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Knowledge Legitimacy: How Trans-Patient Behavior Supports and Challenges Current Medical Knowledge

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In this article, I examine the accounts of transsexual/transgender patients and their involvement with medical professionals in the Midwestern United States. Data are taken from 22 in-depth interviews and one year of participant observation of three transsexual/transgender organizations. I show that trans-patients are made aware of larger political, religious, and cultural ideologies through their medical experiences. Trans-patients internalize these views, which affect how they make sense of their medical treatment and how they choose to alter their behavior in future medical encounters. Trans-patients, in an attempt to gain credibility and avoid stigmas, prepare how they will approach doctors to improve their likelihood of receiving desired treatments. The data will reveal that through their approach, trans-patients both support and challenge existing medical knowledge. Patients support medical discourse by using established medical language in their interaction with doctors. Patients challenge medical knowledge by resisting established medical decisions.

Keywords: *health care, access to; health care, users' experiences; qualitative research, general; transsexuals*

The core of this article lies within a larger study examining discrimination experienced by transsexuals. One form of such discrimination, addressed here, is that experienced during medical treatment. Transsexuals must battle stigmas as many societal members believe them to be sexual deviants, pedophiles, and mentally unstable. Aside from these stigmas, transsexuals must confront additional stigmas found in the medical arena. These include proving to medical professionals that one is "real." Whether one hopes to be perceived as an authentic transsexual woman or man depends on what services one desires and believes one will receive. Avoiding stigmas and establishing credibility in the doctor-patient relationship is important, as doctors are the gatekeepers or the ones who decide who receives which treatments. Adding to the difficulty of securing particular treatment, transsexuals' medical requests are many times seen as unconventional, strange, and sometimes harmful. Moreover, medical

professionals' knowledge related to transsexuals lacks consistency and is highly debated, which I will show can create more patient obstacles to and opportunities for care. I will explore the ways that patients make sense of their care, alter how they approach medical professionals to ensure obtaining the medical treatments they request, and how they legitimize and challenge current medical knowledge.

Broadly speaking, transsexuals are those who feel that they are the opposite sex from the one assigned to them at birth (Brown & Rounsley, 1996, p. 6). Many, but not all, seek hormonal and surgical assistance (Green, 2004). All respondents in this study are considered transsexual according to the definition provided above. Whether seeking transsexual-related or nontranssexual-related medical care, transsexual patients are viewed as unconventional compared to other patients because they disrupt the biological connection to our strict binary gender system and because of the particular medical services they request. Throughout this article, when referring to the participants in my study, I will use the terms trans-patient, trans-people, and trans-individual interchangeably.

Trans-individuals face unique experiences as they attempt to navigate medical arenas. Trans-patients'

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presentations to doctors stem from their understanding of broad ideologies transmitted through the medical encounter. To obtain particular treatment, patients prepare how they will conduct themselves in the medical setting. Their approach can both support and challenge existing forms of professional knowledge. Below, I will more broadly address medical sociological debates and specifically focus on Hirschhorn's (2006) work on knowledge legitimacy.

Theoretical Framework

The Sociology of Medical Knowledge

The sociology of medical knowledge addresses how people acquire information. According to social constructionists, medical knowledge is neither static nor objective. Knowledge is not a set form of truths that are waiting for our discovery of them. Accepted knowledge is seen as having more to do with successful organization by powerful claims-makers and the theories they promote, rather than only facts (Brown, 1990, p. 392). Social constructionists show us that it is the continual interaction of multiple forms of knowledge, experience, and power relations that impact medical actions and relationships (Brown, 1995, p. 37). To comprehend the medical encounter, I think it is useful to begin with the appropriation of medical knowledge and how it is understood, used, and challenged by doctors and patients.

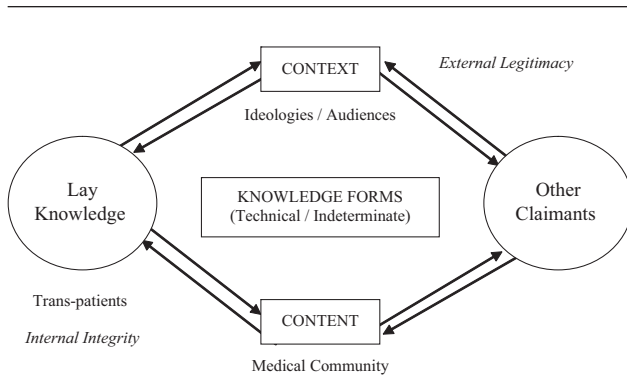
Hirschhorn's Model on Knowledge Legitimacy

Hirschhorn (2006) argues that it is the type of knowledge used by medical professionals that impacts the level of legitimacy granted to those who employ it. Although Hirschhorn's work revolves around biomedical and complementary and alternative medicine, my work will demonstrate how patients can be integrated into the process of knowledge legitimacy. Hirschhorn's model (see Figure 1) reveals two aspects of professional knowledge form: technical and indeterminate (see also Jamous & Peloille, 1970). Technical knowledge (codified medical knowledge) is formal, abstract, and specialized. Indeterminate knowledge (doctors' experiential knowledge) is charismatic and gathered by medical professionals through their experiences. It is the application of indeterminate knowledge that is

socially legitimated, whereas technical knowledge is scientifically supported and aligned with "cognitive rationality" (p. 537). Hirschhorn states that knowledge can transform either into everyday (accessible to lay persons) or exclusive (further controlled by professionals) knowledge (p. 541). An example of everyday knowledge would be patients' ability to access information about hormones from the Internet, whereas an example of exclusive knowledge would be that doctors are the gatekeepers to trans-patients ability to access sex reassignment surgery.

Hirschhorn's (2006) conceptual model also includes context and content, whereas the addition of patients—explained in this work, and claims-maker—addressed in future work, are my contribution. According to Hirschhorn, the content of knowledge is created, discussed, and debated by "insiders" or those individuals who make up the medical community. The context is where knowledge is validated by societal members. Legitimacy arises between the interaction of knowledge form with both context and content. Knowledge gains external legitimacy when it is accepted by societal members and is aligned with current political, economic, social, and cultural ideologies. Knowledge forms gain internal integrity when they are successfully articulated by members of the professional community. Knowledge content agreed upon by those in the professional community is further legitimated, justified, and made more exclusive when it is successfully accepted by the public. My research will shed light on how trans-patients are made aware of, grasp, and incorporate knowledge forms (e.g., indeterminate and technical) into how they present their problems to medical staff. Additionally, my study will address how at times, trans-patients assist with making knowledge even more exclusive through their adoption of medical language and a desire for doctors' assistance while simultaneously utilizing everyday, accessible knowledge to challenge the information doctors have about them. Hence, beyond exploring the impact that societal ideologies (context) and the medical community (content) have on knowledge legitimacy, I also hope to show how trans-patients' medical experiences are both produced by legitimated knowledge and can support and resist this knowledge. My purpose is to see how Hirschhorn's theoretical model assists in understanding trans-patients' medical experiences, their approach to medical encounters, and their ability to legitimate and challenge medical knowledge.

Figure 1
Knowledge and Legitimacy Claims



Note: Adapted from Hirschorn, 2006. Reprinted with permission.

Medical Power: The Interaction Between Doctor, Patient, and Knowledge

Early views about professional medicine began with Freidson's (1970a) idea of professional dominance. In his view, health care and medical information were top-down and coercive over patients. Medical/psychological agencies monopolize medical knowledge and establish medical professionals as experts through formal training and licensing (Conrad & Schneider, 1992). Dominant institutional structures increase their overall professional power through their ability to medicalize the body and confer legitimacy to patients. Medicalization occurs when more aspects of life are placed under the definition, scrutiny, and control of medical authority. By medicalizing the body, religious, economic, political, and social beliefs are shrouded under the more legitimizing power of science (Brown, 1995; Conrad, 1997, 2005; Riessman, 1983). Legitimizing institutions, through their ability to create language used to discuss individuals, confirm societal norms (Gans, 1995) and serve as a form of social control (Brown, 1995; Conrad & Schneider, 1992; Parsons, 1951; Zola, 1983). Diagnosis is the language used in social control. Diagnosis demarcates the line between normal and abnormal and provides medical professionals the power to deal with nonconforming individuals on behalf of society at large (Arney & Bergen, 1983; Brown, 1995, p. 39). Professional dominance has tremendous impact on how patients understand and experience the medical encounter. It is this power, held by doctors, that alters trans-patient presentations in ways that will ensure they receive the "proper" treatment or diagnoses they desire.

Following a social constructionist view, patients internalize the dominant view of society—even if it disparages them—and therefore, adhere to strict societal rules (Spector & Kituse, 1987, p. 75). Medical and psychological fields, aligned with societal ideologies, articulate strict expectations for particular conditions. How patients present their problem to doctors reflects their understanding of how societal members, including doctors, view them (Conrad, 1997, p. 140). People so relegated to the fringes of society attempt to redefine their spoiled (disparaged) identity and secure credibility by working to manage both tension and information in the medical encounter (Epstein, 1996, p. 12; Goffman, 1963; Werner & Malterud, 2003). Many patients feel the need to present themselves and their medical requests in a way that proves most successful in receiving particular assistance (Bury, 1982; Charmaz, 1983; Risman, 1982, p. 320; Williams, 1983, 2003). Patients make use of the legitimacy provided by such professions to increase their acceptance in society (Fox, 1977, p. 21). Trans-patients' understanding of their medical treatment and their approach to their practitioners reflect their internalization of accepted norms. They work to avoid stigmas in the medical relationship so as to maximize their likelihood of receiving treatment.

Recently, professional power is becoming demystified (Broom, 2005a, p. 321) or reconfigured (Starr, 1982; see also Wiles & Higgins, 1996) as medical knowledge/decisions lack a scientific basis (Brown, 1990; Lutfy, 2005; McClean & Shaw, 2005) and patients have increased access to medical information. Seen as consumers, patients arrive at the medical encounter with more tools for negotiation. Currently, more power is awarded to patients as they not only expect more from their medical care but they are encouraged by the medical field to take control of their health concerns (Broom, 2005a, 2005b; Lawton, 2003; Siminoff & Step, 2005; Williams, 2003). Patients have the ability to choose doctors, use alternative medicine, join support groups, and even access medical information on the Internet (Conrad, 2005, p. 4; Starr, 1982; Wiles & Higgins, 1996, p. 342). Increased information translates into more knowledge for patients, which narrows the gap between them and the "experts" (McClean & Shaw, 2005, p. 746). Increased access to information gives the patient more credibility in the decision-making process, which can shift the power imbalance, challenge professional

dominance, and allow patients to resist current hierarchic medical models (Broom, 2005b; Lofmark & Hammarstrom, 2005; Werner & Malterud, 2003). On the other hand, in achieving medical services many patients use the language and perspective already accepted in the medical/psychological field (McClean & Shaw, 2005), which inadvertently support professional knowledge and add to practitioners' power. Currently, the main forms of knowledge used to diagnose and treat transsexuals are the *Diagnostic Statistical Manual of Mental Disorders* (DSM-IV-TR)¹ and *Harry Benjamin's Standards of Care* (SOC).² When trans-patients effectively use medical knowledge they can be viewed as credible and worthy of sought-after treatments. In their attempt to meet medical needs, patients both legitimate and dispute medical knowledge. Trans-patients fit into the debate surrounding forms of knowledge, knowledge legitimacy, and existence of accessible versus exclusive knowledge.

Method

The data stem from a year-long participant-observation study of three trans-organizations in a large Midwestern city in the United States and interviews with 22 self-identified trans-people during 2005–2006. Data were analyzed using a grounded theory approach.³ This research was reviewed and accepted by the Institutional Review Board.⁴

All respondents interviewed were White, with a mean age of 48 years. Generally speaking, other than a few exceptions, these statistics are reflective of the overall group members present that I observed during social and group functions. Interview respondents included 2 individuals born intersex and living full time as women, 20 born male presenting or living as part- and full-time women, and 2 born female where 1 was currently living full-time as a man and the other individual lived as a man for a few years only to begin transitioning back to live as a woman. Although I allowed my respondents to self-identify, I found that how they described themselves was not always aligned with definitions presented in the literature. Regardless of their self-identification, this article is primarily concerned with trans-patients' understanding of their medical experiences.

Results

Treatment by Medical Professionals

Patients can ascertain broad societal norms through their medical treatment (Goffman 1963). How one is treated by medical professionals is just one type of societal reaction to particular forms of deviance (Freidson, 1970a, 1970b). Freidson argues that forms of professional authority and dominance are uncovered through physicians' ability to refuse treatment and their control of both the flow of information and the decisions made over treatment options (Freidson, as cited in Siminoff & Step, 2005). Trans-patients either learn, or are reminded through medical treatment, what is an appropriately acceptable way of being. Trans-individuals express their awareness of such messages in the forms of treatment they receive. The following narrative reveals refusal of treatment by medical professionals.

There was nobody in the ER and they just didn't help me. My girlfriend overheard doctors and nurses talking shit about me and she asked them for help and they started to laugh.

Although most do not experience outright refusal of treatment, many sense a discomfort with their medical encounter.

Two years ago . . . I had to have X-rays and since I was wearing a sports bra under a sweatshirt one of the X-ray technicians noticed I had this bra on and she kind of looked down on me. . . . And then she was just cold and distant after that.

No, well recently I went to a doctor to [do] something unrelated to being transgender and he was asking me a lot of questions about transgender and I felt he should have been asking me other questions, not those questions. And one time I went to a gynie [gynecologist] and she was referring to us as "tranny-boys" and addressing us like we were pets—it felt like it was an icky situation.

I shouldn't say she freaked but there was a change in her. Just something you can see in her body language. You can sense it. She got a little nervous, avoided eye contact and left the room probably quicker than [she] would have normally. I felt like I was patronized I guess.

These experiences reflect the distance that one feels when receiving medical care.

Refusal of particular treatments by some doctors not only reaffirms their dominance, but it also solidifies societal views about the definition of normal males or females, appropriate ways to treat each gender, and under what conditions particular treatments are most acceptable.

With my new doctor he says he doesn't like to even give hormones to women. He really feels that it is for a woman and not a man.

More than receiving messages about what is the appropriate gender treatment, trans-individuals learn that particular medical options are available only for approved medical reasons and for the right people, and sometimes available only in certain geographical locations. Doctors might justify the removal of certain body parts because they are diseased, whereas any other reason is denied. This is displayed in the following account when a respondent attempted to have her other testicle removed to assist with her transition from male to female.

I had testicular cancer. He removed one a few years ago. When I went back to him again to have the other removed, he said no, he doesn't do that kind of stuff. I also need to explain that I cannot get breast implants in this area [2 hours outside of Chicago], I have to go to Chicago to get them. They will not work on transgender here.

Within the medical encounter, doctors reiterate societal values about what constitutes both "appropriate" people and medical treatments. Doctors' treatment of trans-patients is further justified when the content of their knowledge is aligned with societal values. Through these encounters, trans-patients learn how their approach to medical staff might need to be altered to access the treatment and services they desire (Goffman, 1959). Trans-individuals incorporation of commonly held views assists in how they make sense of medical care and alter their future behavior within a medical encounter.

Making Sense of Medical Care

Not all patients experience inappropriate treatment by medical staff. However, trans-patients reveal that positive responses from doctors have more to do with

the patients' presentation than doctors' particular knowledge. Trans-patients' accounts show how they internalize societal beliefs about normality and disdain for those with such a condition. Therefore, trans-individuals expect lesser treatment (Goffman, 1961) and/or successfully separate their treatment into two parts: professional and personal.

I have been really lucky and hit the right kind of people or maybe I present things in a nonoffensive way so they don't get their backs up.

It's like with everything; you just can't shove it in their face. You can't. You can't shove it in their face.

These words show an interesting view about how one makes sense of medical care. Rather than expecting medical attention as a right or a service expected as part of a practitioner's job, trans-patients believe that their requests are perhaps inappropriate or unreasonable. This is not surprising, as they are battling stigmas. I have also heard these types of responses when some spoke about public reactions to their presentations. They expect people to be confused, inquisitive, and sometimes just plain rude. I found accounts in which individuals understood broad societal views about people like them, and hence were willing to be observed by inquisitive medical staff. When I asked one such person if being observed was bothersome, she responded,

Doesn't bother me at all. I look at it from the educational aspect of it I guess. The more they know, I am a reasonable person. I know people are curious.

This individual hopes that by allowing others to ask questions and view her body, she will edify them. She later tells me that perhaps this education will eventually change peoples' perception and the future quality of care for trans-individuals. The flipside is that being on display might solidify and deepen the spoiled identity of trans-people. Continued stigmatization of trans-people might justify current negative treatment of trans-patients by medical staff and limit the types of care appropriate for trans-patients.

Trans-patients explain why they did not receive the appropriate care they would normally expect by interpreting their treatment as a difference between staff being professional and being kind. Additionally, patients separate themselves into medical and personal beings.

She was professional in her work but the warmth that I was greeted with evaporated. And she did not, we did not discuss whether I was transgender or not.

I care more about being treated well then getting good health care. I have done a good job of finding her and feeling comfortable with something before going to see them.

Trans-patients separate the doctors' job of treating their medical condition from how doctors treat them as a person. Therefore, they are able to believe they are receiving adequate medical care while still realizing that doctors do not embrace them; some accept such care because they realize their very presence goes against societal norms.

Patients are increasingly being viewed as consumers. Having the ability to pay for medical visits and medication is one guarantee that people will not have to worry about quality care. Insurance, at least for those who have it, can cause many to be denied particular services. One respondent realized that it is her financial situation that allows her to have appropriate care.

Although I can certainly see how many people would have that [inappropriate treatment] but remember that I'm not a person, a poor person. I hold a position of authority and that opens a lot of doors and people understand what is going on. I live in a rich community and so you know I don't have to go to clinics, I don't have to do things that people tend to do that get discriminated against.

One's class and status in society is important in understanding unique standpoints of individuals and their relationships with both doctors and insurance providers. One's quality of care is dependent on the level of power one possesses. Some doctors might provide assistance for the right price, but when a trans-patient misses a payment or can no longer pay, services cease.

He's [doctor] not a nice guy. He gave me my hormones . . . and my insurance card wasn't covered and I was stuck with \$500 worth of bills that I didn't pay and up until around July and when I went in there everything was cool, I'll pay you when I can do it. Because they know there are limited people we can go to . . . they know they can take advantage of you.

Money and power allow some to have more credibility, which creates a very different medical experience than

for those who lack this power. To increase power and credibility within the medical encounter, trans-patients must decide how to present to the doctor and avoid stigmas that might hinder their treatment.

Patients' Approaches to Medical Professionals

In order to ensure quality care, maintain credibility, and receive particular treatments, trans-patients consider how they will approach the doctor. How patients manage information (Goffman, 1963; Werner & Malterud, 2003), or what they choose to disclose to doctors, depends on what medical treatment they want and what they believe is the best way to receive these services. Some trans-patients are careful with what they reveal to their doctor because they fear being denied quality medical attention for (non)trans-medical issues.

Some trans-patients, either because they have already fully transitioned or because they do not want treatments related to transitioning, choose to conceal their trans-identified identity because they want to be seen as real men or real women. Some who have visible characteristics, or stigma symbols (Goffman, 1963), of their changing/past gender, attempt to keep their identity protected by lying to their doctors. Lying is a way to escape conflict within a relationship in which the doctor, as a gatekeeper, has considerable power. Patients use lying as a way to reinforce their position in the power structure (Fainzang, 2002, p. 120). They want to be seen as authentic (Goffman, 1963) and deserving of appropriate treatment.

One individual, born intersex and raised male, who is now transitioning to female, attempts to conceal her new identity as a woman to ensure the best treatment.

They noticed breasts and difficult not to and I chalked it up to gynecomastia. And then they also noticed the scar from the vaginal closure and I chalked that up to a childhood injury and at that time I was trying to, as much as possible, [present] as the role of the guy.

She feared that if her doctor was aware that she was born intersex or that she was attempting to transition to female, she would not receive the care that she expected. Therefore, she believed that the sure way to be treated appropriately was to play the "role of the guy." This meant that she would need to address any stigmas noticed by the doctor that brought her identity into question. Individuals are

well prepared to respond to doctors' questions to avoid detection of their transitioned state. This transitioning male-to-female trans-patient wanted to be seen as a woman, not as a transsexual:

And I had a cervical exam and the doctor is like, "I can't find your cervix." And I said it was because I had a hysterectomy. He was, at first he was baffled. I don't think he even questioned my gender or physiology, or he couldn't find my cervix, and he just said, "Okay."

By successfully avoiding detection, patients believe they will receive the treatment they want. Another trans-patient shared that by concealing her trans-identity she had more flexibility to make an appointment whenever she desired instead of the designated day reserved for trans-patients. She revealed that her medical practitioner scheduled all trans-patients on the same day so that regular patients were not offended. Trans-individuals desire fair and appropriate treatment and through trial and error learn that there are acceptable ways of being in the doctor's office, where how one looks and what gender one claims (Goffman, 1963) must be consistent. Therefore, patient behavior is prepared in such a way to ensure that individual medical needs are met.

Patient Understanding of Medical Knowledge

Trans-patients support existing medical knowledge by adopting particular language accepted in the field. Even if patients find the doctors' information about people like them to be limited, they continue to support the medical structure by attempting to work within it. This account shows the benefit of accepting medical diagnoses:

But since I was diagnosed with a medical condition which is part of transsexualism, I have GID [gender identity disorder—a *DSM-IV-TR* label]. Being a transsexual is a symptom of that. I'm protected under that.

Having a medical diagnosis solidifies that one has a "real" condition. When one is given an official label, he or she is generally awarded a card or piece of paper explaining their diagnosis. Trans-patients call this their "get out of jail free card," and use it in public situations in which their identity is challenged. So for male-to-female transsexuals, for example, this card lets security/police know that one is medically diagnosed as a transsexual and, therefore, should be allowed in women-only spaces, such as public restrooms.

Although some trans-patients believe they have the ability to self-diagnose their gender identity disorder, most still value and seek out professional confirmation. What is interesting with this next account is that even though trans-people are provided agency in diagnosing themselves, use of the term "diagnose" continues to indicate that one uses medical language to establish legitimacy.

This is a self-diagnosed condition. But you are not always right. You might diagnose this is a problem but until you go through your issues, you have to confirm it, let's put it that way. Until you confirm it, you still have a problem. . . . Until you are diagnosed as a transsexual you are a sexual deviant.

This respondent shows that although trans-individuals have some input in dealing with issues related to being transsexual, they still need an official medical diagnosis. A professional diagnosis can shed the stigma of being confused with a sexual deviant. On the other hand, the following patients explain that medical diagnoses can mislead patients into thinking that this diagnosis is correct for them, or that there is only one path acceptable for such a diagnosis.

There is pressure to use that model [*Standards of Care*] also for their [trans-individuals] own convenience because it is a way to not come to terms with themselves saying, "Oh, I'm going to come out and learn everything about being transgender and have SRS [sexual reassignment surgery] and then I'll be done and everything I want to be."

There are not enough options. . . . The common view is that these are the steps that I will only be successful, like if I do these things.

She made assumptions about me and didn't give me a lot of options about a hysterectomy—only gave me one option. I'm trying to deal with that kind of anger.

These respondents view limited transsexual medical knowledge as diverting trans-people from understanding who they really might be, as it is the only medically accepted path available.

Trans-patients respond in various ways when they believe that their doctors do not possess enough knowledge about them. Some simply refuse to return to such ignorant practitioners.

One doctor I saw after the war was like, "Huh?" I quit going to those doctors. One doctor said, "Well, you should get a new hobby like woodworking." She had no idea—she wanted to cure me by keeping me busy.

This account shows that not only is this patient willing to terminate a medical relationship, but that she also questions this practitioner's medical response to her issues. Those who decide to end medical relationships might then choose to take time to interview potential prospects.

They are all great—but that is from my own growth—I got a new practitioner a few years ago but I interviewed her first and explained to her about how I have been treated.

Others stick around and attempt to educate their current practitioners.

He was obviously not that well schooled on transgender or intersexed issues in particular. But at the time I just wanted someone to write me my scripts [prescriptions] . . . make sure that I wasn't going to drop dead from blood clots or something. And there pretty much I ended up telling him what he needed to do, "Okay, these are the tests you should run," and he also knew I was a PA [physician's assistant], so gave me *carte blanche*.

My current doctor does know and she is very open and she asked why [I believed I was transsexual] and I told her these are my issues and I want you to know and she shared info about good surgeons and I said you don't know what I am—I don't want a sex change. My first appointment lasted 45 minutes—I was educating her.

Doctors' lack of knowledge regarding hormones and surgeries is a commonly held concern as many doctors are not well-versed on these issues as either medical or personal choices. Some trans-individuals take the time to learn about issues related to their health so they are better prepared to discuss these topics with doctors.

Trans-individuals, either from trial and error or through others' experiences, share tips to ensure their needs. One such experience revealed to me that taking the time to see a therapist to confirm that one is a real transsexual and then hoping the medical doctor would prescribe hormones is not only time consuming, but unlikely. Rather, to find a doctor who will prescribe hormones, some trans-individuals will self-medicate for several months through the purchase of hormones on the Internet. Assuming that doctors desire to care for and keep patients healthy, they then approach the doctor and tell him or her that they need assistance in regulating hormones as the hormone

usage could have grave side effects. Patients are aware of what the doctor's role is in caring for patients and use it to their advantage.

They want to be good doctors and their job is to care for you.

Patients then share with the doctor all the harmful side effects of taking such drugs without professional guidance. They will tell their doctor what prescriptions they need and what particular tests are needed so that long-term negative physical effects do not develop.

However, not all doctors work against trans-individuals. Some doctors attempt to maneuver around various insurance and medical constraints to guarantee trans-patients obtain the assistance they need. One barrier faced by trans-patients is that insurance companies can refuse to cover trans- and non-trans-related medical services simply because they identify or have been diagnosed as having a gender identity disorder.

My current physician has two file folders. Everything that is transgender is run through my female name but my male medical treatment is given to the insurance.

By separating one's medical care under two different names, doctors are helping the patient to hide their transsexual identity. By doing this, one can avoid possible health insurance discrimination, for both trans- and even nontrans-related medical care.

The previous narratives show that trans-patients further legitimize trans-related medical knowledge. They do so by utilizing established medical language in medical encounters as they discuss their care. They also support existing medical knowledge by following particular transitional paths as set out by the medical/psychological field, as seen in the *DSM-VI-TR* and *Standards of Care*. Although many ultimately support medical knowledge, they do so to both obtain desired treatments and to acquire a diagnosis. A diagnosis legitimates trans-individuals, as one is seen as less stigmatized and in need of particular treatment. A diagnosis is also desired by medical professionals because it justifies their medical decisions, such as prescribing hormones and performing surgeries.

However, despite the fact that many, perhaps inadvertently, legitimate medical knowledge, some do realize the inherent problems within this system. Many trans-patients recognize the lack of medical knowledge and appropriate responses provided by

practitioners. Rather than merely adhering to medical decisions, some reveal that they choose to terminate medical relationships, educate their doctors, and interview potential medical professionals. Patients also recognize and appreciate when doctors, although working within the constraints of the system, do what they can to provide treatments and get them covered by insurance companies.

Including patients' experiences builds on Hirschhorn's (2006) model of knowledge legitimacy. Trans-patients provide external legitimacy to current trans-knowledge forms by using medical language and seeking out medical attention for their needs. When trans-patients accept the knowledge used by medical practitioners, they justify its continued use by the medical field. Trans-individuals further provide external legitimacy to knowledge aligned with societal ideologies when they accept poor treatment from medical staff. For example, many trans-individuals, as mentioned earlier, understand when doctors do not treat them or are distant toward them. Hence, they expect doctors—just like the larger public—to treat them as stigmatized individuals, as strange patients asking for nonconventional treatment. By working within the existing medical system, trans-people also extend internal legitimacy to knowledge forms. By adhering to doctors' decisions, trans-patients further confirm knowledge which has been agreed upon by those in the medical community. In addition, through this process, trans-patients assist in making knowledge more exclusive, where doctors are the only gatekeepers to certain medical treatments. However, I would argue that trans-patients have made previously exclusive forms of knowledge more accessible by seeking out information about hormones from the Internet and others in their community. Through their "work," trans-patients are better equipped to demand particular treatment and attention from medical practitioners, and hence, can possibly alter the type of knowledge legitimated by the medical community, or at least how they treat trans-patients in the future.

Discussion

I have shown that the inclusion of patients, especially trans-patients, is useful in comprehending the process of knowledge legitimacy. My work builds on Hirschhorn's (2006) model by explaining how trans-individuals learn societal views about people like them in the medical encounter. Trans-patients internalize

these views in ways that allow them to make sense of their medical care. Additionally, how trans-patients understand societal/medical views about them contributes to how they will present their needs to doctors, to ensure receiving appropriate treatment. By controlling what information is relayed to practitioners, trans-patients attempt to avoid stigmas that could be detrimental to receiving quality care. Securing credibility within the medical encounter will make patients more effective in both meeting individual needs and possibly challenging medical knowledge. Although, as trans-patients create more opportunities for realizing their immediate needs, I would argue that it is the voices of certain "credible" trans-people that have the most ability to impact knowledge forms. Patients who are most "credible" might only legitimize certain transitional paths as they utilize language and perspectives already accepted in the medical framework. I argue that patients' legitimate medical knowledge (both in content and context) by accepting and working within the existing medical discourse. This is evident in that they internalize societal/medical views, especially in their desire to avoid stigmas and the means by which they seek out and use current medical discourse to obtain medical care.

However, I also argue that some trans-patients, even if they utilize and support medical knowledge to obtain their needs, do engage in forms of resistance and challenge medical knowledge. By terminating and actively seeking out new medical relationships, trans-patients convey that they are not satisfied with current methods of treating trans-people. Trans-patients also "work" to make previously exclusive medical knowledge more accessible. They acquire this information through interaction with each other and the Internet, and use this knowledge to push for particular treatment not normally granted to them. Hence, through their "work," trans-patients can introduce to doctors fresh perspectives about treating trans-people. Such ideas might develop into renegotiations among the medical community that could ultimately legitimize a new form of knowledge. Although more research would need to be gathered from the medical community, I would like to study whether, over time, new forms of medical knowledge can be introduced, legitimated, and sustained, and what role trans-patients play in this process.

My findings build on current knowledge/legitimacy literature by including the importance of patients more generally, and the unique challenges faced by trans-individuals more specifically. My work with trans-patients shows the unique challenges

they face as they must overcome stigmas, build credibility, and contribute to a trans-medical debate that has not yet been settled. I have added to the current discussion about the complex process of the medical experience by revealing the ways that patient behavior is both produced by the current medical structure and impacts knowledge content in ways that allows more medical freedoms and constraints.

My study points to the need for more research in this area. In my upcoming work, I will include the experiences of doctors and psychologists who treat trans-patients to gain a more complete picture. I would be interested to see if trans-patients' approach in the medical encounter actually creates new discussions for medical experts surrounding the care of trans-people, or if doctors perhaps provide treatment for reasons other than a change in medical perspective (e.g., to make work easier, to increase profit, and so forth).

Notes

1. Most recently revised in 2000, the *DSM-IV-TR* is a manual used by professionals in diagnosing those with GID, or gender identity disorder. Many transsexuals seek out/need this official medical diagnosis to medically/surgically transition to the opposite gender. GID replaced transsexualism as an official diagnosis in 1994.

2. *Harry Benjamin's Standards of Care* is currently undergoing its 7th revision. The World Professional Association of Transgender Health (previously the Harry Benjamin International Gender Dysphoria Association), made up of medical/psychological professionals, maintains and utilizes this document, which is used by many to monitor the treatment of trans-patients.

3. Adhering to a grounded theory approach during the data collection time frame, I compiled both field notes and fully transcribed interviews and began to comb through responses looking for common themes.

4. My study was approved by the Institutional Review Boards of both Loyola and Concordia Universities. Organization presidents were contacted, informed of the research, and agreed to have me participate in observation. In addition, I introduced myself and my interest in collecting data to all members on the first day of my research. Individual interviewees were recruited from these organizations; I provided full information on their rights as research participants and received their signed consent to conduct and tape the interviews.

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