Gender-Affirming Surgery for Transgender Individuals: Perceived Satisfaction and Barriers to Care

La chirurgie de réassignation de genre pour les personnes transgenres : la perception de satisfaction et d'obstacles aux soins

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Abstract

Purpose: The purpose of this study was to examine the perceived satisfaction and barriers to care for transgender patients after they decide to undergo gender-affirming surgery (GAS). **Method:** A survey consisting of 21 multiple-choice and short-answer questions was distributed to transgender organizations and online forums across Canada and the United States. The data were then analyzed using descriptive statistics. **Results:** There were 32 participants, 12 who identified as female to male and 20 as male to female. The mean age was 36 years, with a range of 18 to 81 years. The mean age of their first GAS was 33 years, and the range of wait time was 6 months to 7 years. Most of the participants received information about GAS from transgender websites and transgender surgery clinics (91% and 50%, respectively). Most participants (74%) felt like they had access to appropriate care and 89% felt like their surgeons provided enough information about GAS. There were 38% of participants who would change their experience with GAS. Participants stated several barriers toward receiving GAS: financial (73%), finding a physician (65%), and access to information (63%). Surgical transition was important to the quality of life for 91% of participants and 100% were happy with their decision to undergo GAS. **Conclusions:** Transgender participants demonstrated that GAS is important to their quality of life and this study showed significant barriers to GAS.

Résumé

Objectif : La présente étude visait à examiner la perception de satisfaction et d'obstacles aux soins de la part des patients transgenres après qu'ils ont décidé de subir une opération de réassignation de genre (ORG). **Méthodologie :** Les chercheurs ont distribué un sondage composé de 21 questions à choix multiple et à réponse courte aux organisations transgenres et aux forums en ligne du Canada et des États-Unis. Ils ont ensuite analysé les données à l'aide de statistiques descriptives. **Résultats :** Au total, 32 personnes ont participé au sondage. Douze se sont identifiés comme hommes trans et 20, comme femmes trans. Ils avaient un âge moyen de 36 ans (plage de 18 à 81 ans). Ils avaient un âge moyen de 33 ans lors de leur première ORG et avaient dû attendre de six mois à sept ans pour la subir. La plupart des participants avaient reçu de l'information au sujet de l'ORG dans des sites pour les personnes transgenres et des cliniques chirurgicales de réassignation de genre (91 % et 50 %, respectivement). La plupart des participants (74 %) trouvaient qu'ils avaient eu accès à des soins appropriés et 89 % trouvaient que leur chirurgien leur avait fourni assez d'information sur l'ORG. Cependant, 38 % des participants auraient modifié leur expérience de l'ORG. Les participants ont souligné plusieurs obstacles à l'ORG : la question financière (73 %), la quête d'un médecin (65 %) et l'accès à l'information (63 %). La transition chirurgicale était importante pour la qualité de vie de 91 % des participants et ils étaient tous heureux d'avoir subi une ORG. **Conclusions :** Les participants transgenres ont démontré que l'ORG est importante pour leur qualité de vie, et la présente étude a établi qu'ils devaient affronter des obstacles substantiels pour y accéder.

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Introduction

Gender dysphoria refers to a desire to be treated and identified as a gender that is contrary to one's gender at birth and can result in significant distress and/or impairment.¹ These individuals, collectively referred to as the transgender community, have historically been marginalized and have been the subjects of discrimination.² In recent years, however, the transgender population is becoming more vocal, more visible, more accepted, and less stigmatized.² They are also seeking pharmacological and surgical transition at earlier ages and in higher numbers.³

Despite this progressive movement, transgender patients (TGPs) continue to encounter many barriers in their efforts to access treatment.⁴⁻⁷ The process of transition for many TGPs is often a long and arduous one with many obstacles to overcome.⁶

The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary professional association that publishes standards of care for transgender and gender nonconforming persons. Its goal is "to provide clinical guidance for health professionals to assist transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well being, and self-fulfillment".⁸ The WPATH outlines consensus-based general criteria for gender-affirming surgery (GAS)⁸ which are as follows:

- 1) Persistent, well-documented gender dysphoria;
- 2) Capacity to make a fully informed decision and to consent for treatment;
- 3) Age of majority in a given country;
- 4) If significant medical or mental health concerns are present, they must be reasonably well controlled.

In addition, WPATH outlines specific criteria for specific surgical procedures in patients who meet the general criteria. For example, specific criteria for hysterectomy and salpingo-oophorectomy in female to male (FtM) patients and for orchidectomy in male to female (MtF) patients include "12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual)".⁸ Specific criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients include all of the above as well as "12 continuous months of living in a gender role that is congruent with their gender identity," also referred to as "real-life experience."⁸ Appropriate implementation of the WPATH standards of care requires proper assessment and written documentation by qualified mental health professional. In addition, all members of the patient's health-care delivery team must be united in decision and share responsibility for making irreversible changes. This

qualitative study examines perceived satisfaction and perceived barriers to care in a group of TGPs who have undergone GAS or are considering GAS.

Methods

Between November 2015 and January 2016, a 21-question survey was distributed to transgender organizations across Canada and the United States and was posted online through transgender forums. In total, 25 transgender organizations were contacted, and they were divided into 10 Canadian organizations, 10 American organizations, and 5 American and Canadian organizations. Transgender individuals were invited to participate if they were MtF, FtM, or other trans-identifying adults. Survey respondents were required to be over the age of 18, American or Canadian citizens, and to be considering, or have undergone, GAS in their transition. The survey was distributed using an online secure platform, and data were collected in a confidential and anonymous manner. Each respondent received a standard recruitment message that included implied consent by completing the survey. The University of Calgary ethics review board provided approval for this project (Ethics ID: REB15-2219).

The survey consisted of multiple-choice and short-answer questions pertaining to demographic information, treatment to date, barriers to care, impact of treatment on quality of life, and satisfaction with treatment. The domains that were identified were based off an extensive literature review of the barriers to health care that the transgender population faced. The data were read and analyzed by the primary investigator (H.E.-H.). Quantitative statistics were performed to determine the demographics of the respondents. Qualitative statistics were also performed to assess the ordinal variables of attitudes (strongly agree, agree, disagree, strongly disagree, and not applicable).

Results

Demographics

Thirty-two self-identified transgender adults completed the survey. Seventeen were American (53%) and 15 were Canadian (47%). Twelve identified as FtM (37.5%) and 20 as MtF (62.5%). The mean age of the respondents was 33 years, with a range of 18 to 81 years.

Treatments Received

Fifty-nine percent of respondents had previously undergone some form of GAS. The mean age of their first GAS was 33 ± 7.3 years, and the range of wait time was 6 months to 7 years. The mean time between deciding to include surgery in

Figure 1. Female to male procedures.

Figure 2. Male to female procedures.

the treatment of their gender dysphoria to ultimately having surgery was 2.8 ± 0.9 years and a range 0.5 to 7 years.

The medical and surgical treatment received by FtM respondents included various combinations of none, hormonal therapy, mastectomy or breast reducing/contouring, hysterectomy and bilateral salpingo-oophorectomy, and genital reconstructive procedures (Figure 1). The medical and surgical treatment received by MtF respondents included various combinations of none, hormonal therapy, facial feminizing surgery, top surgery such as breast augmentation, and lastly genital reconstructive procedures (Figure 2). Within the FtM group, 41.7% had bottom surgery which included any of the following: metoidioplasty, urethroplasty, vaginectomy, scrotoplasty, phalloplasty, hysterectomy, and bilateral salpingo-oophorectomy. Within the MtF, 40% had bottom surgery which included orchiectomy, penectomy, labiaplasty, clitoroplasty, and vaginoplasty.

Information Access

Transgender websites were a main source of information for 94% of the respondents, and surgery clinics in 50% (Table 1).

Table 1. Sources of Information About GAS for Respondents.

	FTM		MTF		Total	
	Total (Out of 12)	%	Total (Out of 20)	%	Total (of 32)	%
Transgender website	12	100	18	20	30	94
Blogs	8	66	9	45	17	53
Transgender surgery clinic	8	66	8	40	16	50
Relative/friend/acquaintance	4	33	8	40	12	38
Mental health professional	2	17	8	40	10	31
Family doctor	3	25	2	10	5	16
Magazine	0	0	3	15	3	9

Abbreviations: FTM, female to male; GAS, gender-affirming surgery; MTF, male to female.

Ninety-four percent of respondents stated that public websites influenced their treatment decisions, with one stating that “the Internet made me realize I could do all the things I wanted to do.” Half of the respondents (50%) received information about GAS from transgender surgery clinics. Thirty-eight percent received information from relatives/friends/acquaintances. Thirty-one percent received information about GAS from a mental health professional and 16% received information from their family doctor. Magazines were not used frequently (9%) as a source of information for GAS. One respondent felt that there was a “lack of information about transgender struggles, options for transitioning, and how these procedures work for people who have not consulted a medical professional.” Another respondent felt that it would have been “helpful to have some sort of resource or way of comparing outcomes from different surgeons and how satisfied people [were] with different aspects of the results.”

Barriers to Care

Potential barriers listed on the survey included financial, access to information, support from family and friends, finding a physician, discrimination, uncertainty about their decision, family planning, and denial for care by a health-care worker (Figure 3). The majority of respondents agreed that finances (73%), finding a physician (65%), lack of support from family and friends (64%), and difficulty with access to information (63%) were barriers to GAS. On the other hand, very few respondents felt that denial by a health-care worker (16%), family planning (22%), uncertainty about their decision (23%), or discrimination (30%) were barriers to care. Respondents repeatedly mentioned finance as a barrier: “While other aspects of access to care could have been improved, affordability was, by far, the biggest barrier.”

Impact of Treatment on Quality of Life

Eighty-four percent of respondents agreed that their surgical transition was important to their quality of life. One respondent

Figure 3. Barriers to gender-affirming surgery.

stated that “before surgery, I had a lot of depression and dysphoria centered around that part of my body, and surgery alleviated this.” Another respondent stated that GAS had a profound impact on their psyche and that the “tiny persistent force alerting me to the ‘wrongness’ between my legs has disappeared, and I can finally go about my life and move on, like other people can.”

All respondents who had received GAS agreed that they were happy with their decision to undergo GAS. One respondent stated: “My body feels like mine,” and another stated that this was the “best thing I ever did for myself.” For one respondent, GAS was lifesaving: “After 3 attempts at suicide, I knew that life was no longer possible without transition.” A major aspect of gender dysphoria is the desire to be treated and identified as the expressed gender, as one respondent stated eloquently: “The surgery has given me what I should have been born with. I have always felt that the Y chromosome was a birth defect!”

Satisfaction

Most respondents were satisfied with their GAS experience, with comments such as it was “nice actually liking my body for once” and that they “have nothing but pleasant memories of the event, from start to finish.” Surgical transition was important to the quality of life for 91% of respondents and 100% were happy with their decision to undergo GAS. Thirty-two percent of respondents felt that they would change some aspect of their experience with GAS, in particular: timeliness of their surgeries ($n = 1$), finding a different surgeon ($n = 1$), having more of a local surgical support community ($n = 1$), insurance coverage ($n = 1$), improvement in the surgeries (lack of lubrication and depth of vagina; $n = 1$), and scar placement ($n = 1$).

There was no statistical difference between the FtM and MtF groups, nor was there a statistical difference between their satisfaction rates between medical and surgical treatments.

Discussion

Currently, there are many treatment options for gender dysphoria, including hormone treatment, real-life experience, counseling, psychotherapy, and GAS.⁹ The physical transition from one sex to another allows TGPs to resolve the distress and conflict they had, ultimately bringing patients closer to achieving personal wellness.⁹ Other studies have demonstrated an undeniable beneficial effect of GAS on postoperative outcomes such as subjective well-being, cosmesis, and sexual function.⁹⁻¹⁴ Gender-affirming surgery has been part of the treatment of gender dysphoria for more than 80 years and is now widely accepted as therapeutic.⁸ Respondent bias could explain the high level of satisfaction among survey respondents, and nonresponders may not be as happy, may have had a bad outcome, or may have had a failed procedure.

The transgender community has specific health information needs and concerns.¹⁵⁻¹⁷ Particular areas of need include information pertaining to types of treatment, health-care proxy, cancer, adolescent depression and suicide, adoption, sexual health and practices, HIV infection, surrogate parenting, mental health issues, transgender health issues, intimate partner violence, and intimate partner loss.¹⁸ Obtaining information from health specialists remains challenging for patients, in particular information regarding GAS options, procedures, and outcomes specific to their own situation.

Financial issues and confusion around funding of care represent another barrier to care for many patients. No province provides coverage for the full range of transition-related

services or procedures.¹⁹ Examples of procedures recommended by the Canadian Professional Association for Transgendered Health that provincial health plans currently do not cover include tracheal shaving, vocal cord tightening, hair removal, and facial feminization. These matters are further complicated by uncertainty among both providers and provincial payors about what is regarded as “medically necessary” and what is “cosmetic.”

Patients in many geographic locations face a limitation in the number of qualified mental health professionals who perform assessments required to proceed with surgery as well as limitation in the number of surgeons who perform GAS.²⁰ Transgender health care is not yet incorporated into the medical education curriculum, and therefore, most health-care professionals lack the requisite knowledge to provide accurate treatment and management for TGPs.²¹⁻²³ Despite the progress to advance transgender-specific health care, the transgender population continues to endure discrimination and underrepresentation.²⁴ Some patients therefore travel to other jurisdictions to receive consultation and treatment, requiring the patient to pay out of pocket in most cases. This results in a patient-perceived inertia in navigating the pathway toward GAS.²⁵

A final barrier for transition within the transgender community is lack of social support. There is stigma attached to not conforming to one's biological gender, which in turn leads to prejudice, discrimination, isolation, and possible ostracization.^{26,27} For these reasons, many transgender individuals are hesitant or are reluctant to disclose their gender identity due to the possibility of negative consequences.⁶ This in turn contributes to marginalization and poor health outcomes within this population.²⁷⁻³⁰ There is room for improvement in socio-structural interventions tailored to promote support among the transgender population.

Conclusion

This study demonstrates the high level of satisfaction and improved quality of life in transgender respondents undergoing GAS. This marginalized population reports persistent barriers spanning financial, social, and qualified provider issues that should be addressed.

Declaration of Conflicting Interests

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