforted by the clinic's efforts to facilitate my access to surgery as an out-of-province patient.

I received exceptional care during my top surgery experience. This included gender-affirming care at all times, as the clinic staff asked what name and pronouns I preferred and used them accordingly. They also understood the gender euphoria that can come with completing top surgery as critical moment in a patient's life. They shared genuine excitement in the milestone of my journey. Furthermore, staff were easily accessible during my time in Ontario and when I returned to PEI. I contacted the clinic regarding surgical drain pain while in Ontario and was able to get a same day appointment to sort out my problem. When I experienced a post-operative complication upon returning to PEI, I was able to communicate with the clinic through email for guidance on the issue.

I was incredibly fortunate to have my mother with me during my time in Ontario. As she is a Registered Nurse, she provided me with exceptional pre- and post-operative care. My mother was key in facilitating my top surgery journey. She helped me with everything from easing my worries before surgery, to changing my surgical dressings, and providing personal care during my recovery. I was able to relax in my healing knowing I was receiving proper post-operative care from a trained health care professional.

I often ponder how different my top surgery experience would have been without my mother’s support. It is during these times that I realize my position of great privilege in the transgender community. I was also privileged to receive financial support from family to fund my top surgery, travel related expenses, and ease of recovery. Indeed, I was required to privately fund the costs of my surgery ($7,910), transportation via airplane, as well as food and accommodations for eight days. My great aunt offered to absorb the financial burden. Additionally, I received financial support from other family members that facilitated in the ease of my recovery as I was unable to work.

Changing My Gender Marker

The process of changing my gender marker was lengthy and frustrating. After undergoing top surgery, I pursued the change of my legal gender marker. This process posed financial and institutional barriers such as paying for and accessing a lawyer, as well as scheduling difficulties. At that time, individuals requesting a change of their legal gender marker on PEI were required to have undergone gender-affirming surgery. There were no specific surgeries stipulated as long as two physicians wrote letters stating that the individual had undergone a gender-affirming surgery. This posed potential scheduling issues as one of the letters had to be notarized by a lawyer in the presence of one of the physicians.

On PEI, residents must contact Vital Statistics to legally change their gender marker. Upon contacting Vital Statistics, I was informed that the process would be changing in the next month to a much simpler process. As it would take a few months under the current legislation to process my application, I was advised to submit my application when the new process was in place. I was also informed that the new process only required a letter from a physician declaring my gender identity, which I was able to obtain. As such, I patiently waited for the legislation to change and had my legal gender marker changed in June 2016 when I was 23. This experience was influenced by the regional and historical contexts in which I existed.

Hormone Replacement Therapy

Hormone replacement therapy had been on my mind since coming out as transgender, but it took several years for me to make the decision to begin treatments. Before making my decision, I had to consider the impact and effects that hormone therapy would have on my body, family, and friends, as well as whether I could emotionally handle these effects. I also had to consider navigating a pathway to access this therapy. Throughout these indecisive years, I watched videos of transgender people beginning hormone therapy and dreamt of the day that I might begin to see the changes that they were seeing. Although this thought was exciting to me, I was hesitant to start taking testosterone due to the effects it would have on my body. I knew that many of the effects of testosterone therapy were irreversible and therefore, I would be unable to reverse my decision if I was unhappy with any of its effects. Furthermore, all effects could not be anticipated, and people can react differently to therapy. These were concerns for me.

I was also unsure if I could cope with the feelings of my loved ones in addition to my own personal feelings relating to the process. I felt that my loved ones and I had already experienced significant discomfort in my coming out as transgender, and in pursuing hormone therapy, this would occur again. My intuition was telling me that I would be happier in receiving hormone therapy, however I was unsure of how the drastic changes would make me feel. As this was a life-changing decision, my mind raced in circles until I reached another breaking point in which I decided to put my well-being above the feelings of others and pursue hormone therapy.

The pathway to begin testosterone therapy was unclear. In the intersecting historical and regional contexts in which I pursued hormone therapy, there were no formal pathways for accessing these services. Furthermore, there was no one that I knew of to advise me in navigating this process. Fortunately, I felt comfortable with my family physician and scheduled an appointment to discuss this with her. I was informed that because my gender marker had been changed to male, the process would be much simpler in that I would be treated similar to a cisgender man receiving treatment for low testosterone. I was also fortunate in that my physician was willing to begin and monitor my hormone therapy by following best practice guidelines and consulting with an out-of-province endocrinologist. Specifically, my physician noted in my medical records, “Let Aly know that I discussed his BW [blood work] with a hormone specialist.” Moreover, my physician was able to access the counselling notes from prior years. These notes provided evidence to my gender dysphoria diagnosis and were used in determining my eligibility for, and accelerating my access to, hormone therapy.

I was 23 when I began hormone therapy in the summer of 2016 after learning through online sources that some transgender people begin therapy with low-dose testosterone treatments. This can ease the transition process and allow an individual to feel more in control of their treatment. This was appealing to me as it eased my worries of the irreversible nature of hormone therapy, as well as the adjustment my family and friends would face. I was privileged in that my family physician supported this decision. After a month of undergoing low dose injections, I became impatient waiting for the effects of the testosterone to change my body and I made the decision to begin receiving a normal treatment dose. My family physician respected my decision and adjusted my dose. For approximately seven months my physician administered my hormone injections. My medical records indicate that on January 27, 2017, my mother "start[ed] doing them at home." I was privileged in having a health care professional administering my injections and giving me time to become comfortable administering them on my own.

The Pursuit of Bottom Surgery

I began my pursuit of bottom surgery in 2017 when I was 24. Before making the decision to undergo bottom surgery, there were a number of issues I had to address. These included the increasing dysphoria relating to my genitals as well as researching and contacting clinics that performed these procedures. Financing the surgery was another consideration because the PEI government had not announced public funding for these procedures. As the dysphoria that had manifested in my chest dissipated with time, I found myself becoming more dysphoric of other areas of my body. For me this meant that I was experiencing extreme discomfort with my genitals. I felt that there was a severe disconnect between my mind and genitals – a mistake in my creation. As a result, I experienced a constant state of restless dissatisfaction. I was uncomfortable with the genitals I was born with and to improve my quality of life, I needed surgical intervention.

After months of researching potential procedures online, I began a pursuit similar to my top surgery journey. I began contacting clinics across the globe to get a sense of the procedures they provided and their costs. My only access to these procedures was through private funding and out-of-province travel. My search revealed costs of $40,000 to $100,000 to undergo surgery. As a result of my search and limited ability to privately finance surgery, I was undecided on a clinic for bottom surgery.

My medical record states that I made an appointment to “discuss surgery options” with my family physician in May 2018. At this appointment, I shared that other provinces provided public funding for bottom surgeries and patients were referred to a clinic called ‘GRS Montreal’ for treatment. My physician made a referral request to Health PEI. Below is an excerpt from the letter I received from Health PEI regarding this referral:

> Health PEI is in receipt of a referral request for the above named patient to receive Out-of-Province services at the GRS Clinic in Montreal, Quebec. Health PEI has denied payment for this request. The reason for this is the GRS Clinic is a private clinic and services provided at private clinics are non-insured under the Hospital and Medical Services Insurance Plan on PEI.

My medical records state that I became increasingly “frustrated” upon being “denied for transgender surgery.” I knew that if I lived in another province, such as BC, I would have been approved for this procedure.

The PEI government announced that they would begin to publicly fund gender-affirming surgeries in May 2018. The day after the announcement, I scheduled an appointment with my family physician to discuss a bottom surgery referral. My family physician supported me in this endeavor and sent a referral request to Health PEI immediately. At the time of this writing I have not yet been contacted by the clinic that will be performing my surgery, but Health PEI has approved funding for my procedure.

Transgender Health Advocacy

My experiences accessing health care as a transgender person ignited my desire to participate in meaningful health care change. However, this was not always the case. In the early years of my transition my strong desire to appear normal and hide that I was transgender led to my avoidance of other transgender people and advocates. In recent years (ages 20-26) this perspective has changed. My self-reflection data states that “I felt I owed it to those who have made it easier for me today to continue on improving things” and I began to “put myself out there,” connecting with organizations such as the PEI Human Rights Commission, the PEI Transgender Network, and Health PEI. The creation of this thesis was ultimately fueled by my need to advocate for transgender health care services and gender-affirming health care, while simultaneously fighting for my own health. Today, I embrace the strong, patient, and empathetic person I have become from facing adversity.

Chapter Summary

This chapter chronicled my journey accessing health care as a transgender person. I have provided descriptive explanations of my personal experiences (my childhood/pre-coming out years, coming out, accessing health care services, and health care advocacy) within their cultural, regional, and historical contexts. These experiences included social relations with my family and friends, health care professionals and staff, as well as the general public. In re-storying my lived experiences, I have gained insight into my experience and revealed epiphanies or turning points in my narrative. These findings will be discussed in relation to the current literature and framed using queer theory in the next chapter.

Chapter 5: Findings and Discussion

This chapter is organized thematically. Four major themes were identified through data analysis. Each major theme is separated into individual sections, with relevant subthemes and interpretation. Connections and differences between the findings and literature available at the time of this writing are discussed. This chapter provides answers to the research questions that framed my study: How do I make meaning of my lived experiences accessing health care as a transgender person? How accessible are transgender health care services on Prince Edward Island? What are the barriers and facilitators to accessing health care services for transgender people?

Theme 1: Ill Health and Personal Transformation

The first major theme identified was "Ill Health and Personal Transformation." This includes subthemes relating to my physical and emotional health, as well as my internal personal transformation resulting from my experiences. For the purpose of this thesis, health is defined as "the state of the human body, a mental state or the likelihood of longevity" (Fogel et al., 2012, p. 851). Personal transformation is defined as "changes in mental structures and worldview that lead to increased wisdom and well-being" (Weiss, 2014, p. 204). The subthemes in this section include poor health, negative emotions, and personal transformation.

Poor health

Several mental and physical health issues were apparent throughout my journey as a result of my gender identity. It was clear that I experienced poor mental and physical health due to the lack of health care services and resources available for transgender people. The social context of PEI also had an effect on my idea of what a transgender person was and how someone who was transgender would be treated. This knowledge led to inner shame regarding my identity and the suppression of my truth, which was followed by the deterioration of my mental and physical health. This finding suggests that identifying as a non-normative gender can greatly influence a person's health. The silencing I experienced due my gender identity had a direct impact on my mental and physical health, and access to health care.

There are consistencies between this subtheme and current literature discussing transgender people's experiences of poor mental and physical health. My experiences of depression mirror current literature stating that female-to-male transgender individuals have a depression rate of 66% (Bauer et al., 2013). This rate is much higher than the Canadian depression rate of 8% (Mental Health Commission of Canada, 2013). Other sources confirm that gender identity has an effect on health outcomes relating to access to health care (Fredriksen-Goldsen et al., 2013). Additionally, my experiences of poor physical health are consistent with reports about Canadian transgender youths indicating that they are unable to access necessary physical care (Veale et al., 2015) and have unmet health needs (Giblon & Bauer, 2017). The finding that my health improved as I was able to transition also confirms previous literature (Veale et al., 2015).

Negative feelings

Strong negative emotions were prominent throughout my journey. I have considered being transgender to be a target on my back and became fearful of introducing myself to situations because of past negative experiences. I also expressed being plagued with worry for my health, my access to health care, and being provided with proper health care. In turn, I experienced confusion relating to my gender dysphoria, who to raise my concerns with, and how to navigate the health care system to receive the care I desperately needed. This left me feeling frustrated and hopeless. It was apparent that I felt alone and trapped with nowhere to turn, expressing hopelessness due to the lack of safe spaces to discuss my feelings related to my gender identity, as well as the lack of information and resources available. These negative feelings were due to my non-normative gender identity, and the power imbalance between the health and social systems in which I existed and those identifying as a non-normative gender.

This subtheme is consistent with literature discussing the negative feelings experienced by transgender people accessing health care services (Veale et al., 2015). In other studies, transgender people express similar feelings relating to fear of negative experiences in health care settings. These negative experiences relate to their gender identity (Clark et al., 2017). My experiences of confusion regarding where to go to access health care are also consistent with current literature (Veale et al., 2015). Furthermore, this finding confirms literature that transitioning on PEI is a frustrating process (Martel, 2018). My frustration with institutional practices echoes previous literature. Namaste (2006) attributes this frustration, in part, to the world's extensive reliance on documents, lack of protocol, lack of explicit information, as well as conflicting and inconclusive answers to questions posed by transgender people. My narrative details all these frustrations.

Personal transformation

My journey has led to my personal transformation – strength and resilience, in particular. At the beginning of my journey I felt silenced, disempowered, and ashamed of my gender identity. As my journey unfolded however, there was a shift in my perspective. This shift was related to my gender identity and sense of purpose. As I gained experience and confidence in my specific context, my negative feelings dissipated and my health improved. I also began to view my experiences as opportunities for change rather than misfortunes. I felt empowered by a broken system in which I could play a key role in improving and making meaningful change. In recognizing my social responsibility, I now see my life as having meaning and purpose. Additionally, the creation of this thesis illustrates what Ellis (2010) says of conducting autoethnography – it was therapeutic: improving my understanding of my experiences and acceptance for who I am.

My personal transformation was influenced by my volunteer work with PEI's provincial health authority. I experienced inner change in my journey, as well as a change in my view of life, my view of the world, and my learning attitude (Pan, 2014). Personal transformation is impacted by stress and suffering, and it confirms the critical role of sociocultural context in personal transformation (Weiss, 2014). My personal growth and resilience echoes literature on transgender people's strength. Namaste (2006) states that transgender people experience "fundamental adjustments to all aspects of one's life" (p. 166) and "somewhere in the gaps of health care, civil status and employment, transsexuals must manage to survive" (p. 166).

Theme 2: Privacy and Safety

The second theme to arise from data analysis was Privacy and Safety. Privacy can be defined as "a right to control access to, and uses of, places, bodies, and personal information" (Moore, 2016, p. 44). Safety can be defined as freedom from preventable harm (Jackson et al., 2016). Throughout my experiences accessing health care services it was apparent that I felt my privacy was breached and my safety was put at risk. Although this may have been unintentional, it led to my avoidance of care in certain circumstances, which led to poorer health outcomes.

Privacy

I was greatly concerned for my privacy in my journey. This included feelings of my privacy being breached in terms of my non-normative gender identity and medical gender transition. The majority of these experiences occurred in waiting rooms of health care settings where the public was able to overhear my personal information such as when my legal name was called out in a public waiting room. This also occurred when completing sensitive and confidential paperwork in public areas such as being asked to provide information relating to the sex I was assigned at birth (such as ovarian or uterine pain) to health system staff in the presence of the public or staff who were not responsible for my care. My main concern in these situations was the exposure of my transgender status. Privacy concerns relating to health care professionals' access to information regarding my gender identity and medical transition were also revealed. This included instances in which health care professionals could access information that exposed my transgender status when I did not feel it was relevant or necessary to their work.

My privacy concerns relating to my gender identity are addressed by Trans Rights BC which states that transgender people have the same right to privacy for their gender identity as they do for medical information (Trans Rights BC, n.d.). This confirms my desire for privacy of my gender identity in health care settings to be the same as medical information. Additionally, the Ontario Human Rights Commission (n.d.) has a policy on preventing discrimination because of gender identity and gender expression. Their best practices checklist explains that privacy should be maximized relating to information of a person's gender identity, such as any information that identifies that the person's gender identity differs from the sex they were assigned at birth. It also describes that a transgender person's gender and medical history should be kept private, secure, and limited to only those who need this information (Ontario Human Rights Commission, n.d.). My experiences provide evidence that these privacy concerns are not always respected in the health care system and there is a need for these best practices to be incorporated on PEI.

Safety

Many safety concerns relating to my access of health care services as a transgender person were identified. These included my safety in health care settings, health care professionals' confusion regarding my name and my gender identity, health care professionals' knowledge in transgender health, and the provision of incorrect information regarding my care. These experiences presented opportunities for errors in my care as well as negative experiences in health care settings. The safety concerns that I expressed were due to being transgender and would not exist if I identified as a normative gender identity.

These findings are consistent with current literature describing the health care related safety concerns of other transgender people who feared harassment and violence in public settings, such as health care settings (Scheim et al., 2014). Privacy in waiting rooms of medical clinics is of particular concern to transgender people who can be "subject to embarrassment and possible ridicule when their name was called" (Namaste, 2006, p. 162). When health care professionals are unaware of or confused about a patient's gender status or make assumptions based on name and appearance, this can result in their providing inaccurate information regarding a patient's health. My experiences also reflect the importance of transgender people feeling safe to disclose their gender status to health care professionals to ensure they receive appropriate and correct care (Deming et al., 2016). Additionally, my findings of safety concerns is consistent with literature describing health care system failures at implementing inclusive practices, such as the failure to implement inclusive waiting room practices (Scheim & Travers, 2017).

Theme 3: Barriers and Facilitators to Care

The third theme identified was Barriers and Facilitators to Care. Throughout my journey, I experienced barriers in accessing health care as a transgender person. At the same time, I recognized the role that privilege played in facilitating my health care access in opposition to framing my story as a matter of fortune and misfortune. Barriers to care can be defined as "anything that restricts the use of health services by making it more difficult for some individuals to access, use or benefit from care" (Caulford, 2014, p. 400). Facilitators to care means providing "support to individuals or groups to achieve beneficial change" (Petrova et al., 2009, p. 38). The subthemes in this section include comfort with health care professionals and staff, training and education in transgender health, gender-affirming care, safe spaces, education and support for family and friends, travel and financial barriers, family support, and peer support.

Comfort with health care professionals and staff

My narrative details my discomfort with health care professionals and their staff. This discomfort was due to my identification as a non-normative gender identity. I was uncomfortable discussing what I was feeling in terms of gender dysphoria and medical gender transition with health care professionals and staff. I was also uncomfortable accessing general health care services due to being transgender. At other times, I experienced comfort with health care professionals and staff after receiving their support for my gender identity and transition. This comfort increased my health and access to health care.

My experiences are consistent with previous literature describing transgender peoples' discomfort discussing their gender identity and health care needs due to their uncertainty of a health care professional's trans-friendliness (Gahagan & Subirana-Malaret, 2018). This discomfort led to my avoidance of care, which confirms a previous study (Clark et al., 2017). If being transgender was considered normal in the social and institutional contexts in which I existed, I would have entered health-related appointments without worry. Instead, I worried about possible negative reactions or my ability to access health care due to my non-normative gender identity. This is consistent with other transgender patients who feared negative experiences relating to their gender identity (Bauer et al., 2014).

My lack of knowledge that my family physicians and counsellor were trans-friendly posed as a barrier to my care. In my case, this led to personal distress and delayed disclosure of what I was feeling. Had I been aware of my counsellor and family physicians' trans-friendliness and support for my transition, I may have shared my concerns earlier and avoided this distress and delay in my treatment. These concerns are addressed by resources such as OUTSaskatoon's Q-List of service providers, which includes health care professionals, that are supportive of LGBTQ2S people and are safe to access (OUTSaskatoon, n.d.).

Alternatively, my experiences relating to comfort with health care professionals and staff are consistent with current literature. In particular, this pertains to my comfort with the health care professionals that supported my gender identity and transition. This comfort and support improved my access to health care services and overall health. This is consistent with literature describing health improvements in transgender patients that are comfortable discussing their gender identity and health care needs with their family physician (Bauer et al., 2015). This confirms a previous study's finding that higher levels of health accompany those who are comfortable with their family physician and those with family physicians who are aware of their gender identity (Clark et al., 2017). Additionally, this finding is consistent with literature discussing transgender peoples' experiences with clinic staff creating safe spaces for them (Veale et al., 2015). I experienced this with staff at the clinic that performed my top surgery and at my first family physician's clinic.

My positive experience with a counsellor on PEI differs from Jay Gallant's negative experience (Martel, 2018). While Jay's counsellor dismissed his concerns relating to his gender identity, I was embraced and supported by my counsellor. The positive reaction I experienced in disclosing my transgender identity facilitated my access to care and Jay's experience introduced a barrier to health care access (Martel, 2018). This finding is more important for transgender people than cisgender people. Although cisgender people require access to counsellors who will embrace and support them, they do not need to concern themselves with accessing counsellors who will support their gender identity.

Training and education in transgender health

Throughout my journey I met health care professionals who lacked knowledge in providing transgender health care. This included a lack of training and education in transgender health, as well as a health care system that lacked policies and guidelines for health care professionals for providing care to transgender patients. This was a barrier to receiving timely and proper care and led to low confidence in the care I was receiving. There were instances in which I provided education to health care professionals and facilitated in my care.

My experiences with health care professionals lacking education and training in transgender health are consistent with current literature. My experiences confirm transgender people's limited access to medical transition readiness assessments on PEI (Neatby, 2018) as well as the challenges relating to accessing assessors to conduct readiness assessments (Frohard-Dourlent, 2017). My experience differs from transgender people in BC who have described their referral to an assessor as easy (Frohard-Dourlent et al., 2017). My experiences educating health care professionals on transgender health and care are also reflected in previous literature (Veale et al., 2015). In previous studies, transgender people report that their health care providers lack education and training in transgender health, which leads to patients educating their health care providers (Taylor, 2013). These studies also describe transgender people's concerns with their providers' lack of knowledge and competence in transgender health (Taylor, 2013 & Clark et al., 2017), which were evident in my fight for health. In addition, this finding echoes previous literature stating that transgender people are "unable to find the information and resources they need" and "cannot find support" (Namaste, 2006, p. 160).

These educational concerns are addressed by BC's Provincial Health Services Authority through the website, Trans Care BC. To keep health care professionals up to date on transgender health information, they have created a section specifically for health care professionals. This section includes transgender health-related education, resources, training opportunities, medical forms, clinical resources, and patient materials (such as how to get surgery) (Trans Care BC, n.d.).

Gender-affirming care

My access to gender-affirming care facilitated my journey. This included experiences in which I was asked which pronouns and name I used, and gender-affirming language was used. I received gender-affirming care at the clinic where I underwent surgery as well as in health care settings when my proper name and pronouns were used. I felt safer in health care settings providing gender-affirming care. I was also more comfortable discussing my health care needs in these settings and more confident in the care I was receiving. As all care environments are considered to be cisgender-affirming, the provision of gender-affirming care is more critical for transgender people.

My experiences are consistent with the experiences of other transgender people relating to gender-affirming care. Receiving gender-affirming care is a facilitator to care (Scheim & Travers, 2017). My experience is also comparable to literature discussing transgender people's positive experiences in trans-friendly clinic environments (James-Abra et al., 2015). Although the previous study was located in the context of assistive reproduction services, this finding is similar to my positive experience with the clinic that performed my top surgery. The trans-friendly environment of the clinic that performed my top surgery was created through the provision of gender-affirming care.

Safe spaces

Throughout my journey I experienced a lack of safe services to discuss my gender identity and dysphoria. This included access to health care settings in which I knew I could safely ask questions or receive information relating to being transgender. It was clear that I felt unable to safely discuss what I was feeling with anyone on PEI. This included people in both health care and non-health care related positions. At other times, I experienced safe spaces to discuss my gender identity and gender dysphoria in health care settings. This occurred after receiving positive reactions from providers as well as at the clinic that conducted my top surgery. This unevenness in health care experiences was an important feature of my fight for health.

In my experience, there were few safe spaces in the health care system to discuss how I was feeling or to access information and learn about gender identity and dysphoria. Some literature states that the uncertainty of the health care system's stance on non-normative gender identities is a barrier to care for transgender people (Gahagan & Subirana-Malaret, 2018). By contrast, another study that found that 89% of transgender people attending a BC clinic feel that staff have created safe spaces (Veale et al., 2015).

Education and support for family and friends

While I received support from my family and friends throughout my journey, there was a lack of support for them available through the health care system. I asked about educational resources about transgender people and how to support transgender loved ones. I asked about counsellors with specific training in supporting the family and friends of transgender people in their transition. Cisgender people do not require counselling or educational resources to help their loved ones understand being cisgender. There is no stigma attached to being cisgender; no support relating to their gender identity is necessary.

There is one notable resource to address this need for education and support for transgender people's family and friends on PEI. PFLAG has a resource titled, *Our Trans Loved Ones: Questions and Answers for Parents, Families, and Friends of People Who Are Transgender and Gender Expansive*. This resource provides information and answers the questions to improve understanding of the transgender experience. Specifically, it presents information relating to social support, psychological support, medical support, and an expert opinion for childhood, adolescence, and adulthood. The section on adulthood includes a section for partners and spouses of transgender people. First person stories from a father, mother, and spouse of a transgender person are also available (Barz & Owen, 2015).

Travel and financial barriers

I experienced barriers relating to travel and finances in my journey. These included the required travel and associated costs to access medical transition related health care services out-of-province. I was required to travel out-of-province in order to access a variety of health care services, and incurred costs each time. Travelling for care also required that I take significant time away from work and school. When I was unable to afford the money or time required for my care, I delayed or went without care. Although cisgender people are required to travel for care, it is not related to their gender identity. In my case, these travel and financial barriers would not have existed if I identified as a normative gender identity.

Current literature describes travel as a barrier to health care with transgender people travelling travel two or more hours to access surgical appointments (Veale et al., 2015). Travel barriers are cited reasons for transgender people avoiding care (Clark et al., 2017). Although I live in an urban area, my travel concerns relating to accessing transgender health care are consistent with barriers faced by those living in rural areas. These concerns have been addressed through the use of telehealth services, which provides timely access to care and reduces travel requirements to access health care (Jong et al., 2019). Telehealth is a cost-effective strategy that could be adopted to address financial barriers to transgender health care services (Jong et al., 2019).

My experiences with financial barriers to care are supported by the current literature. Barriers include the lack of public-funding for gender-affirming surgery on PEI as well as additional costs such as travel related costs, aftercare supplies, and facilities (Veale et al., 2015). Financial barriers are reasons for transgender people avoiding care (Clark et al., 2017). Contrast this with a study that reports that two-thirds of transgender people in BC have had their surgery funded through their provincial government (Veale et al., 2015). This speaks to the key differences in financial related barriers between PEI and BC.

As my narrative illustrated, travel for medical care can affect school attendance and, according to one study, employability for transgender people. Irving states that “undergoing medical transition processes, taking time off work to attend doctor's appointments, or attending to bureaucratic matters, such as changing one's identification, are misunderstood by employers as frivolous activity that endangers rather than strengthens an individual's employment" (2017, p. 173).

Family support

My journey to care was facilitated through family support. This included family support for my non-normative gender identity and transition as well as financial and medical support. In particular, my mother's role was critical to my successful health care journey. My mother provided significant support relating to my medical transition. This included care relating to gender-affirming surgery and hormone therapy. She also facilitated my access to care through an advisory role, teaching me how to advocate for my health and instilling confidence in me and the health care system. My family also supported me financially when I underwent chest surgery at a private clinic outside of PEI. This included costs associated to undergoing surgery, as well as transportation, accommodation, and meals. It also included financial support in my recovery as I was unable to work during this time.

Similarly, a previous study reports that high levels of family connectedness result in better health for transgender people (Veale et al., 2015). The financial support I received from family contrasts with the experience of other transgender people who had to personally fund their care (McCarty, 2016) or were unable to access proper care (Martel, 2018). The medical care relating to my hormone therapy and top surgery that I received from my mother differs from Ash Arsenault's experience. They had to access a walk-in clinic for support in administering hormone therapy injections (Neatby, 2018).

Peer support

The support I received from my peers facilitated in my access to health care. This included support from other transgender people living on PEI with whom I connected through social media. Their names were made public because their transgender advocacy work was published in newspapers. Other times I found them through word of mouth. My transgender peers provided information that was crucial to my health care access. This included information about navigating the health care system, trans-friendly health providers, and system changes, such as public funding for gender-affirming surgery.

Transgender peers provide significant information to each other that facilitate their access to care. A previous study reports that transgender men use peer networking strategies to identify health care that is culturally competent (Taylor, 2013). My experiences also parallel those of other transgender men ask other transgender men about their experiences with identifying health care providers (Taylor, 2013). My experiences mirror previous findings that transgender peers are a source of information and leadership when facing difficulties accessing and receiving health care (Taylor, 2013). My accessing of peer support in these situations was due to my non-normative gender identity. If I were cisgender, I would have raised my concerns with health care providers. In my journey I chose to raise my concerns with my transgender peers because I felt that they held more information relating to my health care than health care professionals.

Theme 4: An Ideal System and Hope for the Future

The fourth theme identified was *An Ideal System and Hope for the Future*. Throughout my journey I engaged in wishful thinking about what I had hoped to experience when accessing health care services as a transgender person. For the purpose of this thesis, an ideal health care system is one in which there is equitable access to health care for people of all genders. Hope for the future refers to my optimistic attitude in the health care system's ability to improve transgender health care.

An ideal system for transgender patients

Throughout my journey it was evident that there was an ideal health care system I longed to access as a transgender person. This ideal system possessed services that I was unable to access because they did not exist. An ideal system would have safe spaces where patients might discuss gender identity and expect early access to and awareness of medical transition services. There would be public funding for and safe pathways to gender-affirming surgeries. Health care professionals would have training and education in transgender health. There would be a public list of trans-friendly health professionals and intake processes would ensure that patients' proper names and pronouns were used. The trans community could expect patient privacy and safety policies that considered their unique needs. There would be an information hub to aid in navigating the health care system. An ideal system would also adopt the informed consent model of transgender care to "remove the distress narrative from the center of the transgender experience" (Schulz, 2018, p.88) and reduce barriers to care access (Schulz, 2018).

Finally, my personal ideal system would be one in which my gender identity was medicalized. Social issues, such as gender identity, have become "more and more 'medicalised', or viewed through the prism of scientific medicine as 'diseases'" (Lupton, 1997, p. 189). While other transgender people may not feel the same way, this is how I embody my experience.

Health care advocacy is a positive outcome of an ideal system. My advocacy work allowed me to move from feeling silenced to feeling embraced. At the beginning of my journey I did not want to be an advocate for transgender health as I wanted to appear normal. As I became more involved in the pursuit of my own medical gender transition, I recognized my ability to advocate for transgender health and the role I could play in the movement towards a better life for transgender people. This included advocating for my own health and the health of others, which is demonstrated by the creation of this thesis.

This finding is consistent with a recent study with transgender people's wish to access the services available in a different health care system (Baker & Beagan, 2015). This finding also confirms another report that self-advocacy facilitates transgender people in navigating situations (James-Abra et al., 2015). Extra work is performed by transgender men in their attempts to access care (Taylor, 2013), which is something that I felt I had to do. Furthermore, I spoke of becoming health literate and gaining knowledge in health care policies and practices to facilitate my journey. These strategies are reflected in previous literature as well (Taylor, 2013).

Hope for the future

The hope for the future of transgender health care that I expressed during my journey grew through my advocacy work. This included hope for the future of the health care system and hope for a future in which transgender people are able to access health care services with the same ease as cisgender people. The hopelessness I felt at the beginning of my journey dissipated as I experienced and participated in the change and movement towards an ideal health care system for transgender people. This hope was maintained through my involvement in these processes.

This finding of hope for the future appears in literature discussing hope for positive change in the future, including transgender health care. Transgender people educate health care professionals with the hope that providing this education will facilitate improved provision of health care (Ross et al., 2016). This was demonstrated in my experiences. My hope for more inclusive and accessible care for transgender people and my hope that PEI will improve training and education about health care for transgender people are also reflected in current literature (Juric, 2019; Ware, 2018).

Chapter Summary

Four major themes and several subthemes were identified to describe my journey accessing health care as a transgender person. These included: Ill Health and Personal Transformation; Privacy and Safety; Barriers and Facilitators to Care; and An Ideal System and Hope for the Future. These findings were compared to current literature and novel findings highlighted. Chapter six presents final thoughts on learnings from my patient experience, the limitations of my research, recommendations for future action and research.

Chapter 6: Conclusion

This study addressed health care accessibility for transgender people living on Prince Edward Island. In using critical autoethnography and queer theory, this study contributes to filling the methodological and theoretical gaps that exist in current literature. It also contributes to filling the gaps in transgender health-related autoethnographies and transgender health literature in the PEI context. My study was unique in that it provided an insider account of accessing health care as a transgender person. This contributes knowledge relating to the health care needs of the transgender community, new ways of thinking about transgender people, and improving understanding of non-normative gender identities. The findings of this study may be used to shape a health care system that recognizes non-normative gender identities, that may in turn, improve the lives of transgender people.

This chapter begins with a discussion surrounding learning from my patient experience and the contributions of this study to current research. This is followed by the presentation of the limitations of my research, potential areas for future research, and recommendations generated from the findings.

Learning from My Patient Experience

This research allowed me to examine my patient experience in great detail. As health authorities move towards patient-centered care, understanding the patient experience is crucial. Therefore, understanding my experience as a patient may be useful in advancing patient-centered care for transgender people, and ultimately the adoption of gender-affirming care guidelines. In health care, authoritative knowledge is considered to be the knowledge that is gained from experts. Although I am an expert in my own experiences and truth, I do not claim to be an expert in health care systems and how they are structured to facilitate access to care. By studying my experiences and contributing to this area of work, I am facilitating in the disruption of this concept that knowledge is solely gained from health care system experts. The use of critical queer theory allowed me to analyze how my patient experience was impacted by my identification as a non-normative gender identity.

Contributions to Current Literature

This study makes several contributions to the current literature. The findings demonstrate some of the specific health impacts of health care inaccessibility for transgender people and provide insight into the negative impact of the PEI social context on a transgender person's health and their access to care. My study also explored the feelings of hopelessness and aloneness that can be experienced due to identifying as a non-normative gender. This demonstrates the importance of access to transgender role models in ensuring that transgender people do not feel alone in their journey. As role models for cisgender people are easily accessible, this stresses the importance of transgender visibility.

The finding of personal transformation contributes an example of the potential shift in a transgender person's perspective over the course of their journey. Rather than framing transgender individuals as powerless victims of the health care system, this critical autoethnography demonstrates the empowering transition to an advocate who is becoming part of the solution. It is possible that this finding was not expressed in previous literature due to differences between study methodologies and data collection methods. My position as this study's researcher, my identity as a transgender person, and my role as an advocate may have illuminated this finding of personal transformation.

The theme of privacy and safety contributes to current literature as it provides a detailed account of my privacy and safety concerns as a transgender person in the PEI context; a place where you know someone everywhere you go. My study also highlights different social determinants of health that relate to not living in a major urban centre. Although these concerns exist for both cisgender and transgender people, this is a critical concern for transgender people. This is because exposing a cisgender person’s gender does not have the potential to reveal a confidential aspect of their medical history, however exposing a transgender person as transgender does. It is possible that this finding did not surface in previous literature due to the questions posed by other researchers and was illuminated in the current study due to my use of autoethnography, my insider perspective as a transgender person, and my geographic location.

Additionally, this study illustrates that the time needed to travel to access out-of-province services and the resulting loss of time at school and/or work can result in delays or avoidance of care. This reveals a key gap in health care service accessibility. The time needed to travel to access care also creates financial concerns related to loss of wages and missed education. These barriers are more significant for transgender people with lower socioeconomic status.

Identifying an ideal system contributes to the understanding of what transgender people want and need the health care system to be and points to the many gaps that exist in Health PEI’s policies and guidelines. My story also provides guidance in making recommendations for improving the health care system for transgender patients – a finding that has not been illuminated in other studies due to the data collection methods used. For instance, survey methods do not typically generate these findings while this autoethnography and my chosen position as an insider to the research problem revealed the need for an ideal system. This is because my data comes from my live experiences as the source of authority. I, as a transgender person, am an authority on my experience and in this knowledge. The health system and medical field can benefit from knowledge generated from the experiences of transgender people's navigating a flawed system.

This study contributes to the literature by demonstrating the importance of involving transgender people in health system improvement to improve their hope for the future. This narrative provides evidence that we can replace hurt and helplessness with hope for the future. By involving transgender people in improving health care, we can mend the relationship between the system and the transgender community. This will also empower transgender people. It is possible that my position as a health care advocate has been key in illuminating this finding.

My gender identity shaped my health care experience. My concern for my family shaped many of my health care interactions. Current literature does not discuss this. Existing literature does not discuss the interactions that physicians have with transgender patients and how these interactions influence health care accessibility for transgender people. My study also revealed the unevenness in transgender people's health care experiences. This unevenness leaves transgender people wondering what kind of experience they will have each time they go to their physician.

Limitations of Research

An autoethnography is, by definition, the exploration on one person's narrative in social context. I acknowledge that drawing on one person's story at a particular moment and age may be considered a limitation. This limitation was managed through the use of multiple sources of data (personal memory data, self-observation/self-reflection data, and external data sets) to ensure triangulation and rigour (Chang, 2008). Examining this allows me to identify potential future research directions. As I was the only participant in the study, only my voice is presented. My experience may differ from the perspectives and experiences of others who identify as a non-normative gender. As a result, it is possible that aspects of health care accessibility for transgender people on PEI have not been identified.

Although I have shared experiences that covered several years, I am 26 years old and therefore, I cannot speak to the experiences of older transgender adults. There are adult health care related experiences that I have not experienced which were not examined in this study. Such experiences may include fertility care, transitioning with children, transitioning while permanently employed, and experiences in long term care facilities. This limited my ability to comment on access issues that individuals identifying as a non-normative gender identity may experience in these settings.

Future Research

There are several avenues for future research on the topic of transgender health care accessibility. To improve access to health care for transgender people living on PEI additional perspectives should be considered. Perhaps, a qualitative study could be conducted to gain input from more of the key stakeholders in transgender health care accessibility. These key stakeholders could include PEI's transgender community, families of transgender people on PEI, PEI health care providers, and PEI policy makers. Such a study would provide an improved understanding of multiple perspectives in this specific context. Alternatively, this study could be repeated in other Canadian provinces to gain an understanding of the differences that exist between provinces and to improve understanding of the issue in each province's specific context. This could provide guidance and potential solutions to health care access issues.

The perspectives of other gender identities could also be captured in future research directions. In particular, a study that included transgender women and those who identify as non-binary would provide a more robust picture of health care accessibility for the transgender community of PEI as a whole. A study with more transgender men participants would provide multiple perspectives and contribute an improved understanding of health care accessibility issues faced by transgender men.

Recommendations

Our growth and understanding of trans experience have changed over time through continuous questioning of this experience. This questioning should persist to continue to evolve and should be considered with the following recommendations. I generated four recommendations to improve access to health care for transgender people living on PEI.

A gender-affirming health care policy

I recommend that Health PEI create and adopt a gender-affirming health care policy. This policy would address the key safety and privacy concerns that I had in my journey, which impacted my access to health care. A gender-affirming care policy might include changing intake processes and waiting room protocols to reflect and embrace non-normative gender identities. This would include practices that ensure that a transgender person's identity status is protected from the public, such as by the inclusion of proper pronouns and names in health records and databases. This policy could also include practices to ensure that the information identifying a patient as transgender is only shared with health care providers and staff when it is necessary to their care. The Ontario Human Rights Commission's policy on preventing discrimination because of gender identity and gender expression could be used as a guiding tool in this endeavor. In addition, this policy could include guidelines for health care providers and staff in ensuring the use of gender-affirming care, such as the use of proper pronouns, proper names, and language. The existence of a gender-affirming care policy would let transgender people know the health system’s acceptance for transgender patients and commitment to their care.

Pathways to access medical transition related health care services

I recommend that Health PEI create pathways to access transition related health care services, such as hormone therapy and gender-affirming surgeries. These pathways to care should be clear, safe, timely, and include access to primary care providers that support their gender identity and transition, endocrinology services, readiness assessments, gender-affirming surgeries, and post-operative care and support. The pathway would consider the needs of those without primary care providers or unsupportive primary care providers in accessing primary care relating to their non-normative gender identity. It would also include access to endocrinology services provided by an endocrinologist or to a primary care provider who can/will consult with an endocrinologist. Pathways should be created that include public funding for gender-affirming surgery and related costs. This pathway would also create a system for post-operative support on PEI. In addition, this would include ensuring that communication regarding post-operative care can continue with out-of-province clinics when patients return to PEI. Trans Care BC could be used as a guide for this recommendation.

Education and training for PEI health care professionals and staff

I recommend that Health PEI provide education and training in transgender health to health care professionals and staff. This would include introductory information on non-normative gender identities, how to use gender-affirming language, and the importance of non-judgemental responses for staff in gate-keeping positions, such as receptionists. Additionally, this may include toolkits for health care professionals similar to Trans Care BC’s toolkit that includes information relating to gender-affirming health care options, the role of the primary care provider, hormone readiness assessments, overviews of hormone therapy, surgical readiness assessments, an overview of gender-affirming surgeries and information relating to working with transgender youth (Trans Care BC, 2019). Providing education to health care professionals would also improve access to mental health services for transgender patients and their loved ones seeking support. Furthermore, this thesis may be of practical use in providing an insider understanding of accessing health care as a transgender person. This could bring insight and awareness to health care professionals and staff in training, those who lack experience working with patients identifying as non-normative gender identities, as well as those with previous experience.

An online information hub

I recommend that Health PEI create a publicly accessible transgender health online information hub for the public, transgender community and health care professionals and staff. This information hub could provide education and resources for the general public to increase understanding and acceptance of people who identify as non-normative genders. Similar to Trans Care BC, it could include resources and health system navigation information for those identifying as non-normative genders. Resources could be separated into sections for transgender children/youth and transgender adults to ensure that pathways to care are clear. A section might also be included for the families and friends of transgender people to access information on being transgender, how to support a transgender loved one, and where to find support.

Additionally, this online information hub could include a section for health care professionals. This section could include the information provided by Trans Care BC, such as education, training opportunities, medical forms, clinical resources, and patient materials (Trans

Care BC, n.d.). I recommend that this online information hub also include a listing of trans-friendly health care providers. This could be similar to OUTSaskatoon’s list and serve to ensure that transgender people can safely access health care providers that are knowledgeable in transgender health (OUTSaskatoon, n.d.). Online information hub could also include strategies for health care professionals who choose to improve their visibility as trans-friendly providers. This could be through the development of transgender flag stickers or other materials for providers to put in their waiting rooms and offices.

Concluding Remarks

This thesis demonstrates the urgent need for change in the health care system regarding health care accessibility for those identifying as non-normative genders. Judith Butler once said "‘Critical’ does not mean destructive, but only willing to examine what we sometimes presuppose in our way of thinking, and that gets in the way of making a more livable world" (cited in Public Affairs, UC Berkeley, & Public Affairs, 2015, para. 14). The health care system and health care decision makers must transform their current ways of thinking about gender in order to provide a service that is accessible to all. They must change their processes to reflect these new ways of thinking in order to recognize the existence of this marginalized community and their needs. These changes can improve the health of transgender people and reduce the oppression we face in society.

It is my hope that one day transgender people will access health care with the same ease as those identifying as normative gender identities. I am also hopeful that those who come after me will not have to fight for their health in the same ways that I have. In all ways possible, I will continue to facilitate the process of improving health care for transgender people. As someone who has had their voice heard, I aspire to empower others to share their experiences and be a part of this meaningful change as well. I would like to acknowledge the transgender community and anyone questioning their gender identity; please know that there is nothing wrong with you, you are not alone, and you deserve timely and adequate access to proper health care.

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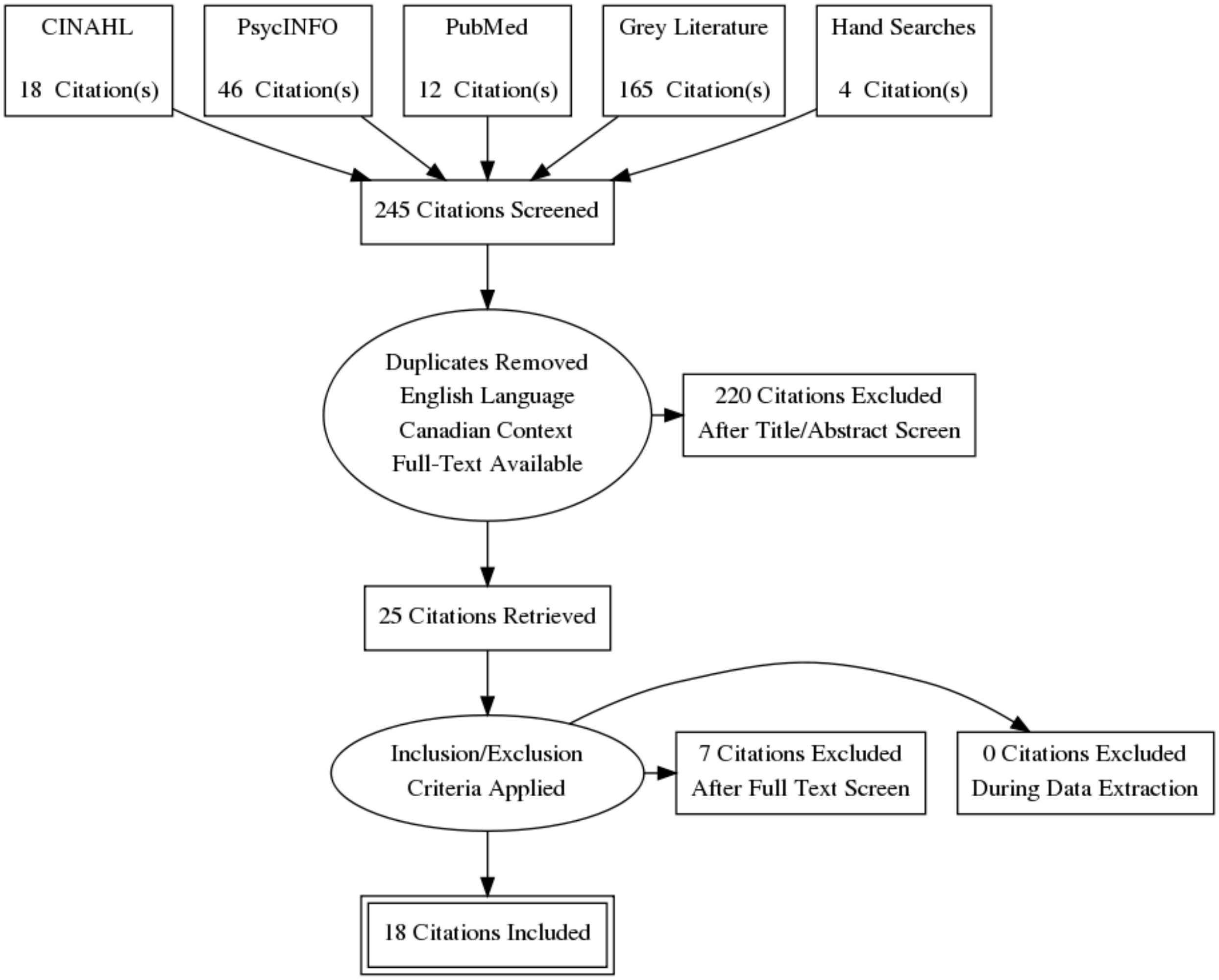
Appendix A: PRISMA Diagram of Literature Search



Appendix B: Analysis of Selected Literature

Author Pub Year	Type of Source	Study Design	Barrier to Care			Facilitator to Care			
			Theme	Theme	Theme	Theme	Theme	Theme	Theme
#1 Giblon & Bauer, 2017	Journal	Survey	Health care provider and health care system related barriers	Lack of access to services					
#2 Bauer et al., 2015	Journal	Survey	Health care provider and health care system related barriers						
#3 Veale et al., 2015	Report (hand-search)	Survey	Health care provider and health care system related barriers	Lack of access to services		Family and peer support			
#4 Gahagan & Subirana-Malaret, 2018	Journal	Survey	Health care provider and health care system related barriers	Negative experiences in health care settings		Previous positive experiences and care environment			
#5 Clark et al., 2017	Journal	Survey	Health care provider and health care system related barriers	Financial and travel barriers	Negative experiences in health care settings	Provider and health care system related facilitators			
#6 Scheim & Travers, 2017	Journal	Semi-structured interviews	Health care provider and health care system related barriers	Lack of access to services	Negative experiences in health care settings	Provider and health care system related facilitators			
#7 Taylor, 2013	Journal	Semi-structured interviews	Health care provider and health care system related barriers	Financial and travel barriers	Lack of access to services	Family and peer support	Self-advocacy		
#8 Frohard-Dourlent et al., 2017	Report (hand-search)	Survey	Health care provider and health care system related barriers	Financial and travel barriers	Lack of access to services	Provider and health care system related facilitators	Previous positive experiences and care environment	Availability of and access to health care services	Family and peer support
#9 Rotondi et al., 2013	Journal	Survey	Financial and Travel Barriers	Lack of access to services	Negative experiences in health care settings				
#10 Steele et al., 2017	Journal	Survey	Lack of access to services						
#11 Bauer et al., 2014	Journal	Survey	Lack of access to services	Negative experiences in health care settings					
#12 James-Abra et al., 2015	Journal	Semi-structured qualitative interviews				Provider and health care system related facilitators	Previous positive experiences	Care environment	Self-advocacy

Author Pub Year	Type of Source	Study Design	Barriers to Care		Facilitator to Care	
			Theme	Theme	Theme	Theme
#1 Jenkins, 2017	Newspaper	Interview	Travel			
#2 Martel, 2018	Newspaper	Interview	Negative Experience	Difficulties accessing proper gender-affirming surgeries		
#3 MacDonald, 2014	Newspaper	Interview	Negative experience	Access to health care services and supports		
#4 Neatby, 2018	Newspaper	Interview	Negative experience	Access to health care services and supports		
#5 McCarty, 2016	Newspaper	Interview	Wait lists		Access to health care services and supports	Public-funding for gender-affirming surgeries
#6 Mulholland, 2018	Newspaper	Interview	Negative experience	Difficulties accessing proper gender-affirming surgeries		

Appendix C: Informed Consent

Consent to Take Part in Research

Title: A Fight for Health: My Transgender Journey for Care

Investigator: Aly Inman

Taking part in this study is voluntary. You may participate in this study and leave at any point in the research process.

Possible Risks/Harms:

-emotional and/or physical pain as a result of the deep reflections required
-exposure of personal information

Benefits:

-the potential to change health care services and health care accessibility for transgender people
-provide voice for a marginalized community

The Research Ethics Board (REB) of Memorial University of Newfoundland has explained that ethical approval is not required for this research project.

By signing this form, I agree that:

1.) I have read and understand this consent form.
2.) The possible risks/harms and benefits of this study are understood.
3.) I understand that I have the right to withdraw from this study at any point in time.
4.) I will attend to the three founding principles of TCPS2.
5.) I will make efforts to protect my privacy and confidentiality.
6.) I will make efforts to protect the privacy and confidentiality of others.

Signature of Participant:

Appendix D: Visual Timeline of My Journey