

# **“The agency to choose what’s right for their body”:** Experiences with Gender-Affirming Surgery in British Columbia

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# Executive Summary

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The Qualitative Study of Gender-Affirming Surgery Experiences in BC is the result of a collaboration between the Stigma and Resilience Among Vulnerable Youth Centre (SARAVYC) at the University of British Columbia, and Trans Care BC, a program of the Provincial Health Services Authority. Trans Care BC's role is to enhance the coordination and availability of trans health services and supports across the province.

This study is the first to offer some insights into the experiences of people in British Columbia who seek to access gender-affirming surgery. We interviewed 35 people who had at least one surgical readiness assessment and/or one surgery while residing in British Columbia in the last 5 years. We hope that the stories that they shared can help identify gender-affirming and supportive practices, as well as gaps in the recent system of care, so that the information can help our province continue to move towards a patient-centered model of gender-affirming surgical care.

## KEY FINDINGS

- Primary care providers can be key supports and advocates as people navigate the healthcare system to access gender-affirming surgery. **Participants felt supported when healthcare providers respected their gender, knew how to provide routine care in a gender-affirming way and how to make referrals, and/or were willing to educate themselves about trans health.**

Many of our participants, however, encountered primary care providers who lacked knowledge and competency when it comes to trans patients.

- People often relied on themselves to obtain information about surgical readiness assessments and gender-affirming surgery. **Having information made people feel more empowered to make choices about their healthcare,** and advocate for access to these medically-necessary surgeries. Community-based resources and peer supports (both online and in-person) provided essential assistance in this process.
- Many participants were unclear about the purpose of surgical readiness assessments. Some felt the process was a gatekeeping mechanism meant to limit access to gender-affirming surgery. Participants also shared observations of inconsistent practices during the assessment appointment, and felt they had difficulty predicting what would happen in these appointments. In a few cases, participants reported that the assessors affirmed their experiences and **positively helped them prepare for surgery by practicing within an informed consent framework.**
- Participants often encountered long delays between different steps of the process to access gender-affirming surgery. A lack of clear and transparent commu-

nication about how long each step would take and why led to feelings of frustration and stress among many participants.

- **Non-binary participants** were aware of the additional barriers they could face in a society and medical system where gender and sex are often assumed to be binary categories (with the only options being male/man and female/woman). This often created **additional stress and uncertainty**, especially during the assessment process. To avoid or respond to these barriers, non-binary participants employed different strategies, including educating themselves about their rights, educating their providers, and keeping quiet about their non-binary identity.
- Participants experienced a notable lack of clear communication and transparency in certain situations. This included people who were referred to out-of-country surgeons, people who had to travel to other provinces or medical jurisdictions for care, and people who were deemed ineligible for surgery due to their high Body Mass Index (BMI). **These participants reported long delays and a lack of information that created significant barriers for them.**
- Participants reported mixed experiences in terms of interactions with surgeons and staff at surgical centres. When the surgical centre was far from where people

lived, whether it was in a different province or outside Canada, **patients often felt they did not have enough time to ask questions or discuss the procedure at length with their surgeon.** On the positive side, most people who stayed in an aftercare facility after surgery reported positive experiences, enhanced by the presence of other trans people going through similar surgeries.

- **Follow-up care was also more difficult when people lived far away from their surgical centre.** Few people had access to healthcare providers trained and skilled in post-op care functions for trans people close to where they lived, and many had difficulty communicating with their surgical centre, even with the help of a primary care provider. People often experienced stress during their recovery as they were unsure if they were recovering appropriately. Some were hesitant to access emergency services because they did not trust that emergency healthcare providers would be knowledgeable about their surgery or treat them with respect.

# Introduction

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## CONTEXT FOR PROJECT

In this report, we use the word *trans* as an umbrella term for people whose gender does not match the sex and gender that they were assigned at birth. This includes trans men, trans women, and non-binary people, although many people use different terms to talk about themselves and their gender.

The field of trans health has evolved a lot in the last ten years. In 2012, the DSM-V (the manual that offers a common language and criteria for psychiatrists) changed the diagnosis from ‘gender identity disorder’ to ‘gender dysphoria.’ This new label is meant to avoid pathologizing gender identity. Instead, mental health professionals should focus on the more temporary experience of dysphoria, described in the DSM-V as “a marked incongruence between one’s experienced/expressed gender and assigned gender.” Not all trans people experience dysphoria. But this shift marks a key change in healthcare, and it has led to greater awareness of gender-affirming care.

Gender-affirming care is a broad category that includes routine care, counselling, hormone therapy, and surgical interventions, as long as the care is provided in a way that recognizes and affirms the gender of the person seeking care. Trans people may choose to access one, many, or none of these forms of care. While this report focuses on gender-affirming surgery, it is important to remember that not all trans people require or are interested in medical interventions such as hormone therapy or surgery.

Access to gender-affirming surgery has also changed significantly in the last five years in British Columbia as efforts are underway to implement new supportive practices when it comes to gender-affirming care. This includes a shift to a strength-based model of community-based care that emphasizes people’s right to self-determination. The creation of Trans Care BC, as well as ongoing advocacy by leading clinicians and community advocates, aims to enhance the coordination of trans health services and supports across the province, bringing gender-affirming care closer to home wherever possible.



## GOAL OF PROJECT

Up-to-date information is needed to increase capacity for gender-affirming healthcare, but we currently know little about people's experiences when they (try to) access to gender-affirming surgery. This study aims to fill this gap: it is the first to explore, in-depth, the experiences of trans people in Canada who are accessing, or have accessed, gender-affirming surgery.

This study was part of a larger partnership with Trans Care BC to evaluate the experiences of people who want to access, or have accessed, gender-affirming surgery. An online survey was conducted simultaneously, and a community-friendly report of survey results was recently published.<sup>1</sup>

In this report, we used interviews to describe people's experiences in more detail and help explain the realities behind some of the numbers highlighted by the survey. The goal is to identify positive practices as well as gaps in the recent system of care. Our hope is that this information will help our province continue to move towards a patient-centered model of gender-affirming surgical care.

<sup>1</sup> Frohard-Dourlent, H., Coronel Villalobos, M., & Saewyc, E. (2017). *A survey of experiences with surgery readiness assessment and gender-affirming surgery among trans people in Canada: Focus on British Columbia*. Vancouver, BC: Stigma and Resilience Among Vulnerable Youth Centre, School of Nursing, University of British Columbia.

# Methods

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## RECRUITING PARTICIPANTS

We recruited participants in two ways. At the end of our survey on gender-affirming surgery, we invited people to indicate if they were interested in being interviewed by our team. We followed up with people who provided their email address. We also advertised the interview study on social media, in community organizations, on websites, and invited people to contact us directly if they were interested in participating. We made specific efforts to reach out to organizations that work with trans populations that are especially under-represented and/or marginalized.

To be eligible to participate in the study, people needed to be 18, and to have had at least one surgery or a surgical readiness assessment in the last five years. Many of our participants had also gotten an assessment and/or surgery prior to that cut-off. Since so much has changed recently with regards to gender-affirming surgery, we highlight when negative experiences are linked to outdated practices.

In total, we recruited 35 people, ages 24 to 69, between August 2016 and October 2016.

## USING INTERVIEWS TO GENERATE DATA

We chose to conduct interviews so participants could describe their experiences and tell their stories in their own words. Interviews help researchers understand how certain situations can happen, how people feel about these situations, and what people wish had happened differently. For this topic, interviews are useful for understanding the current barriers to care that people experience when they seek out gender-affirming surgery.

Most of our interviews happened in-person. Our team took two trips outside of the Lower Mainland so we could interview people face-to-face outside of the province's main urban region. In order to reach more people living in remote or rural areas, some interviews were conducted over Skype. In all cases, our interviewers had contact information for someone with counselling experience or for support services so that participants could get support after the interview should they need it. Participants also had the option to not answer any questions that they were asked.

In this report, we use pseudonyms for all of our participants, unless someone specifically asked that we use their name. About half of our participants chose their own pseudonym. We also use the pronoun(s) that participants used as of the publication of this report.

# Participant Demographics

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All 35 participants identified as transgender or under the broad trans umbrella. As per the study's eligibility criteria, participants had gotten a surgical readiness assessment and/or gender-affirming surgery in the last five years. About a quarter of participants had only received an assessment, and the rest had already undergone surgery. Although not all participants resided in BC at the time of the interview, they had all accessed – or were in the process of accessing - gender affirming surgery through the BC healthcare system.

Participants talked about a wide range of surgeries, including vaginoplasty, chest surgery, orchiectomy, phalloplasty, and breast augmentation. Most people had their surgeries paid for by the provincial health insurance (Medical Services Plan or MSP), but a few participants paid for at least one surgery out of pocket.

Participants ranged from age 24 to 69. Trans women represented almost half of the people we interviewed. Trans men made up about a third of the people that we interviewed. A third of people also described themselves as non-binary or somewhere on the non-binary spectrum at the time of the interview.

We made efforts to recruit participants from a wide range of backgrounds, with more success in some areas than others. Most of our interviewees were white: only three people we interviewed were people of colour, and another two were indigenous. Half of the participants were employed full-time, and half worked part-time or were unemployed (including some people on disability or medical employment insurance), students, or retired. We mostly interviewed people living in the Lower Mainland or on Vancouver Island, but we also spoke with people in the Interior of the province and with one person in the Yukon. About half of our participants lived in the province's two main urban centers, Vancouver and Victoria.

We also intentionally interviewed people who had both positive and negative experiences with the surgical readiness assessment and with surgery, so that we could capture the range of experiences that people have in BC when they seek out gender-affirming surgery.

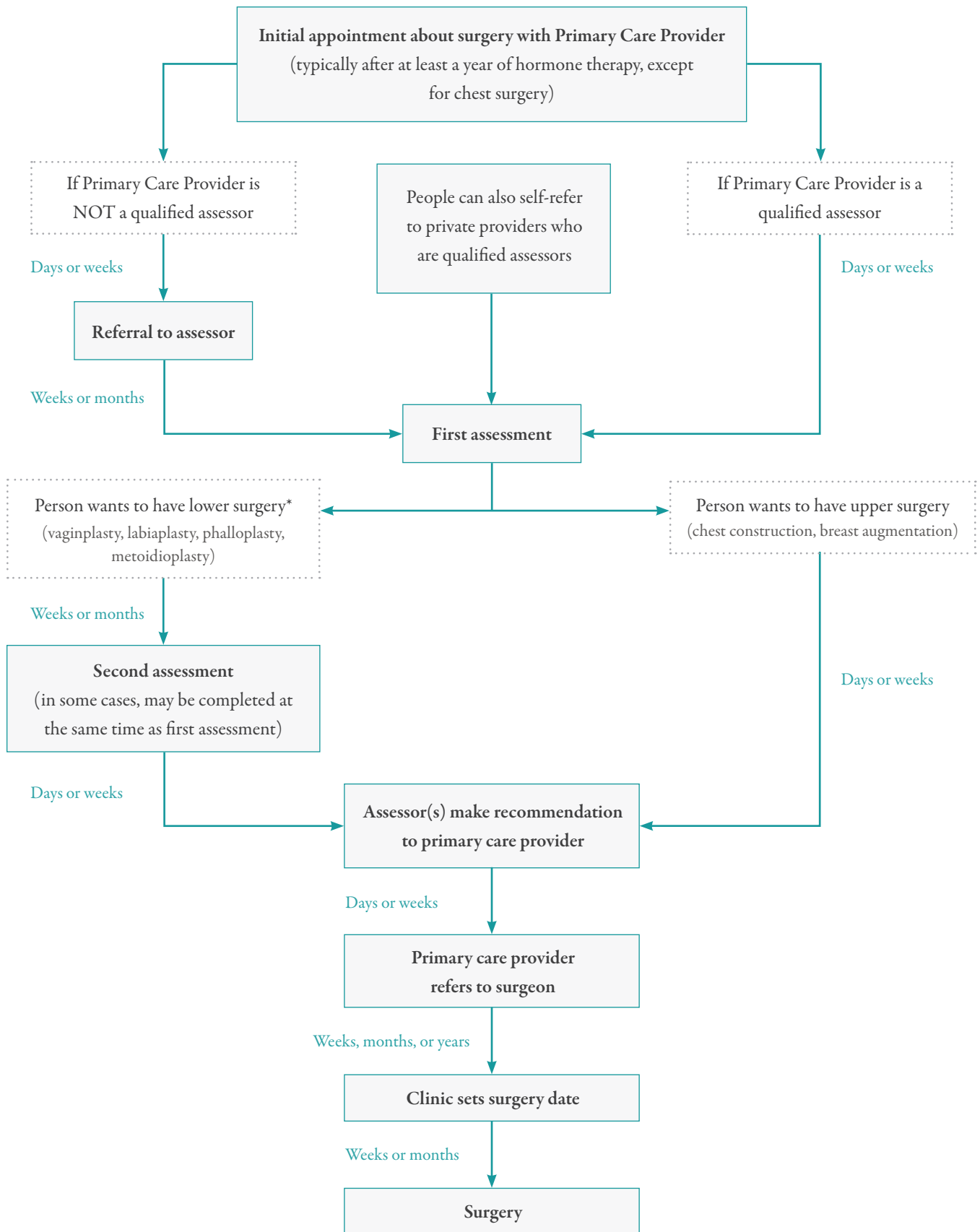
# Current process for accessing gender-affirming surgery

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The graphic below provides a visual summary of the pathway(s) to gender-affirming surgery in BC, from referral to surgery, as of May 2017. This graphic does not include steps to hormone therapy (for example, as per WPATH guidelines, most people will be expected to be on hormones for 1 year prior to being eligible for lower surgeries).

In addition to the overall pathways, it is important to understand the typical wait time between each step, so we have included that information. Waiting is an integral and often lengthy part of the process of accessing gender-affirming surgery. Wait times vary depending on the number and location of qualified assessors and surgeons, as well as the size of the wait list for both.

Some individual situations can lead to very different pathways that are not captured here (for example if you need to have surgery out-of-country, or if you are accessing the BC system from the Yukon).



\*For hysterectomy/bilateral salpingo-oophorectomy and orchiectomy, 1 or 2 assessments may be needed depending on the requirements of the surgeon.

# Referral to Assessment

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Getting referred to an assessor is the first step in people’s journey towards gender-affirming surgery. Although many healthcare providers can refer a patient to an assessor, most referrals are done by primary care providers and endocrinologists. Referrals are not always necessary, and people can also self-refer to private providers. Primary care providers can also do the assessment if they are trained as qualified assessors, but this is less common.

In this section, we describe the start of this process and discuss what made it easier or harder to access a surgical readiness assessment.

## EXPERIENCES WITH PRIMARY CARE PROVIDERS

In theory, primary care providers offer essential support throughout the entire process of accessing gender-affirming surgery. Family doctors and nurse practitioners can:

- conduct assessments for hormones and surgery (if trained to do so),
- initiate and monitor hormone therapy (if trained to do so),
- provide routine care, resources, and referrals to specialists (endocrinologists, assessors, and surgeons),
- answer questions to help patients prepare for surgery,
- facilitate navigation of the healthcare system, and
- do post-surgical follow-up care.

When primary care providers did these things, participants described positive experiences, and did not usually struggle to obtain a referral for an assessment. This was often the case when primary care providers were knowledgeable about trans healthcare or were qualified assessors themselves. For example, Ray told us how affirming, open, and friendly his healthcare providers were when he visited a clinic that specializes in trans healthcare. “For the first time in my life I felt understood.” Ray broke into tears as he spoke to us, underlining that this kind of affirmation was key to his positive experience. Others mentioned the benefit of having access, even occasionally, to primary care providers who are trans and/or non-binary who could understand “what you’re going through on a personal as well as professional [level]” (Ray).

## GENDER-AFFIRMING PRIMARY CARE LOOKS LIKE...

- Respecting a patient’s gender identity
- Using current gender-affirming language that mirrors the way people talk about their body
- Being willing to learn and find out about new ideas, language, and practices
- Believing that patients are the experts of their own experience
- Knowing how to make appropriate referrals and help one’s patient navigate their way to gender-affirming surgery

Primary care providers who specialize in trans health are rare, especially outside of major metropolitan areas. Yet we also heard positive stories from people with family doctors who did not have previous experience with trans people but respected their patient's identity and worked to educate themselves about the topic. Linda shared that her doctor "[took] it upon herself to become the authority in [the region] for trans health" after Linda came out to her. She recounted how this doctor would reach out to colleagues whenever she needed additional information, saving Linda having to travel long distances to visit specialists. Markus also sang the praises of his family doctor:

“**Having a GP that I do trust and feel comfortable with and have a long history with was important. [...] Pretty much I've had the same GP since I was a kid. [...] When I first came out about wanting to transition, she was really supportive. She said, you know, I don't have a lot of experience with this, but I'm totally willing to learn and put in the effort to come up to snuff on everything I need to know. And whatever referrals you need, whatever, so she was really good about that and has continued to be. She's really good about advocating for her patients.**

Other participants shared stories of primary care providers who supported them by tracking down lost paperwork, helping them make their way to surgery by getting answers when needed and advocating for them, and providing careful follow-up care after surgery.

But not all our participants' experiences were positive. Many others found interactions with their primary care providers frustrating. This usually happened when providers showed a lack of trans competency and, sometimes, an unwillingness to learn. In the worst cases, providers gave outdated information, were reluctant to learn some basic trans competency skills, or even refused to treat their trans patients.

“**I think more family doctors, GPs, whatever, need to have way more basic trans, non-binary, whatever you want to call it, 101. The most basic, basic information, training, education around it. Whether they're brand new doctors coming out of university or whether they've been doing it for 25 years. They need to understand the basics. Just to even be more open and approachable.**

- ALICIA

Many participants who had discouraging experiences noted that their primary care provider “had never treated a transgender patient before” (Lauren). However, this lack of previous experience alone did not always lead to negative interactions if the provider was willing to learn and address this gap in their knowledge. Many people did not think that their providers’ ignorance was malicious. Ronan explicitly said, “I don’t think [my doctor] has any negative intentions. He just is clearly not educated.” Similarly, Devon said:

**“None of [my providers] have been trained or anything or have an education in that, but they’re just doing the best they can.”**

A lack of knowledge had consequences for patients, even if it was unintentional. Participants felt they had to be the ones to educate their healthcare providers on basic knowledge about interactions with trans patients, such as using the correct pronouns or up-to-date language. In the meantime, they had to endure difficult interactions. Ray could not always access a trans specialty clinic because of distance. He shared his experience with his family doctor in comparison:

**“My [family doctor] was not very great in the beginning of my transition as far as she knew nothing about trans healthcare and would constantly misgender me. And that took some very firm assertiveness on my behalf in saying, “Look, it’s not okay.” “Well, you’re not legally male yet.” “I don’t care. The fact that I told you I identify as male, I’m asking you to use this name. I’m asking to use proper pronouns.” And, “Well, in letters if I do a referral I have to say she.” I’m, like, “No, you don’t.” So it was a bit of a struggle, and I almost turfed her a few times.”**

It can be frustrating if providers resist or do not seem to learn over time. Participants described that having to educate your own healthcare providers can be an exhausting, time-consuming task.

A lack of trans competency could also mean that patients possessed more information than their provider(s). This included knowledge of how the referral processes and access to gender-affirming surgery worked, as well as basic information about how medical interventions (such as hormone therapy or surgery) might affect trans patients. One participant recounted that his primary care provider prescribed him a medication containing estrogen that would have made his periods return— something he did not want— and only learned of this side effect when he checked in with a trans specialist.

Gaps in knowledge had a negative impact on people’s relationship to their primary care providers because people were not sure that they could trust their provider to offer them the highest level of care. Ronan noted, “It’s not nice knowing that my doctor might not know how to take care of me.”

Finally, some participants reported not even having access to a primary care provider. Some people who lived in smaller cities relied on providers in Vancouver during their transition because they did not have access to a competent GP in their own communities. Going to a walk-in clinic felt particularly challenging as participants had no guarantee that they would find a trans-competent doctor. If patients struggled to find trans-competent primary care providers, it could be more difficult to access assessors and thus create delays.

Supporting trans people who want to access medical care is within the scope of practice of primary care providers. Devon noted, “a lot of it overlap[s] with anything else, right. Like, a referral’s a referral.” Yet a lack of



up-to-date language and information made participants feel like their providers were less certain or willing to fulfill their medical needs, compared to what providers would do for other patients.

### **GATHERING INFORMATION AND ADVOCATING FOR ONESELF**

Finding information about access to gender-affirming surgery was very important to our participants. Early on in the process, people had to figure out what to do and what they wanted. Most people wanted to feel properly informed because, as Helen said, “You’re going through a major life-changing snip-snip, might as well be sure exactly what’s going on.” Being properly informed is essential for consenting to medical or surgical care.

As described earlier, participants could not always count on their primary care providers to have information about gender-affirming surgery. Ronan shared his disappointment:

**““ When I first spoke to my family doctor, he said he was going to get back to me with some information. I felt very hopeless 'cause I wasn't - he was taking forever to get back to me. And already I felt like he didn't really know what he was talking about. And then when finally he answered and gave me the website that didn't provide me any information, I was very angry.**

Even when they had the support of a primary care provider, many people said they had to play a “guessing game” (Hunter) to find relevant information because they could not find a clear pathway to surgery. This search for information started before the assessment and continued throughout the process.

People often obtained much of their information by themselves, by researching online, calling surgeons' offices, or talking to peers. Online communities and websites were a big part of how people looked for information, because the Internet could connect them to other people who had gender-affirming surgery. Usually, participants already had information from interacting with other trans people, whether online or in-person. Many people reported conversations with friends and community members (some of whom were involved in the healthcare system) that helped identify how to access a trans-competent primary care provider or an assessor, whether or not they could go to an assessor privately, how to have their care covered by MSP, etc. Many people felt that having clear and detailed information helped them make informed decisions about their healthcare and advocate for themselves.

The process of asking for the care someone wants or needs is often called 'self-advocacy.' For participants, self-advocacy involved educating their providers on what steps needed to be completed and in what order, relentlessly calling or e-mailing medical offices that were difficult to reach, pushing through barriers, and correcting providers when they had wrong information.

**““ I've been doing a lot of research, actually, since I was 13. I mean, because back in the day nobody knew about being genderqueer. And so I would go on YouTube videos and look at the people that have had the top surgery.**

- NJ

Self-advocacy also meant finding the right providers. Syd, who lived in a smaller city in British Columbia's Interior, described having to "hunt down" his assessor. Valerie also said:

**“ I’ve had to advocate for myself on a lot of cases. Even getting help and starting with the care, right, I had to really push to get an appointment to see someone.**

For many people, having information felt empowering. But information was not always easy to find. When information was not easily accessible, participants described the process of getting gender-affirming surgery as lengthy, frustrating, and disempowering. Ben explained:

**“ Just the whole system was very confusing and hard to navigate. And there was moments of, oh maybe I could go this route. But it just—none of it really made any sense to me. And there was no one helping guide you through that process.**

Matthew also had a difficult experience despite his relative privilege:

**“ It was hard. [...] I consider myself to be a fairly competent individual. I work in healthcare. I know people in healthcare. I know how to navigate large systems. And it was super fucking complicated. And that made me concerned for myself, but it also made me think, like, how are people managing through this who don't have the level of privilege and support that I have? If I'm struggling this much, there's a lot of people that are really having a hard time with this.**

Information was especially difficult to find when someone was in an uncommon situation (for example, if they needed an unusual procedure or had a condition that made surgery more risky). This amplified the frustration and resentment felt by participants. A small number of participants described being constantly referred to different people, being given contradictory information, and struggling to find people who could answer their questions or explain what the next steps were. Sage shared:

**“ My doctor and my doctor's colleagues didn't know much about [being referred to a surgeon outside of Canada] themselves. So I think there needs to be greater learning on their part, because I had questions that they couldn't answer. Again, I didn't know. Did I have to come up with the down payment? How did the process work? I had no idea. And I couldn't get any answers.**

Having information was important for people to navigate their way to gender-affirming surgery, and to feel informed about their care. When information was difficult to find, participants experienced delays as well as frustration.

## SUPPORT SYSTEMS: ONLINE AND OFF-LINE COMMUNITIES

Participants described that support systems were essential throughout the process of accessing gender-affirming surgery. This support was important from the start, when participants tried to find trans-competent primary care providers and accurate information about the process of gender-affirming surgery. Support could look like many things: sharing helpful information, offering emotional support, or providing material support.

All our participants described having a strong personal support system in the form of supportive family and/or close friends. Family and close friends provided important emotional and material support. They became essential when people travelled to surgery and/or when they needed help while recovering. While this is encouraging, it also raises the question of what happens for people who do not have access to such strong networks.

Participants often emphasized the importance of being connected to people with a similar lived experience. Taylor said: “Having connections to [the] trans community is how I got through this.” Many people found these connections through community-based support groups. NJ mentioned attending a group for gender-queer people where they could “share [their] experiences with other people that are waiting for the surgery as well.” Linda also described an online support group that helped her obtain information despite her distance from a larger urban center.

These groups provided comfort and a place to help cope with waiting and with negative experiences. Chris described his support as “more knowledgeable than the medical system.” He went on:

“For a lot of the knowledge, it’s not the system, it’s the people that the system is supposed to be serving that are actually the people with the information. So my friends and my contacts who happen to be trans are the ones that have been really in the know.”

Peer groups and community members were helpful, but a few participants noted that outdated or false information could circulate within trans communities. This suggests that community-based practices do not eliminate the need for clear and transparent pathways to surgery.

Some of our participants were also active in their local communities and personally knew key people working in trans healthcare. Among the trans women she knows, Sage felt like the ones who had contacts “fare[d] better” than those who did not. Such statements, raise concerns for people who do not have this kind of access.

“In the same way that people with life-threatening illnesses are moving forward in the waitlist, I feel like for many people, it’s not life-threatening for me, but I think that if I were in a position maybe where I didn’t have the kind of support I had, it would be.”

- NELSON

# Surgical readiness assessment

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All participants had been to at least one surgical readiness assessment appointment. The purpose of a surgical readiness assessment is to ensure that a person is prepared for the surgery, in order to have the best possible post-surgical outcomes. Assessments are conducted by a qualified healthcare professional and are usually a requirement of surgeons who perform gender-affirming surgeries.

Assessments have changed a lot in the last 10 years. Until 2012, an MSP tribunal had to approve someone for their surgery to be covered by MSP. After this practice stopped, qualified assessors could assess patients individually, but for most lower surgeries (including vaginoplasty and phalloplasty), a single chief assessor signed off on all assessments. This sign-off, which was not required by MSP but was required by most surgeons, created a bottleneck with the paperwork. To remedy this situation, this sign-off is no longer necessary since December 2016. Qualified assessors (one or two depending on the type of surgeries) can send the paperwork directly to the surgeon's office without additional process.

The assessment appointment is meant to focus on whether the person is ready for surgery, what supports they have in place to assist them during recovery, and if they meet the criteria for surgery outlined in the World Professional Association for Transgender Health (WPATH) Standards of Care V7.<sup>2</sup> However, our interviews suggest that not all assessors practice in this way.

While some people likely experienced practices now considered outdated because they went through their assessment before recent changes were implemented, the range of experiences suggests a lack of standardized practices and procedures in the province. Variation in experience may be connected to the range of disciplines of qualified assessors in BC – they include GPs, NPs, psychiatrists, and psychologists. All these practitioners are trained differently.

<sup>2</sup> See WPATH website (<http://www.wpath.org>) for more information.

## UNDERSTANDING THE PURPOSE OF THE ASSESSMENT

People often did not know the purpose of assessment or what the appointments would involve. Jessica pointed out that “no one ever really tells you exactly what the criteria are.” Cass said:

“ I [...] wasn’t really told how long it would be or much of what it would actually entail. It was more or less, okay, come—your appointment’s at this time. You’re seeing so-and-so and that’s it. So I got to panic for two months as it got closer, not knowing quite what was going to go on.

A few people were also confused about the reason for assessments. For example, they thought assessments were necessary to have their surgery covered by MSP. This has not been the case since the MSP tribunal was disbanded in 2012. Generally, the assessment is a requirement of the surgeons, in alignment with WPATH Standards of Care V7.

“ There’s just this hoop I had to jump through, but not one that actually benefited me.

- MATTHEW

The lack of clarity often caused extra stress. Participants knew their assessment was key to their accessing gender-affirming surgery, but did not know what to expect. Egbertyne explained:

“ [The assessment appointment] was a lot less stressful than I thought it would be. Going into it I had no idea, [...] I didn’t have any idea from anyone what the experience would be like. Whether I was going to have to justify myself to a gatekeeper or convince anyone. But it was much less stressful than I’d anticipated.

Questions asked during the assessment sometimes added to participants’ confusion. During the appointment, some participants were asked questions that felt irrelevant, which made them more confused about the purpose of the assessment. Jessica said: “[some questions] seemed super general and some of them seemed totally unrelated to my being trans or surgery or anything.” It made her wonder, “Why did I have to wait several months to do this?” Many people shared Jessica’s uncertainty as to why the assessment had to happen at all.

## FEARS OF GATEKEEPING

Many people approached the assessment process believing it was a gatekeeping mechanism. They felt that the assessment was a step meant to control and limit access to gender-affirming surgery. Participants often talked about assessor(s) as people who “make a decision over your life that’s super important to you” (Taylor), rather than seeing the assessors as resources who could offer information and offer a space to talk about overall expectations before and after surgery. Matthew explained:

“ I think as trans people we’re cautious of the healthcare system, and assessors are gatekeepers. So whether it’s true or not, I held the belief that there was a set of things I needed to say in order to get the gatekeeper to open the gate. And so I almost felt like I needed to play a particular game in order to get access to healthcare.

Jessica also thought that you should “just tell [the assessor] what they want to hear.” This perception can have a negative impact on the assessment process if it is meant to determine readiness for surgery. Because he thought he needed to give particular answers, the assessment did not feel useful to Matthew. He added: “I didn’t really have an honest conversation, and frankly that would have been really helpful, to have a real conversation with someone.”

Anxiety was heightened when participants did not have an existing relationship with their assessor(s) prior to the appointment. Ben recounted being sent to “this anonymous floor in this anonymous building” for an assessment with a health provider he had never met before: “I was pretty confident that there wouldn’t be any issues. But there’s always that anxiety that exists when someone is a bit of a gatekeeper for you in getting what you need for healthcare.” Many participants shared similar fears.

These fears of gatekeeping may have sometimes been unfounded, but they were based on very real – although outdated – practices. Lauren, who was assessed before the new standards of care were implemented, shared a harrowing assessment appointment where her assessor explicitly identified himself as a gatekeeper with power over her life. She experienced exactly what other participants feared. The fear of medical professionals controlling participants’ lives speaks to a larger history of trauma experienced by trans populations. Many participants saw the contemporary assessment process as a continuation of that history.

“ I think that it’s a real statement about the lack of agency that trans people have in their own medical care that our government feels that trans people need protections from themselves.

- RAQUEL

Some people also felt that the system being confusing worked as another form of gatekeeping. Participants talked at length about disorganized processes they had to navigate. Multiple people reported: their paperwork had been lost at one point; delays were caused by miscommunication between their primary care provider and their assessor(s); or that several inquiries had to be made to MSP before they could confirm that their surgery would be covered. These problems regularly led to multi-month delays, leaving people to feel like the system was set up to keep people out, rather than facilitate their access to a medically-necessary surgery.

Many participants acknowledged that changes in the system could be part of the reason for these challenges. Raquel, whose paperwork was lost and who struggled to be able to make an appointment with her surgeon, said:

“ There was a lot of restructuring going on with how the program actually worked at the time. However, I mean, regardless of the why it went down the way that it did and regardless of the fact that it probably was just, you know, a perfect storm of disorganization from [the] provincial level, it was two years all said.

Not everyone experienced multi-year delays, but many experienced delays at some point in the assessment process due to an unclear or disorganized system. The lack of communication added to the feeling that the system was not set up to help people get the care they needed.

“ It’s really not okay that there are so many barriers to a person having that agency to choose what’s right for their body.

- EGBERTYNE

Although assessments are not meant to act as a gatekeeping mechanism in the current system, many participants experienced them as such. They continued to feel stressed before their assessment because of difficult medical system navigation. This was especially true when participants had no prior relationship to their assessor, when pathways were unclear, or when assessors asked questions that seem irrelevant to surgery preparedness.



## EXPERIENCE OF THE ASSESSMENT APPOINTMENT(S)

Many people approached the assessment appointment with some wariness. Sometimes these feelings turned out to be warranted, sometimes not: people's experiences varied greatly.

A few people had positive experiences with their assessment appointment, which provide guidance for ways the process can be improved. Nelson reported that his assessor was "so supportive and helpful and positive, encouraging." His assessor made it clear that the assessment was not about convincing her that he was ready for surgery, which helped him feel good about the process. Ash said his assessment "felt more like a partnership," and he was asked by the assessor how she could help him get what he wanted. Cass similarly described her assessment as "remarkably easy." She explained: "it was basically just sitting down like this for ten or fifteen minutes, discussing what I expected out of the surgery, if I knew the risks, if I knew basically what I was getting into and if I really wanted it and there you go."

The experiences of Cass, Nelson, and Ash align with what is known as "informed consent." Informed consent is the idea that if patients have information on the risks, benefits, and alternatives for a proposed treatment, they can participate in meaningful decisions about their own healthcare. Some participants explicitly said that they wished the assessment process could be better aligned with these principles.

Most people did not have such positive experiences, and felt that the appointment did not help prepare them for surgery. Hunter felt the assessment had been "a waste of time," while Jessica found her assessment "really pointless" because she "didn't feel like it had anything to do with [her] surgery." Matthew said that his own research was more helpful in preparing him for surgery than the assessment process. Taylor even challenged whether the questions that they were asked (such as, when did you know you were genderqueer?) were relevant to being approved for surgery.

**“ Make sure that I understand what's at stake (so) that I can make an informed choice. But don't say that, you know, some professional has to give me the stamp to say that I know what's right for my body.**

- BEN



Regardless of how the assessment was conducted, some people questioned the necessity and usefulness of the process. Matthew noted that the very existence of assessments raise equity concerns since gender-affirming surgeries are one of only a few surgeries that require this kind of assessment. He said:

“ We need to have checks and balances in place, right. I get where they’re coming from. People who are maybe struggling with mental health or had some other stuff going on, they don’t want to approve the surgery that maybe someone wasn’t in the right frame of mind to. But we only fucking do this for trans people. We don’t do this-- I could go get a nose job tomorrow and not have to prove that I’m not going to regret it later, do you know what I mean? So I think the whole process is bullshit. I think it’s transphobic, and I don’t think it actually does what it’s intending which is really support people through the process.

Our research suggests that there is a wide range in practices when it comes to surgical readiness assessments and that many people have questions about its necessity. It also points to the potential usefulness of having a specific medical appointment dedicated to information and patient expectations as part of the process.

### THE IMPACT OF WAITING

As our graphic on page 8 shows, waiting is an integral part of getting gender-affirming surgery. Every stage of the process involves waiting, but people’s experiences varied greatly in terms of when they experienced the longest waits and how long they ended up waiting.

There were some points where waiting was more common and generated more frustration, such as waiting to get an assessment appointment. Zach shared:

“ I can’t remember exactly [how long I had to wait to see the assessor]. It was a bit of a wait, though. I think it was at least a couple of months because he’s-- he was quite backlogged with patients. I actually had to just go to a drop-in appointment because the next appointment I could book was so far in the future.

The period of waiting for an assessment seems to have been reduced over time, now that more qualified assessors are available and that a single chief assessor no longer signs off on assessments. However, people often still did not know how long the assessment process should take.

Another frustrating waiting period was the time between people’s last surgical readiness assessment appointment and their surgery date. After their assessment, many participants were told that they would be contacted directly by the surgeon, but they had no sense of how long that might take.

During our interviews, a few people remained optimistic despite a lack of information about timing. Ronan commented after his assessment, “it’s nice knowing that there’s an end in sight even if I don’t know when it is.” Lauren was mostly focused on the fact that she knew the surgery was coming. Charlene, reflecting back on her time waiting for surgery, found some value in the

time it gave her and her family to get used to her new self. Still, she described waiting for surgery as frustrating, and Ronan also admitted, “If I knew how long I had to wait, it would be easier to wait.”

Most participants, however, found it very stressful not knowing how long they would have to wait. Charlotte said, “it shouldn’t be so much waiting, so much unknown.” This stress was made worse because participants usually received little to no communication during the waiting period. Markus got confirmation that his surgery would be covered and that he was now on a waitlist, but with little other information:

“It was pretty much absolutely no foresight as to how long this was going to take. We’ll get back to you when you’re closer to the top of the waitlist, kind of thing. And I still have never heard anything and that was, like, probably three years ago.

Some people described the experience of waiting as “really, really, really rough” (Zach). NJ talked about how their dysphoria was getting worse during that time, and Ronan talked about the negative impact that wearing a binder was having on his body. Cass explained that “every delay is difficult” when you have been dealing with dysphoria your entire life. Nelson said that waiting for gender-affirming surgery felt different from waiting for other types of surgery:

“I think that’s maybe the mental health component of it [...]. For my foot, I didn’t need somebody to do that for me, to say, hey, you’re on the list. You’re fine. But I think just because there’s so much emotionally and mentally involved in this process, I feel more strongly about that.

Participants usually told us that they had no way of knowing their position on the wait list, whether there was a single wait list or if each surgeon had a wait list, or whether some other criteria determined the length of their wait. This left them confused about who to call to make sure they were moving up the wait list and wondering if there might be a way to switch surgeons and make the process faster. Nelson felt that having a clear sense of a wait list would have helped a lot. He said:

“I think it’d just be fantastic if there was just some way to say, you know, the waiting list is “x” long now. [...] Anything, I think, just kind of helps me to feel like nobody’s forgotten about me, that I haven’t just dropped off the list and--or something like that.

The fear of being forgotten was not unwarranted, since many participants reported having some part of their paperwork lost at some point. For some people, this waiting period also made them concerned about inequities within the healthcare system, for example if they saw other people moving through the system faster than them with no explanation or understanding as to why that was the case. Many participants emphasized that having surgery felt urgent and life-saving. Having a sense of when it might happen was helpful in reducing overall stress. Knowing wait times was also important to plan properly for taking time off work, putting supports in place, etc.

Many tried to reduce their wait by checking in with MSP or their family doctor. Sometimes these efforts seemed to pay off: Jazmine told us that she was able to get her surgery faster because she called the surgeon's office after they had a cancellation. These efforts seemed to rely on chance, and they did not always pay off, leaving people feeling more disempowered. Scott shared:

**“ I went into depression [while waiting]. I missed work because of depression. I was constantly phoning-- I'd go from feeling proactive by phoning MSP or phoning my doctor or phoning people to try to get things moving, which would make me feel pretty empowered for a little while. And then I'd hit roadblocks, and then I'd just go into a depression.**

When people could afford it, one of the strategies to avoid lengthy wait times was to pay privately for the assessment and/or for surgery. Devon mentioned that being “frustrated about waiting” was a reason he paid privately for his surgery. Ray, like other people who accessed surgery later in life, said that he “just could not quite see [himself] waiting that long.”

This strategy to avoid delays or frustrations only worked if people knew from the start about the option to pay privately and had the funds to do so. Marie, who was also older, also expressed concerns about having to wait because of her age: “what worries me is the longer I wait for surgery, though, the older I'm getting and the more risk it is coming in.” However, she did not have the means to pay privately for surgery.

The option of paying privately also raises the question of inequity and a two-tier healthcare system. Participants who paid privately for surgery generally reported positive experiences at all stages of the process. Participants also noted they were lucky to be able to have the financial means that gave them the choice to pay for their assessment and/or their surgery.

### WHEN CHANGE LEADS TO MORE POSITIVE EXPERIENCES

For many people, one of the longest and most frustrating waiting periods was the time spent waiting for their assessment, especially their second assessment (which is needed for most lower surgeries). This extensive wait was partly the result of circumstances at the time: the people who reported waiting for a very long period of time where usually people who were assessed for lower surgery when most second assessments were scheduled through the one assessor's office. The bottleneck created by having one publicly-funded assessor to do most the second assessments and to sign off on all surgical assessments often generated not only lengthy wait times and a backlog of appointments but also a lot of frustration, caused by: (1) difficulties getting in touch with the assessor's office, (2) a lack of clear communication regarding the process of booking an assessment appointment, and (3) a lack of clarity regarding how long people might have to wait before their appointment. This situation changed in 2016, when the sign-off from the chief assessor was eliminated and the number of publicly-funded assessors increased. As a result, participants who were assessed after December 2016 did not report the same amount of extended waiting between their two required assessments.

# Gender-affirming surgery

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Gender-affirming surgery is a medically-necessary treatment for many people. It affects mental as well as physical health, and it can also have a significant impact on how people are perceived and treated in their daily lives. Nelson explained this clearly:

“ [Surgery] doesn't feel elective. It feels like it needs to be done. .... I would say that in terms of my quality of life, it affects everything because—it affects my mental health. If I didn't have the resources to have support, I could easily see how I would become suicidal because it affects my livelihood, if there are people that are affected by my body not matching the gender that I present. It affects the way I interact with people. So it's not just kind of how I feel. I can feel fantastic and—but if I go out into the world and encounter other people who have their own issues, that can—I mean, it can be life-destroying too, right. People can lose work, families, or [encounter] violence.

Participants in this study had surgery in a variety of settings (public and private clinics) and locations (British Columbia, other Canadian provinces, outside of Canada).

## NON-BINARY EXPERIENCES

Historically, gender-affirming surgery was understood as the final step in someone's transition from one sex to 'the other.' This old model assumes that gender and sex are binaries and/or opposites. This makes non-binary people invisible and does not fit with modern understandings of sex and gender as spectrums.

A number of our participants identified, or had identified at one point, with non-binary gender identities such as genderqueer, androgen, or gender-fluid. All of them were aware of the medical system's historical (and ongoing) tendency not to understand, validate, or accept non-binary identities. This could make the process of accessing gender-affirming surgery more challenging, even when they knew they had a right to this kind of healthcare. Taylor shared:

“ I do think for me there was a feeling throughout all this, and including a bit through the assessment process, where if I hadn't known that the WPATH standards had changed to say that gender-nonconforming or gender non-binary people can have surgery, I don't know if I would have gone through this process with as much confidence either.

Among our participants, it was rare to encounter overt rejection of non-binary identities, but outdated ideas about binary gender and sexuality still had an impact on the experiences of non-binary participants. One outdated practice is the criterion of ‘real-life experience’ (RLE) that required that people live “in a manner consistent with their gender identity” for a year before being able to access medical interventions. Egbertyne had her surgery date cancelled because, according to the letter she got from the surgeon’s office, they did not have proof that she had met this RLE requirement. Egbertyne pushed back against this notion, because they “have no right to tell me that I am not living as my chosen gender when-- especially since it’s in a manner consistent with my gender identity, which is actually non-binary and leaning heavily female.” For non-binary people, this outdated RLE criterion is challenging because mainstream Canadian society does not currently recognize non-binary genders. There is no reference for what it means to live ‘in a manner consistent’ with a non-binary identity. Although Egbertyne managed to get her surgery date re-instated, her story shows that non-binary people sometimes endure additional challenges.

People also felt like their non-binary identity was misunderstood or made invisible in healthcare settings. Taylor said it “blew [the] minds [of healthcare providers]” when they brought up non-binary identities during a workshop. Both Taylor and Egbertyne described their respective surgical centres and staff as emphasizing binary narratives of change. Taylor said of their surgical centre: “it was all very much a ‘you’re

becoming a man’ experience, which is not how I feel about myself.” Often, this was clearly done in an effort to provide gender-affirming care, and Taylor made it clear that they found the staff “lovely” and “phenomenal.” Taylor’s story suggests a lack of awareness around non-binary identities, even among healthcare practitioners who work closely and respectfully with trans populations.

**“ It’s really nice if you can - when you’re having this surgery that’s so important to you - to, like, truly be who you are instead of being, “I’m going to kind of hide that so that I can get this thing I want.**

- TAYLOR

During NJ’s initial consultation, the surgeon was confused and NJ had to explain that they were OK with “not passing as some other people do.” The surgeon asked NJ additional questions and emphasized that there is “no way back” after surgery. NJ reflected: “I don’t want to jump on assumptions, but I think he wanted to make sure because I don’t pass as a male, right, that I’m okay with the fact that there’s no way-- like, there’s no returning. It’s a one-way ticket.”

Additional fears of rejection mean non-binary people have to decide how open they want to be with their providers in order to get the services they need. Taylor admitted to “[going] with the binary narrative” throughout their journey to gender-affirming surgery. They explained:

“**For me I was, like, it’s not worth pushing this. Like, everything feels really good. It’s not worth pushing this, like, where are people at with their understanding of genderqueerness. And if I demand to be seen that way, will the surgeon all of a sudden be, like, “Wait a minute, I’m not going to do this surgery.” I didn’t want to test that.**

This is an understandable reaction to a history of invisibility and misunderstanding within medical settings. However, it raises concerns about access to care when someone feels like they cannot be open with their healthcare providers about a key aspect of who they are.

Conversely, when participants met healthcare providers who were knowledgeable about non-binary genders, they had positive experiences. Ash mentioned to his assessor that he did not feel like a man but rather like he had three genders. “[The assessor] was totally cool with that,” he explained. “And so it was very-- it felt pretty progressive compared to some of the other stories that I’d heard from other people who had gone through the process.”

### **INABILITY TO CHOOSE A SURGEON**

Only a limited number of surgeons in BC are trained to do some gender-affirming surgeries. For other surgeries (in particular, lower surgeries such as vaginoplasty and phalloplasty), no surgeon is available at this time in BC. Under MSP guidelines, for publicly-funded surgeries, if

care is not available in-province, it can be accessed and paid for by MSP out of province. MSP will only pay for someone to go out-of-country if this person cannot use the options available in Canada. This means that if people want to have their surgery paid for by MSP, they have a very limited choice in who would perform their surgery. Some people pointed to the inability to choose one’s surgeon as a fundamental issue. Raquel said:

“**I think that if it was any other type of procedure, it would be an absolute violation of patients’ rights to not have choice in surgeon. If it was cardiac surgery, and I was not comfortable seeing the cardiologist that you had sent me a referral to, and I wanted to see a different cardiologist, it would be an absolute violation of patient rights to not allow me to see that other cardiologist that I want to see.**

This lack of choice was experienced as another barrier to care. Some participants were angry when they had disappointing experiences and/or unsatisfactory results that they felt could have been avoided if they had been able to see a different surgeon.

Limited options also meant that participants described making the decision to have surgery without being able to look at photos of surgical outcomes. They also described not having the opportunity to discuss what technique or procedure was most right for them. This lack of information “makes it very difficult to know what you’re getting into” (Blake). The absence of information about surgical results for publicly-funded surgeons was frustrating for many, and it could lead to low trust and satisfaction with the healthcare system.



Valerie explained: “I already feel like I’ve been betrayed by the province in sending me to a surgical provider where they had no results.”

Many participants did not have funds to pay privately for surgery, but could not wait for a surgery that is medically necessary. They had little choice but to go with a surgeon that they did not select, leaving some participants feeling disempowered. Raquel said: “There’s empowerment in choice, and trans folks [...] in Canada have no empowerment in making choices about their own medical care.”

### **ADDITIONAL BARRIERS TO SURGICAL CARE**

Some of our participants shared situations that made access to the surgical care they needed particularly difficult. We focus on four areas: the out-of-country guidelines, inter-jurisdictional issues, the current criteria for publicly-funded breast augmentation, and the way that many surgeons use a patient’s Body Mass Index (BMI) to determine eligibility for surgery.

#### **OUT-OF-COUNTRY GUIDELINES AND INTER-JURISDICTIONAL ISSUES**

Because Canada has a limited number of surgeons who can perform gender-affirming surgeries, when the available surgeons cannot operate on a patient for some reason, people can be referred to surgeons outside of Canada via the MSP out-of-country guidelines.<sup>3</sup> The couple of participants who had accessed surgery outside of Canada described a process that was lengthy, disorganized, and unfamiliar to the healthcare providers who were supposed to help them navigate this process. Adrian explained that he was “stuck in another loop-hole of having to wait or wait or wait until they decide to do the right thing and fund a surgeon who’s only two states away.” Meanwhile, Sage, who was still struggling to get approved at the time of our interview, said: “all of this process which was completely untransparent and really poor communication resulted in a really stressful

period and emotional rollercoaster.”

Participants were bounced between providers, had to wait months for referrals or information that turned out to be unnecessary, and often had to obtain information themselves about next steps or what paperwork they needed. Sage suggested that the out-of-country process would benefit from case managers who had “some understanding about the stages and steps involved and some transparency about how long it’ll take. Because it was a long wait and I didn’t know what was going on.”

Hunter faced similar barriers when he tried to access gender-affirming surgery through the BC healthcare system while residing in the Yukon. Hunter shared similar frustrations with the lack of consistent information he could find regarding the assessment and surgery, as well as the process of reimbursement for these procedures. In Hunter’s case, the lack of information, lengthy delays, non-transparent processes, and unreliable communication were all made worse by the inter-jurisdictional element. Despite having a supportive local primary care provider, Hunter described his experience as incredibly stressful and frustrating, both pre- and post-surgery.

While the process of getting gender-affirming surgery was described as confusing and frustrating by many, the out-of-country guidelines and inter-jurisdictional situations seemed to especially suffer from a lack of clear pathways and consistent communication.

#### **BREAST AUGMENTATION CRITERIA**

Cisgender people may see breast augmentation as a cosmetic procedure, but this was not the case for many of our participants. Trans women shared that breast augmentation can have a significant and positive impact on their quality of life. Some of them mentioned this is also true of other so-called cosmetic procedures such as electrolysis, which are not currently funded publicly.

<sup>3</sup> [http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/ooc\\_funding\\_guidelines.pdf](http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/ooc_funding_guidelines.pdf)

As of the time of this report, for breast augmentation to be covered by MSP, the criteria are the same as they would be for a cisgender woman who had experienced almost no breast growth. MSP criteria specifies that the attending surgeon needs to confirm that the patient has been on hormones for at least 18 months (unless contraindicated), and that there has been less than an AA cup of breast growth or asymmetric breast growth of greater than 1 and ½ cup size difference. Almost half of trans women in this study discussed being unable to access breast augmentation surgery due to these restrictive criteria that do not seem to take into account that this surgery can be a treatment for gender dysphoria, including frame size and other unique factors for trans women.

Participants often knew the criteria from conversations with healthcare providers or other trans people. However, they reported inconsistencies in how providers interpreted the existing criteria. Raquel said:

“ I had previously [talked] to a doctor about having an assessment for breast augmentation but was essentially told by the doctor that I probably wouldn't qualify. And since then [I] have a new doctor who said let's take a shot at it so--

Like Raquel, other participants recounted being told outright by their primary care provider that they would not qualify for MSP coverage, sometimes with little explanation as to why, and with little recourse to challenge that decision.

Participants felt that restrictions for coverage were inadequate for trans women. Some participants told us that the minimal amount of breast tissue growth that made them ineligible for MSP coverage was not enough to resolve their gender dysphoria nor for them to feel

good about their body and appearance. It was also not sufficient to be read as a woman in their daily life. For some people, being read as a woman is essential to their well-being, and can offer some protection against transphobic violence.

Some participants highlighted that a problem was that the criteria was applied similarly regardless of the person's body type. They explained that this generates inequities in results. Valerie noted that her friends with thinner body types were much more likely to gain a satisfying appearance with a smaller amount of growth, while this was unlikely to be the case for someone of a heavier body type or larger frame like hers.

Valerie also pointed out that the current restrictions for breast augmentation had no equivalent for masculinizing chest reconstruction. She said:

“ If you're showing any development as a trans female, you won't get approved, right. [...] Well, what if you're trans male? [...] If you're a trans male, well, yeah, we're going to get you funding to have a mastectomy and have chest reconstruction. But if you're a trans female, you know, you kind of get what you get. Unless you don't get anything, and then we'll help you.

For her, this difference was a gendered inequity that requires further investigation.



For those who could afford it, paying privately was a way to avoid the existing criteria. However, this was not an option for most. One participant noted that she already had to pay multiple thousands of dollars on other procedures (such as electrolysis) that are essential for daily life, but are not publicly funded. It also reinforces a two-tiered healthcare system where people with more financial resources can have easier access to care.

The current criteria create clear additional barriers to care for trans women, especially since money is often also a barrier for this population. This lack of access can be “invalidating,” explained Valerie. “It felt that I was being sort of excluded from something that, you know, I felt should be available to me as a trans female. It is a very personal thing.”

#### **BMI CUT-OFF**

Another barrier to care that participants experienced was ineligibility for surgery due to being over a particular body mass index (BMI). BMI is a measure commonly used to categorize people as underweight, normal weight, overweight, or obese. Common to most plastic surgery, many surgeons will not operate on a person over a certain BMI.

BMI has been challenged as a singular measure of a person’s health or of their ability to undergo surgery safely.<sup>4,5</sup> One of the issues is that it does not take into account the difference between weight in fat or muscle. Currently, BMI cut-offs create challenges to access to care for people who are over a BMI of 35. Participants who were above the BMI cut-off of 35 reported profoundly negative experiences trying to navigate the healthcare system.

Some participants reported that BMI cut-offs can vary from surgeon to surgeon. Participants also shared that primary care providers often lacked up-to-date informa-

tion on the topic when they made referrals, and could not help them navigate their way to surgery. This could mean additional delays, as people spent time waiting for a consultation with a surgeon who ultimately would not perform the surgery. These setbacks took a toll on participants, especially on their mental health, and it added to the frustration of trying to navigate an already complex system of care. Markus said:



**Waiting six months to see someone to be told that you’re too fat to have surgery with them, is a big deal. ‘Cause then it’s like okay, refer to somebody else. Start from square one. So I found that in general there was a lack of information about the full process all the way through and how to navigate the system.**

It was frustrating for some participants that different surgeons had different BMI cut-offs. They felt these inconsistencies suggested that BMI cut-offs are not about being concerned about potential health issues, but rather about fatphobia on the part of the medical system. For Jay, this was part of a larger message that he got throughout his transition: instead of being supported, he felt he was consistently told, “You have to keep working harder for this thing.”

Knowing that access to a medically-necessary surgery was dependent on weight loss was a “huge worry” (Cass) for some people. Because this restriction encouraged people to lose weight, it could sometimes encourage unhealthy behaviours and outcomes. Jay, who had to

<sup>4</sup> Prentice, A. M., and S. A. Jebb. 2001. “Beyond Body Mass Index.” *Obesity Reviews* 2 (3): 141–47.

<sup>5</sup> Burkhauser, R. V. and Cawley, J. 2008. Beyond BMI: The value of more accurate measures of fatness and obesity in social science research. *Journal of Health Economics*, 27: 519–529.

postpone his surgery date several times because he was over the surgeon's BMI cut-off, explained that it "sent [him] into a depression every single time." Meanwhile, Markus stopped taking mental health medications because they made weight loss more difficult. He said:

“ So I ended up coming off of [these medications] and it was okay for a while. [...] But then really quickly just, like, you know, I've had some issues with eating and eating disorders and stuff like that in the past. So I started to get really obsessive about, like, losing weight and got really unhealthy. And it was just like I got more and more anxious and depressed and stuff. So it was actually a really bad experience for my mental health, obviously. Just in the process of trying to get access to approval for surgery.

For Taylor, this BMI cut-off indicated a focus on cosmetic outcomes, which they felt did not reflect the life-saving nature of gender-affirming surgeries. They explained:

“ If we look at other life-saving surgeries that we wouldn't necessarily be, like, we're not going to give you this life-saving surgery because of your BMI, 'cause you're overweight. So I think there's still this sense of, like, this is a plastic surgery. We want nice outcomes. And the health risk for you doing this surgery isn't worth it for us as healthcare providers. Whereas, like, I look at that I'm, like, we can't measure how many people's lives have been lost because they don't get the surgeries that they need, right. And how do we measure risk in health?

Taylor and others argued that people should be able to decide whether the cosmetic outcome was important to them. This would align with an informed consent model that emphasizes clear communication about

expectations and respects patients' choice to accept higher risks to be able to access medically-necessary surgeries.

## PRE- AND POST-SURGERY EXPERIENCES

### SURGICAL CONSULTATION AND INTERACTIONS WITH SURGICAL STAFF

Once they are given a surgery date, people obtain more information about how to prepare for their surgery and their recovery. When the surgery can be provided locally, a consultation with the surgeon usually happens a few weeks or months before surgery. When the surgery has to be provided out of province, surgical centres usually supply a packet of information to patients ahead of time, and patients have a consultation with the surgeon shortly before the surgery to answer any final questions.

People who got surgery far away from where they lived gave mixed feedback on their experience of getting information from far away. In some cases, information packets were described as useful and comprehensive, but not always. Sometimes, people felt that the information provided was incomplete or even inaccurate. Egbertyne received information that she found "severely outdated," including old terminology and references to outdated standards of care.

Communication with faraway clinics was often described as difficult and disorganized, primarily because it often took clinics a long time to respond to requests for information. Monroe, for example, said that she had gotten better information from previous patients than from the clinic itself. People were sometimes in contact with clinics where English is not the first language of the staff. This could make communication even more complicated, which left participants feeling frustrated and unheard.

The surgical consultation was often the only time that people got to meet their surgeon ahead of the surgery date and ask questions. Experiences varied dramatically

depending on the surgeon, and some participants had different experiences with the same surgeons.

Usually, participants were most positive about the consultation when it happened well-ahead of their surgery date. In these cases, they felt the consultation was a space where they could discuss options, express their preference for certain techniques, discuss their expectations, and ask questions. Zach said:

“**The [consultation with the surgeon] was really, really good. I really liked her. She was easy to talk to. She answered all the questions that I had. [...] I came out of that feeling a lot more prepared for surgery.**

People also felt comfortable when they met with a surgeon who was respectful, used the right pronouns, and was willing to spend time with them to go over the details of the surgery and recovery. This helped alleviate participants' anxiety. Marie said:

“**[The surgeon] just talks with you to get you comfortable and get you-- so there's no surprises. They tell you the whole procedure. They tell you exactly what's going to happen. Everything was very well done.**

In other cases, people had mixed experiences with the consultation. NJ said that their consultation had “not really” been a good experience, but they seemed understanding about the lack of warmth the surgeon showed them. They explained:

“**I mean, because he can be very, like, rushed and I don't blame him. But I think he gave a lot of information about what might go wrong. It was very technical and sometimes it felt really cold. But he has to do it, right.**

Devon shared that he expected his surgeon's cold attitude based on reviews and conversations with friends. He told himself that he would barely have to interact with the surgeon after the consultation so he could minimize the impact that the surgeon's attitude had on him.

Not everyone can dismiss these negative interactions. Jay described his surgeon as acting with “not one ounce of kindness” during the consultation. This was upsetting to him because the consultation is a moment where “a lot of people are very nervous [...], and they need a bit of reassurance from their surgeon.”

Some participants were not simply concerned with the bedside manners of particular surgeons. When people had to travel far for surgery, they sometimes met their surgeon only minutes before their surgery. A number of participants reported that this made them feel rushed, stressed, and uncomfortable, and that they did not have a chance to ask questions. This was troubling to them because they were about to undergo major surgery. Ben described:

“**So [the surgeon] came into the room after-- I think I had been given some sort of pre-medication, and he's, like, hi, I'm [the surgeon], nice to meet you. Do you have any questions? And [...] I was kind of dumbfounded. And I just said, well, can you maybe tell me a little bit more about the procedure you're going to be giving. [...] He said, any more questions? I said, I don't think so. And so he left. I got wheeled up to surgery, like, 10 minutes later.**

Devon said that his surgeon seemed irritated that he had questions, which made him feel “kind of stupid.” Raquel also shared:

“**The appointment with [the surgeon], the consultation, was extremely rushed, and very few questions were answered. And it sort of seemed like an afterthought, you know, as far as the pre-consultation about the surgery.**”

In contrast, people’s experiences with surgical nurses and other staff (such as Licensed Practical Nurses) tended to be positive, although this was not always the case.

Positive interactions involved staff who provided affirming, friendly, and personable care, and who could answer any leftover questions. Two people did report very negative interactions with two nurses. One nurse did not use a participant’s correct pronouns and one berated another participant for having a surgery that the nurse felt was “unhealthy and unnatural.” These interactions seemed to be exceptions. However, they still raise concerns about a lack of trans competency training for healthcare providers who work in surgical settings where these procedures occur, especially in places where staff is in daily contact with trans people.

Sometimes, surgeries happened in surgical centers that do not specialize in gender-affirming surgeries (such as hysterectomies). In these centres, interactions could generate a bit more anxiety because participants were not sure how they would be treated. Ben described going to a public hospital for a hysterectomy where he had a “very respectful” OB/GYN but getting care was “awkward” especially in public spaces such as the waiting room, where patients were assumed to be women.

## LACK OF INFORMED CONSENT

Two participants reported very negative experiences with their surgery due to a lack of communication regarding what procedure(s) would be performed. Markus noticed two days after his surgery that he had an extra incision. No one had told him ahead of time that this might happen, and no one offered information after he woke up from surgery. He only found out exactly what had happened to him when he asked the surgical staff directly about it.

Ben also realized a couple of days after surgery that part of the procedure that he thought he was getting had not been performed. The surgeon had also used a new surgical technique on him but did not let Ben know ahead of time. Ben was also not informed about either of these changes upon waking up, and he struggled to get clear answers from the nursing staff and surgeon about what had happened afterwards. Ben said:

“**I totally feel like nobody bothered to communicate what happened or-- I didn’t have informed consent to whatever it was he did do. Like, if he had come to me afterwards and said, you know what, listen, [...] we ran out of O.R. time. I would have been, like, you know what, that really sucks. But I get it.**”

The lack of information and communication continued after Ben went home and his family doctor tried to communicate with the surgery centre.

These experiences were frightening and upsetting for the participants. Their stories are unusual, but they speak to systemic failures in communication that threatened patient's ability to understand and to consent to what has been done to their body.

### TRAVELLING AND DISTANCE AS MAJOR CONSTRAINTS

Since not many surgeons can perform gender-affirming surgeries in Canada, many participants had to travel for surgery. This included driving, taking ferries, and flying several hours away.

Participants reported that traveling was stressful, and made the process more difficult. There is help available to cover travel costs (such as Hope Air), but for many people, traveling was a financial and practical barrier. Among people who had to travel for surgery, many

wished they could have had the surgery closer to home. Those who could access surgery where they lived sometimes noted that they were grateful for that option. Ben said, "I mean, having the surgery in my own city was just so much easier on me and my family. Huge difference."

One of the concerns about travelling for surgery was that something would go wrong after returning home. Few participants had access to local medical providers with knowledge about gender-affirming surgery who could provide follow-up care. Helen said:

**“ It would have been nice if it could have been done locally. It could have been done closer to home. ‘Cause if there were issues, yes, we were there for 10 days when the majority of the issues would happen in the first few days. But if there were other things afterwards it was just that—dealing with-- back and forth sometimes. It was a bit of a nuisance.**

When people went far away for surgery, they usually spent five to ten days at an aftercare facility. After that, they had to fly home, sometimes before they had their catheter removed or when they still had to dilate every few hours. Participants often explained that traveling home was a painful, stressful, and unpleasant experience that could be made worse by connections, delays, and other typical hurdles of traveling. One person who had surgery at the same time as Salem had a life-threatening bleed on the plane travelling home. Salem said, “I can’t help but think that that might not have taken place if this person didn’t have as far to go.”

Having to travel for surgery often meant that participants did not have people there to help support them through surgery. Many of these surgeries are major procedures, emotionally and medically, so having friends or family nearby could be very important. Lauren, who paid for her daughter to come with her, said, “She came because she cared, and I was really glad she did.” This additional cost places a financial burden on people, who have to pay out of pocket to have their loved one travel with them. This extra spending created disparities between people who could afford to have someone travel with them, and those who struggled to pay for their own airfare.

# After surgery

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## POST-SURGERY RECOVERY CENTRES

For some surgeries, particularly more extensive lower surgeries such as vaginoplasties or phalloplasties, patients were required to stay at an aftercare facility for up to 10 days post-surgery. These aftercare facilities were generally praised by participants. They found them to be spaces where the nursing staff were respectful, attentive, and well-trained in making sure that patients' pain was managed properly. Charlotte described one of these facilities as “[feeling] like a home.” People usually had a good experience with being taught how to care for their body post-surgery and how to best recover: “the more you push yourself the better you’re going to recover and the faster” (Blake).

A benefit of recovery centres was being surrounded by people who “deeply understand exactly what you’re going through” (Charlotte). Sharing recovery facilities with other trans people was often a very positive experience, especially since many people were far away from home with no friends or family nearby. Helen explained:

““ When we got there, there were people who were just finishing up from the previous week. So we got to meet a few of them and, you know, they told us some stories and stuff to take care of. And then so we were able to pass along some of the stories in the house as well. It was great that way.

Some people also mentioned that former patients came to visit the recovery facility during their stay. One such person was described by Monroe as a “big sister,” who gave her and the other recovering patients some tips to make their recovery easier. The opportunity to talk to other people who had gotten similar procedures, combined with the clinical knowledge from the nursing staff, often contributed to positive experiences during this first phase of recovery.

Not everyone had a positive experience while staying at one of these aftercare facilities. Several participants struggled due to what they felt was poor pain management, a lack of clear communication regarding proper wound healing, low quality of care, and unfriendly interactions with nursing staff. Charlene, who collapsed to the floor due to pain at one point, shared:

““ [The nurse] didn’t hurt me. But it felt this is a huge moment for me, and maybe it’s not a huge moment for her ’cause she does this all week. All—month in, month out. But there should have been—[...] I was pretty emotional at the time about it. A little bit more of a bedside manner would have been really, really nice.



These experiences were rarer, but they had a notable negative impact on participants.

### **FOLLOW-UP CARE AT HOME**

When people had surgery far away from their home, they did not have the option to return to the surgeon for follow-up visits. Follow-up care was then done over the phone and email, which people had mixed experience with.

Some people felt satisfied with the amount of follow-up care they received, even from faraway clinics. Helen said she got a helpful booklet of information on how to continue with recovery from home, and was satisfied with her interactions with the surgical clinic after she went home:

““ **The angle they always took was positive, reading through a lot of the notes they were sending, you know. [...] And they were giving options all the way through so--yeah, I really enjoyed--liked the communication and stuff.**

Taylor also had a good experience after going home. Upon leaving the aftercare facility, they were given a “really great package of information, exactly what to do,” including bandages and other medical supplies they would need once they were home.

More often, however, people experienced stress because they were not sure what the healing process should look like. Participants reported that clinics did not automatically check in with them about their recovery – they waited for patients to contact them directly.

Contacting the surgery clinic directly was not always easy. Kendra tried to contact the emergency number that she had been given by the clinic, with no success. Raquel shared, “it’s very difficult to get a hold of them

once you’ve left the surgical facility. It’s very difficult to get any kind of a response if things look like they’re not recovering normal or if you’re nervous about things.” Raquel would have liked to have someone who could help her understand the healing process. She did not always understand why things that seemed worrisome to her were normal. The distance between her and the clinic seemed to make this kind of follow-up care impossible. Jazmine also wished there was home care support in place upon returning from surgery to help ensure that recovery was going well.

Difficult communications were especially stressful for people who, like Raquel, “didn’t have a doctor who was experienced with trans folks who was really committed to learning and taking really great care of me.” In these cases, follow-up care sometimes seemed to be a matter of luck. Monroe, who lost her GP just before going for surgery, did not experience any complications. This was fortunate, because three months went by before she could find a clinic to go in for a check-up. Before then, her “lifeline” was emailing back-and-forth with the clinic. During this period, she noted, “if something is missed, then I don’t know what to do.” Kendra also worried about follow-up care:

““ **And if you have any complications and you have to go to the E.R. here in-- for [my health authority], it’s just-- you might as well just stay at home. There’s no point. They just misgender you and even if your medical file is up to date, they’ll call you from-- by your old-- by your dead name and they’ll, like, just straight up ignore you.**



When people had access to trans competent primary care providers, they usually reported that recovery was not as stressful. Blake was able to access a trans specialty care clinic where nurses were able to reassure him about the results of their surgery, but this was not an option for everyone. Some primary care providers did not have the expertise or experience required to assess the post-surgery site and know what was worrisome or not.

Close friends and family became essential sources of support during recovery. People who had the ability to bring loved ones with them to the clinic or hospital often noted that this was a key help on the journey home.

### COMPLICATIONS

Complications can be stressful after any surgery. After gender-affirming surgery, complications were described as especially scary because people often had to go home to a city or province where no one specializes in these types of surgery.

Participants who experienced complications found the lack of consistent follow-up from surgery centres particularly difficult. Kendra said:

““ When I got home I eventually ended up getting an infection that I had to go and deal with, which was-- which when I contacted [the clinic] about that, they didn't get back to me for, like, 11 days. And I was like, you guys are so on top of it.

Complications were sometimes very scary, especially for people who did not have a lot of experience with open wounds and/or surgery. Ash shared:

““ I had some complication with bleeding coming from the drain tube hole. [...] It was pretty late at night. And we didn't have any nurse contact. Like, we didn't know who to call, basically, especially at that time of night, who could help with this. But we didn't-- weren't going to, like, let it just bleed all night. So we had to do something [...] So that was definitely something I felt was lacking in the healthcare process of, like, who do you call? Yeah, who do you call-- who can help you with aftercare? Because we felt very alone in that.

Some complications, such as urinary tract infections, seemed to be managed easily if people had access to a primary care provider or a drop-in clinic. But when complications were specific to gender-affirming surgeries, participants found it harder to get medical help, because few providers in BC are trained to deal with these types of complications. Lack of communication with the original clinic complicated these situations. Raquel shared:

A number of people also reported that their surgical clinic seemed unwilling to correct issues that came up, such as internal hair growth or asymmetry, or did not communicate clearly with people about potential surgical revisions. This was not always the case: Charlene's GP found an issue while doing a routine check-up a few months after her surgery that required a revision and her clinic proceeded with the revision without any problems.

“ So I had quite a bit of overgranulation which is sort of a normal by-product or it's a complication, but it's an expected complication of this. And fairly easy to treat. However, I think [the surgical clinic] was not very responsive when my doctor had questions about how to treat that over granulation and since coming back to [my city], and talking to my doctor out here, I think we didn't treat it as well as we probably could have.

# Conclusion and Recommendations

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This interview study, the first of its kind in British Columbia, provides an important picture of what it is like to access gender-affirming surgery in the province. For our participants, the journey to gender-affirming surgery was often complicated, with many ups and downs along the way. There are serious concerns about gaps and inconsistencies in the system of care that create a lengthy, difficult, and often emotionally-taxing process rather than facilitate access to these types of medically-necessary surgeries.

We are particularly concerned about the lack of trans competency of primary care providers, inconsistencies in assessment practices, lengthy wait times, the need to travel long distances to access assessors and/or surgeons, and the lack of consistent follow-up care for people returning home from major surgery. Transparency and clear communication are needed throughout the process to help people better understand what the process entails, and how to make informed decisions about their healthcare.

The picture is not all bleak. Many stories shared by our participants illustrate the shift away from treating trans people as mentally ill and show instead an informed consent approach that assumes trans people are the experts on their own lives. Participants shared encouraging stories of supportive practices. They described positive relationships with supportive and knowledgeable healthcare providers who helped them navigate the complexities of the healthcare system, provided respectful and attentive care, and advocated on their behalf to make sure they had access to the care they needed. Community-based supports also played an essential role

in people's experiences by providing emotional support and helping participants find relevant information to make their way through the system.

When supportive practices were implemented consistently, participants were able to access gender-affirming surgery in a way that felt affirming and empowering, mostly free of uncertainty and stress. All people who seek access to gender-affirming surgery deserve these positive experiences. We offer a number of key recommendations based on our findings to highlight these supportive practices and suggest key areas to improve the recent system of care in BC.

Because so much work is happening in this area in the province of BC, we gave Trans Care BC the opportunity to read a draft of the report and provide an update on early steps and actions taken to address the recommendations from the report. Some of the recommendations identified through our research had also been raised during Trans Care BC's community consultation process.

## RECOMMENDATIONS

### **Clearer pathways to surgery with centralized, up-to-date information**

Almost every participant struggled at some point because they were confused about how to navigate the healthcare system. Often they could not find up-to-date information on the specific process to access gender-affirming surgery, or on how to access trans competent primary care providers, assessors, or surgeons.

It is essential to improve system navigation to gender-affirming surgery as well as communication and transparency about this navigation process. People should have easy access to information about the journey to gender-affirming surgery and what to expect at the start of the process. This can be achieved through having centralized information that is easily accessible and updated regularly, with clear time stamps so that people know they are accessing up-to-date information.

This improved system of communication needs to include clear information about the specific steps to follow in case of some common difficulties, such as being over a certain BMI, having a medical condition that might make surgery more difficult to access, accessing out-of-country surgeons, or working across medical jurisdictions (for example, for people accessing gender-affirming surgery in BC from the Yukon).

This information should be available for patients as well as health care practitioners, so that practitioners can provide trauma-informed care and more effectively help their patients navigate the system of gender-affirming healthcare by sharing comprehensive information early on.

## RECENT ACTIONS

In December 2016, Trans Care BC implemented a streamlined referral process for surgeries that removed the requirement of a central provincial chief assessor. Referrals can be made directly to surgeons, which has reduced wait times in the assessment and referral process.

Trans Care BC has created a surgical assessment infographic outlining the steps for assessment. It is accessible at: [http://transhealth.phsa.ca/wp-content/uploads/sites/15/2014/05/Trans-Care-BC\\_Surgical-Assessment-Infographic\\_FINAL.pdf](http://transhealth.phsa.ca/wp-content/uploads/sites/15/2014/05/Trans-Care-BC_Surgical-Assessment-Infographic_FINAL.pdf)

Trans Care BC is developing a new website that will include more surgical information for clients. In the meantime, some information can be found on the Trans Health Information Program site at <http://transhealth.phsa.ca/medical-options/surgeries>

**“ I think it’s better for people to have a timeframe, even if it’s a longer timeframe, than it is to just not have an answer or get told something might change.**

- ALICIA

## RECOMMENDATIONS

**Clearer pathways to surgery with centralized, up-to-date information**

**Consistent point of contact throughout the process**

People need help navigating their way to gender-affirming surgeries without anxiety. Healthcare providers should be available to act as case managers for those who need and want the support, especially in more complex cases. These providers could be trained primary care providers, counsellors, or support workers.

## RECENT ACTIONS

In the spring of 2016, Trans Care BC established a Care Coordination team of health navigators, nurses and a part-time primary care physician. Some of the supports the team can offer are to:

- Provide patient navigation support through the system of care
- Increase support for pre- and post-surgical care, as well as training for other health care providers
- Provide surgical readiness assessments through tele-health (secure video) for patients who have difficulty finding an assessor in their community
- Provide help with surgical care coordination for clients seeking lower surgeries like vaginoplasty, phalloplasty and metaoidioplasty.

“It’s almost like you need something like a case worker, somebody who actually follows your file all the way along. [...] They can be doing the advocating and the work for you ahead of time, looking at your file and, you know, ‘oh, you have diabetes. This might be an issue in getting a surgeon to agree to go ahead with this. I’m going to look ahead of time (and) I’m going to, like, figure this shit out.’ So you don’t have to, like wait around for an extra two years to try to get surgery and get this done and figure out how to do it yourself or maybe never figure it out, you know.

- MARKUS

## RECOMMENDATIONS

### **More consistency in assessments, with emphasis on informed consent**

The assessment process can be useful when it is conducted from a patient-centered, strengths-based perspective that asserts people's right to make informed healthcare decisions for themselves and assumes that trans people are experts on their own lives. Since people often had difficulty navigating the healthcare system, the assessment could also be an essential place for people to learn more about next steps, and alleviate some of their concerns.

More assessors need to be trained to conduct assessments from an informed consent and trauma-informed practice approach. Efforts should focus on training primary care providers so that patients are more likely to be assessed by a healthcare professional with whom they have an established, trusted relationship. Ongoing opportunities for education and training should also be offered so that assessors stay up-to-date with current standards of care. If assessors are not staying up-to-date, mechanisms should be in place to address outdated practices.

Patients and their primary care providers (who are not qualified assessors) should have easy access to information about the purpose of the assessment(s) and what they can expect during their appointment(s).

### **Shorter and more transparent wait times**

## RECENT ACTIONS

Trans Care BC is increasing training for more publicly funded assessors to reduce wait times, and to develop a consistent process that is modelled in a patient-centred, strengths based, trauma-informed approach:

- Prior to Trans Care BC's start in 2015, there were 14 publicly funded assessors across the Province. This figure has increased to 26.
- Trans Care BC will be publishing a list of trained, publicly funded assessors in fall 2017. In the meantime, clients can call our Care Coordination team for further information: 1-866-999-1514
- TCBC's Care Coordination team also provides surgical assessments via tele-health to patients across the province.

## RECOMMENDATIONS

### Shorter and more transparent wait times

Waiting is often a period of extreme stress and frustration for people who are trying to access gender-affirming surgery, as dysphoria and depression can get worse over time. Wait times should be reduced by streamlining pathways to surgery and having more surgeons trained in the most common gender-affirming surgeries.

The lack of transparency about wait times increases frustration, and leaves people feeling abandoned by the healthcare system. Before they are referred to an assessor, patients and their primary care providers should have a clear sense of how long each step of the process might take. If there are delays to see an assessor or a surgeon, there should be clear communication as to why, and how long the patient might have to wait. Patients should have clear information on who is currently performing surgeries and what wait times they can expect, including where they are on the waitlist and what that means in terms of waiting.

Information about private pay options should be more readily available for people who may want to choose that option. However, the priority should be on clarifying and reducing wait lists for people who do not have the option to pay privately for their care. Lengthy wait times for publicly-funded surgeries must be addressed as a significant barrier to care.

## RECENT ACTIONS

Trans Care BC is working to increase the number of new surgeons performing upper surgeries:

- Trans Care BC is supporting work to train new surgeons across BC so that patients can obtain surgery closer to home
- A central intake model through Trans Care BC will be in place in the fall 2017 so that communication with patients about their status on the wait list will be improved.
- The current list of surgeons who are working with Trans Care BC as part of the central upper surgery wait list can be found here: <http://transhealth.phsa.ca/services/service-directory/surgeon-profiles>. As new surgeons become trained and part of the process, their information will be available here as well

## RECOMMENDATIONS

### **Access to trans competent primary care providers in all communities**

Primary care providers are a person's first and main ongoing point of contact in the healthcare system. They play a crucial role in supporting people who seek out gender-affirming care, including routine care, hormone therapy, and surgery.

More efforts should focus on training and educating primary care providers, especially outside metropolitan areas. These efforts should include:

- building their capacity to provide routine care in a gender-affirming way by educating them on gender diversity and gender-affirming language, inclusive of non-binary identities
- increasing their ability to provide trans competent healthcare such as hormone therapy or follow-up care after surgery
- widening their knowledge of trans healthcare, including appropriate referral pathways, so that they can support their patient as they seek out specialized trans healthcare
- providing ongoing training so they can stay up to date with trans health.

## RECENT ACTIONS

Trans Care BC's education team is working to enhance primary care providers' knowledge to provide safe and supportive primary care for trans patients, as well as hormone initiation, monitoring and surgical assessments. An informed consent model is a key part of this training.

**“ I have a lot of resources in Vancouver, in BC. So it would be a lot more practical for me to take advantage of those resources than to go all the way to (another city). (...) Just to have something closer would cut down on costs and travel times and all the rest.**

- SALEM



## RECOMMENDATIONS

### **Creation of Western Canada surgical centre**

The lack of infrastructure to support pre- and post-surgical care for gender-affirming surgery is a major concern for British Columbia. So is the lack of options when it comes to choosing a surgeon.

Setting up a surgical centre dedicated to gender-affirming surgery would help address many of the issues and concerns that currently afflict the system of gender-affirming care in the province. This would provide surgeries closer to home, make follow-up care more accessible, and help ensure that there are primary care providers who are trained in pre- and post-operative care. It should be noted that this option may limit access to publicly-funded surgeries to local options, which may reduce people's choices.

Ideally, this surgical centre should welcome surgeons who can perform more intensive lower surgeries that currently require travelling very long distances, as well as surgeons who can perform all types of upper surgeries.

## RECENT ACTIONS

Trans Care BC has submitted recommendations to the Ministry of Health on how a comprehensive surgical program could provide lower surgeries in BC to bring procedures closer to home.

## RECOMMENDATIONS

### **Clearer pathway to surgery for people with a high BMI**

Given that gender-affirming surgery is medically-necessary for many people, there should be standardized procedures for people who encounter barriers to surgery due to their BMI. They deserve to access surgery without endangering their health.

Information should be readily available about the reasons and specifics of this barrier. If BMI cut-offs stay in place, primary care providers should be trained to support their patients through the hurdles of navigating this additional barrier in a way that does not promote unhealthy behaviours and/or poor mental health.

## RECENT ACTIONS

Currently all surgeons working with Trans Care BC have a BMI cut-off rate of 35. Trans Care BC is working with these surgeons to develop a standard and clear process for patients with a BMI of 35 or higher.

## RECOMMENDATIONS

### Review of breast augmentation criteria

The current criteria for MSP coverage in the case of breast augmentation should be reviewed and expanded to consider the specific needs of trans people who seek access to this surgery. In particular, the criteria should recognize the differential impact of minimal breast growth on different body types.

### Coverage of additional gender-affirming procedures

While the attention is often focused on major lower surgeries, other surgeries and procedures can have a significant positive impact on people's quality of life and facilitate participation in society. Breast augmentation and electrolysis stand out as two procedures that should be covered more systematically for those who need them.

## RECENT ACTIONS

Trans Care BC is working with the Ministry of Health to review the current criteria of breast construction and augmentation to improve publicly funded access for trans people seeking this procedure.

Trans Care BC is conducting an environmental scan on existing models to inform recommendations about expanding coverage of other medically necessary affirming procedures.





