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Barred from Transition: The Gatekeeping of Gender-Affirming Care during the Gender Clinic Era

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Transgender medicine has made great strides in the past century. Biomedical advances in the fields of reconstructive surgery, endocrinology, and pharmacology have expanded the possibilities for gender-affirming care, including surgeries and hormone replacement therapy. Given these impressive medical and technical advancements, it is crucial to analyze the ways in which gender-affirming care has been gatekept. Gatekeeping refers to the practice of limiting health resources and services for certain populations. Transgender individuals have historically and presently experienced gatekeeping of gender-affirming and transition-related services by medical professionals, academic institutions, and insurance providers. In this paper, I draw from archival and scholarly materials to analyze the extent to which transgender individuals experienced care refusals during the 1960's and 70's at university-based gender clinics in the United States. I argue that the gatekeeping of care was historically motivated by medical providers' and gender clinics' desire to produce productive, heteronormative citizens and that gatekeeping allowed medical providers to shape and alter transgender people's medical narratives. Ultimately, this analysis locates current biomedical advances in transgender health and medicine in the context of a long history of care refusals, gatekeeping, and acts of resistance in which transgender people attempted to reclaim their narratives. I aim to illuminate the ways in which medical care was gatekept during the gender clinic era of the 1960's and 70's in the United States and argue that these practices shaped the kinds of medical narratives that transgender people tell in order to receive care.

Introduction

Before he passed away from AIDS-related complications in 1991, well-known trans activist and writer Lou Sullivan stated that he took a certain pleasure in informing the gender clinics that told him "it was impossible [for him] to live as a gay man [that]…it looks like I'm going to die like one" (Pauly, 1988, 27:01). Coming of age as a transgender man in the 1970's, Lou Sullivan sought to medically transition from female to male and faced medical interrogation and gatekeeping at Stanford's gender clinic. Stanford University initiated their Gender Dysphoria Program in 1968 to provide transition-related health care to transgender patients (Stanford University, 1968-1980). When Lou decided to pursue hormone replacement therapy (HRT), a friend advised him against seeking care at Stanford's clinic, warning him that "they wouldn't touch you with a 10-foot pole" (Sullivan, 2019, p. 211). Lou worried, correctly, that doctors would refuse him care because "I don't have the typical transsexual story they want to hear" (Sullivan, 2019, p. 211). These perspectives reflect the extent to which gender clinics in the late 20th century limited access to gender-affirming care for trans people who did not fit a heteronormative, cisgender understanding of transness and the extent to which they produced medical mistrust in their transgender patients.

Medical narratives can be empowering; they allow patients to make sense of the pain or trauma they have experienced and to take agency over their lives. In Lou's case, however, as in the case of many other transgender people, narratives were shaped by doctors who had the power to withhold or grant access to gender-affirming care. The paternalistic model of care adopted by gender clinics in the late 20th century forced trans individuals to manipulate their narratives, to withhold information, and to tell doctors exactly what they wanted to hear in order to receive care. The first time Sullivan applied to Stanford's clinic, he disclosed the fact that he identified as a homosexual man and noticed that his doctor "seemed very suspicious of me and somehow irritated" (Sullivan, 2019, p. 212). Following this medical encounter, Sullivan was unable to get a prescription for HRT. The next time Sullivan attempted to access care, he decided to change his narrative to satisfy the doctors' heteronormative expectations: "I'm making an addition to my story; instead of saying I'm not interested in girls, I'm gonna say that…girls are looking a lot better to me" (Sullivan, 2019, p. 218). By altering his narrative and appealing to the cisgender doctors' ideals of heteronormativity, Sullivan was ultimately able to transition, to live his life as a gay man, and, tragically, "to die like one." Lou's story raises questions about who does and does not get to tell an authentic narrative and to access life-saving medical care.

In this paper, I discuss the problem of medical gatekeeping and care refusals experienced by transgender individuals in the United States in the late 20th century and their impacts on trans medical narratives. To do so, I analyze the mechanisms and motives for gatekeeping of transition-related care at gender clinics using archival material from The Johns Hopkins

University Gender Identity Clinic which operated from 1966 to 1979 in Baltimore, Maryland, and the Stanford Gender Dysphoria Program, which was initiated two years later, in 1968 at Stanford University in California. Ultimately, I will argue that the power to gatekeep transition-related care was driven by heteronormative ideals and went hand-in-hand with the ability to define and shape transgender people's narratives.

Gatekeeping Practices at Gender Clinics

The practice of rigorously gatekeeping and refusing access to gender-affirming care has its origins in the 1960's and 70's gender clinic era and was perfected by doctors who wanted to increase their medical authority. The Johns Hopkins Gender Identity Clinic, which publicly opened its doors to patients in November of 1966, became a model for other university-based gender clinics (Siotos et al., 2019). The Johns Hopkins Gender Identity Clinic was initially intended to be an experimental investigation into the effects of transition-related surgery. The decision to begin offering transition-related surgery "was approved very quietly and only on an experimental basis" (Bowden, n.d., para. 26). The clinic was funded by the Erickson Educational Foundation, an organization which aimed "to support radical and controversial research efforts, particularly in the areas of psychology and transsexualism" ("What makes," 1976, Content with Life section, para. 7). As the Johns Hopkins Gender Identity Clinic's "sole source of research support," ("Statement," 1966, p. 2), the Erickson Educational Foundation likely motivated the experimental nature of the clinic. According to Dr. John E. Hoopes, who helped to establish the clinic, "this program, including the surgery, is investigational" ("Statement," 1966, p. 3). For Dr. Hoopes, the most important result of the clinic was not the ability to provide life-changing medical care to an underserved community, but rather the opportunity "to determine precisely what constitutes a transsexual and what makes him remain that way" ("Statement," 1966, p. 3). Physicians were motivated by a lack of available medical care and knowledge about the effects of surgery (Siotos et al., 2019) and sought to collect "accurate observations on the results of [transition-related] treatment" ("Statement," 1966, p. 3). Because transgender people had "never previously been given adequate medical attention" ("Statement," 1966, p. 3), they posed a new scientific frontier for doctors to probe and experiment on through the gender clinic. Trans studies scholar Gill-Peterson (2018) notes that doctors "were perfectly willing to diagnose, evaluate, and study trans patients in detail for the benefit of their own research before brusquely rejecting their actual requests" (p. 135). Rather than seeking to provide a stable and long-lasting source of transition-related medical care, gender clinics were founded as centers where cisgender doctors could advance their careers and medical knowledge through scientific experimentation on transgender patients.

Due to the clinic's experimental nature, access to transition-related surgery could be given and taken away at will. In order to limit access to transition-related care, gender clinics employed a number of gatekeeping measures. The Johns Hopkins and Stanford clinics, for example, created immense administrative burden for their applicants and patients. At Johns Hopkins, a four-step process was used "for screening, evaluating, treating, and following the patients" ("Statement," 1966, p. 4). Screening involved an application form which featured six pages of questions about personal history, mental health, marriage, and financial status. Applicants received invasive and probing questions such as one which asked them to describe their genitals: "prior to hormone treatment, were you sex organs normal in size, shape, and function…if "no," please list any abnormalities or suspected abnormalities" ("Application," n.d., p. 5). In her book on the history of transsexuality, Meyerowitz (2004) described how applicants were subjected to hours of testing, only to be told that the clinic was not accepting new patients. Similar administrative burdens were put in place at other institutions as well. For example, when Lou Sullivan re-applied to Stanford's gender clinic following his initial rejection, he found that "it's the same 15-page extravaganza I filled out 3 years ago. HELP!" (Sullivan, 2020, p. 281). The application to the Stanford clinic featured an extended list of open-ended questions asking patients to, for example, write a one-page autobiography; discuss topics such as their family upbringing, academic, and social life; and to reveal their sexual history and preferences (Stanford University, 1968-1980).

Further evidence for the administrative burden produced by this model of care can be found in the evaluation process following the initial application. At Johns Hopkins, applicants were "thoroughly interviewed, tested, and evaluated by a psychiatrist, a psychologist, and the surgeons" ("Statement," 1966, p. 4). This process consisted of a week-long evaluation that Siotos et al. (2019) uncritically describe as a "comprehensive assessment" (p. 133), but which might better be described as excessive and invasive probing. During the evaluations, the patient's family members and parents were interviewed, the patients' IQ was tested, and they went through psychiatric, psychological, physical, and genetic evaluation (Siotos et al., 2019). In their article about "sex changes," the U.S. *National Observer* (1976) described this screening process as "meticulous…designed to exclude applicants who are primarily homosexual, transvestic, or psychotic" (Content with Life section, para. 28). This indicates that the evaluation process was meant to exclude patients who failed to meet cis-heteronormative, neurotypical standards. Johns Hopkins' procedure for screening and evaluating patients was "copied, refined, and adapted by at least 40 more gender-identity centers" by 1976 ("What makes," 1976, Content with Life section, para. 28), suggesting that the practice of gatekeeping care was widespread throughout university-based gender clinics. Due to the strict selection criteria, very few patients received surgery at the Johns Hopkins gender clinic. The clinic received about 100 applications per year, and of these, only 5 or 6 underwent transition-related procedures ("Sex change operations," n.d.). By 1972, Johns Hopkins had received 1200 applications to the gender clinic, but only 23 patients had undergone primary gender-affirming surgery (Siotos et al., 2019). After a patient received gender-affirming hormones and surgery, physicians intended to follow them "for an indefinite period of time, probably for the rest of [their] life" ("Statement," 1966, p. 4). Access to medical treatment was therefore reserved for patients who fit the institution's heteronormative standards and agreed to subject themselves to medical scrutiny, interrogation, and life-long surveillance.

The experimental nature of the gender clinics contributed to their eventual closure. In 1979, a controversial study led by Dr. Jon K. Meyer, the former director of the still-operational Sexual Behaviors Consultation Unit at Johns Hopkins, claimed to find "objective evidence that there is no real difference in the transsexual's adjustment to life in terms of jobs, educational attainment, marital adjustment and social stability" (Johns Hopkins University, 1979, p. 1) following surgical intervention. Dr. Meyer faced criticism for shortcomings in his study design, and several other studies opposed his findings ("Sex-change surgery," 1980). Despite criticism, Dr. Meyer's widely publicized results led the Johns Hopkins Gender Identity Clinic to close its doors in 1979, and other academic institutions followed suit (Siotos et al., 2019). In an interview, Dr. Paul Walker, former director of the Texas gender clinic in Galveston, explained that transition-related surgeries were now primarily being done outside of major academic institutions ("Transsex-surgery," 1979). As institution-based gender clinics closed their doors, privately run clinics took their place (Stryker, 2017). The goal of the Johns Hopkins Gender Identity Clinic had never been to provide a stable and widely accessible source of transition-related care, but rather to invite a select group of patients to be studied, surveilled, and monitored for the sake of scientific advancement: "in the larger [academic] centers, the goal is research, and it's up to the rest of the world to provide facilities to use what they find" ("Transsex-surgery," 1979, p. 2). As soon as "clinical experience and research failed to support sex-reassignment surgery, the program was brought to an end" (Bowden, n.d.). The speed with which negative scientific results brought an end to the provision of transition-related care at university-based clinics demonstrates the power that these institutions had to restrict access to care.

The Impact of Gatekeeping on Medical Narratives

Physicians' ability to control patients' access to transition-related care was intimately tied to their control over transgender narratives. To justify medical intervention and establish authority over transgender people, physicians created a medicalized narrative of transness. The medicalization of transness refers to the process by which non-normative gender identities became categorized as a medical problem (Hsieh & Shuster, 2021). In 1966, the Johns Hopkins gender identity clinic released a press statement in which they claimed that "the high incidence of suicide and self-mutilation among these people testifies to the magnitude of the problem" ("Statement," 1966, p. 4). As Stryker (2017) argues, physicians' desire to help and their "willingness to intervene has gone hand in hand with their power to define and judge" (p. 51). Presenting transness as a "problem" allowed medical practitioners to use their "social power to determine what is considered sick or healthy, normal or pathological, sane or insane" to transform what was a "neutral form…of human difference into unjust and oppressive social hierarchies" (Stryker, 2017, p. 52). Because "sickness" legitimizes medical intervention, access to medical treatment "depended on constructing transgender phenomena as symptoms of a mental illness or physical malady" (Stryker, 2017, pp. 52-53). In summary, the pathologization of transgender identities allowed providers to extend medical authority over gender non-confirming patients (Davis et al., 2016). Repeated reference to "the *problem* of the transsexual [emphasis added]" and to transgender patients as "extremely unfortunate individuals" ("Statement," 1966, p. 3) illustrates the medicalized view of transness held by the gender clinics' doctors. Dr. John E. Hoopes "arrived at the unavoidable conclusion that these people need and deserve help" ("Statement," 1966, p. 2). Additionally, John Money, one of the primary doctors at the Johns Hopkins clinic, found gender ambiguity to be pathological (Fausto-Sterling, 2000). The clinic's approach therefore relied on a "model of medical patriarchal benevolence" (Malatino, 2020, p. 62) in which the benevolent desire to help a suffering population also presented an opportunity to extend medical power and control over that population. By medicalizing and pathologizing transness, physicians at Johns Hopkins gained the authority to control trans people's narratives and the power to gatekeep their care.

Physicians' medical authority over the "problem of the transsexual" gave them a large degree of control over trans patients' narratives. In their 1966 press statement, physicians at the Johns Hopkins gender clinic claimed that the "most important result" of their work was the opportunity "to determine precisely what constitutes a transsexual and what makes him remain that way" ("Statement," 1966, p. 3). To answer this question, Dr. Hoopes spoke for his patients, claiming that transgender people "feel that nature has somehow gone awry, almost as if their mind is in the wrong body" ("Statement," 1966, p. 2). Trans people, however, often attempted to refuse this narrative. Lou Sullivan, for example, stated that "I don't feel like "a man trapped in a woman's body" (Sullivan, 2019, p. 217). Sullivan's friend corroborated this observation and noted that "nobody does, that's just a catchy phrase coined by the medical profession" (Sullivan, 2019, p. 217). Trans activist Jamison Green, who, like Sullivan, pursued care through the Stanford Gender Dysphoria Program, also refuted the "wrong body" narrative, stating that he "never really felt like [he] was born into the wrong body" (Levy, 2000, para. 5). By positioning themselves as the authorities on transness, physicians gained social power and created false narratives to maintain their authority over "the problem of the transsexual."

Maintaining medical authority and control over trans individuals was productive for physicians; it allowed them to uphold heteronormative ideals and impose normative narratives on their transgender patients. The "standard, hegemonic medical advice given to trans folks in the 1970s…was to go stealth, blend in, and live as normatively as possible" (Malatino, 2020, p. 23). This sentiment is revealed in a letter from Paul McHugh, the former Director and Psychiatrist-in-Chief at Johns Hopkins, to one of his colleagues. In the letter, Dr. McHugh feigned disbelief at Dr. Beyer's claim that gay transgender people existed, writing: "surely you are teasing me when you say that you know of males who, following SRS [sex-reassignment surgery], have a lesbian sexual orientation…Surely you jest" (McHugh, 1994, para. 2). Dr. McHugh's refusal to believe that lesbian trans women existed reflects the heteronormative values held by many physicians during this time. It was this same refusal to believe that gay trans people existed that resulted in Lou Sullivan's initial rejection from Stanford's gender clinic and his subsequent decision to falsely claim that "since I've really decided to do this change, girls are looking a lot better to me" (Sullivan, 2020, p. 218). Physicians granted medical care to patients whom they believed would be able to enter heterosexual marriages, raise families, and conform to binary gender norms. For transgender women, the Stanford Gender Dysphoria Program was a place "where one goes if one is very small, very willowy, very blonde, likes to wear high heels and heavy makeup…[patients] must blend in the population. We hope you get married." (Levy, 2000, Sandy Stone section, para. 7). According to Meyerowitz (2004), some doctors required their patients to undergo training to help them conform to conventional gender roles and stereotypes, and patients were generally expected to live as heterosexuals and, "better yet, to marry after surgery" (p. 224). Patients who did not fulfill heteronormative standards were rejected from the clinic (Meyerowitz, 2004).

Patients were aware of providers' heteronormative standards and changed their narratives to fit their doctors' criteria. Gill-Peterson (2018) noted that many transgender individuals who sought transition-related interventions took care to emphasize that they were not homosexual. According to Meyerowitz (2004), transgender "patients coached one another on what they needed to say and do to qualify for operations" (p. 226), demonstrating the way in which the trans community created and shared convincing medical narratives. In a letter to Stanford's Gender Dysphoria Program coordinator, Sullivan (1980) wrote that he knew he "had an 80% chance of being rejected [from the clinic]…because of [his] interest in men as sexual partners" (p. 1). He "had even considered lying" to the clinic about his sexual preferences, but "felt it important to be straightforward, possibly paving the way" for other non-heteronormative transgender applicants (Sullivan, 1980, p. 1). However, even Sullivan, who staunchly refused to conform to heteronormative norms, eventually decided to lie about his sexual identity in order to receive care. Ultimately, patients knew that an "investment in [cisgender] medical narratives would be returned with [the provision of medical] help" (Gill-Peterson, 2018, p. 153).

In addition to the creation of heteronormative ideals, physicians placed parameters around what a successful transition narrative looked like. To measure the success of medical intervention, physicians at Johns Hopkins used patients' "total adjustment and contribution to society…[as] major yardsticks of the value of treatment" ("Statement," 1966, p. 5). Success or failure were determined by whether "these people [were] happier and *more useful citizens* following surgery and other therapy than they were before [emphasis added]" ("Statement," 1966, p. 5). Specifically, "adjustment to life" was measured "in terms of jobs, educational attainment, marital adjustment and social stability" (Johns Hopkins University, 1979, p. 1). Similarly, the patients in Dr. Meyer's controversial study were evaluated for "success in four areas – legal (arrest record), economic (job level), cohabitation (by sex of partner), and psychiatric (contact with psychiatrist, outpatient treatment, or hospitalization)" ("Transsex-surgery," 1979, para. 5). Overall health, well-being, and satisfaction of the patients did not seem to be considered. Instead, physicians primarily defined success in terms of the production of useful, economically valuable, and heteronormative citizens. Although Meyer recognized that transition-related surgery was "subjectively satisfying" (Johns Hopkins University, 1979, p. 2) to those patients who received it, this finding did not convince him of the surgery's value. By measuring success in terms of overall adjustment to life in economic, professional, educational, legal, and social terms, rather than in terms of patient satisfaction and well-being, doctors linked success with a transgender person's ability to fit in, to be productive, and to "live as normatively as possible" (Malatino, 2020, p. 23).

Ultimately, as Edmiston (2019) argues, the history of the gender clinics is complicated. Although university-based gender clinics used gatekeeping tactics to exclude patients who were gay, mentally ill, gender non-conforming, or otherwise marginalized, patients who did manage to receive surgery were typically satisfied with the results. Transgender patients were grateful for the opportunity to access care; "they were desperate, and thankful to anyone who would help them" (Bowden, n.d., para. 25). Edmiston (2019) suggests that a nuanced analysis of the Johns Hopkins Gender Identity Clinic's legacy should "acknowledge a complicated mix of harm and benefit to the transgender community" (p. 371). While gender clinics such as those at Johns Hopkins and Stanford fulfilled a desperate need for transition-related care, this care was provided in a way that privileged cisgender knowledge, enforced cis and heteronormative ideals, and compelled transgender people to manipulate their narratives. A nuanced analysis of the history of the 1960's and

1970’s gender clinic era in the United States should take into account the ways in which advances in medical care and surgical options for transgender people went hand-in-hand with the production of medicalized and pathologized understandings of transness.

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