Providers and Patients as Activists: Bureaucratic Encorpment in Two Midwest Gender-Affirming Health Clinics

by

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ABSTRACT

For transgender and gender-expansive people, medical transition is not a single event but a long and complex process involving constant exchanges between people, bureaucracy, and bodies. As patients pursue transition care, they must interact not only with healthcare staff but also with the minutiae of gender-normative healthcare bureaucracy as they move closer to achieving what they envision for their bodies. Further, every individual's bodily materiality possesses a unique biological history that shapes the body's progression through transition. Adopting a practice approach and drawing from new materialist perspectives recognizing bodily agency, I bring bodily materiality into view as a key participant in the situated interactions providers and patients have with gender-normative bureaucracy in two Midwest gender-affirming health clinics with different organizational cultures.

Through ethnographic observation of clinical appointments and routine bureaucratic practice, debriefing interviews with gender-expansive patients, and medical record analysis, this dissertation demonstrates how bodily materiality shapes gender-normative healthcare bureaucracy just as bureaucracy shapes patients' bodily materiality as patients pursue their transition plans. I call this co-embodiment of bureaucracy and the body *bureaucratic encorpment*. Recognizing the body as an equal participant in the interactions providers and patients have with healthcare bureaucracy will refine efforts to target healthcare resources to these communities.

PUBLIC ABSTRACT

For transgender and gender-expansive people, medical transition is not a single event but a long and complex process involving constant exchanges between people, bureaucracy, and bodies. As patients pursue transition care, they must interact not only with healthcare staff but also with the intricacies of gender-normative healthcare bureaucracy as they move closer to achieving what they envision for their bodies. Further, every individual's body possesses a unique biological history that shapes the body's progression through transition. By understanding providers and patients as responsible for bringing bureaucracy into being, I bring the body into view as a key participant in the interactions providers and patients have with gender-normative bureaucracy in two Midwest gender-affirming health clinics with different organizational cultures.

Through ethnographic observation of clinical appointments and routine bureaucratic practice, debriefing interviews with gender-expansive patients, and medical record analysis, this dissertation demonstrates how bodies shape gender-normative healthcare bureaucracy just as bureaucracy shapes patients' bodies as patients pursue their transition plans. I call this co-embodiment of bureaucracy and the body *bureaucratic encorpment*. Recognizing the body as an equally active participant in the interactions providers and patients have with healthcare bureaucracy will refine efforts to target healthcare resources to these communities.

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CHAPTER 1: INTRODUCTION AND METHODOLOGY

Introduction

It is a quiet spring day at small community Glendale clinic. I sit on a tiny upholstered stool as I listen to Molly, a healthcare practitioner trained to provide gender-affirming healthcare, talk about the difficulty of representing transgender (trans) and gender-expansive clients in the clinic's electronic medical records. She frequently relegates details about clients' transitions in electronic records to a miscellaneous note section because there are no existing fields that capture transition-related changes like hormone therapy and orchiectomies. Molly considers electronic records a pain. "People are paying for my undivided attention, and you're missing that face time," she says to me. Soon, it is time for the second appointment of the day with client Damien, who has traveled from out of town to the clinic to check his testosterone levels and have a pap smear done. He tells the check-in staff he has been experiencing cramps recently. During the pap smear, he and Molly talk at length about his kids and the godsend existence of yard sales for letting unused things go. Afterwards, Molly tells Damien that one of his laboratory values is high and she will have to lower his testosterone level slightly. "Ugh, the computer won't let me in," Molly grumbles as she tries to input a note about the dose change into Damien's record. "Yeah, I prefer paperwork, too," Damien says. "Yeah—paperwork doesn't stop working on ya!" Molly replies as she fiddles with the record. She turns back to Damien. "I don't know what to tell you about the cramps," she says. "But you're not the only one." Damien nods and says he has researched it on the Internet and read that other guys have them too. "I found nothing," he says. "I've also seen nothing [online]," Molly says. "That's a good thing."

Later during a phone interview, I ask Damien if there was anything that could have been improved about his appointment. He replies that he goes to this clinic precisely because he has always felt comfortable here. “I don’t feel rushed… I like how it’s laid back there. I feel like I can just say whatever I want to without thinking about it and I’m not gonna feel judged.” A stark contrast to going to the clinic in his hometown, he says, where he would be embarrassed to ask questions. He pauses. “And probably wouldn’t even go.” His daughter suddenly coos loudly in the background and we both laugh. I ask, “What’s an example of how the environment is laid back, like you said?” Damien doesn’t hesitate in his answer. “Mainly in the very beginning when I started transitioning, I obviously didn’t pass as male because I hadn’t started hormone therapy or had surgeries. But right from the beginning, even walking in and looking female but transitioning to male they instantly respected my pronouns and they’ve never slipped up or made me feel like I wasn’t a male. Do you know what I mean? They never made me feel like I was anything but a man.”

Simply by attending medical appointments, transgender and gender-expansive patients challenge medical assumptions about the relationship between gender and biological sex. Damien’s experience moving through this community gender-affirming health clinic reveals the many factors that culminate in a satisfactory medical appointment. Damien’s appointment showcases that satisfactory transition care does not only require biomedical knowledge about bodies in transition, but also the maintenance of a bureaucratic clinic space wherein patients are incorporated into standardized medical technology, receive honest guidance about transition-related care, are regarded appropriately during historically gendered medical procedures, and do not feel rushed or judged for asking questions about their care.

We are in a sociopolitical moment where biomedicine understands gender and sex as two distinct experiences of gender linked to two distinct biological sexes (Fausto-Sterling 2000). This dominant gender-sex model is incorporated into bureaucratic systems at the multiple levels mentioned above and directly impacts the healthcare of people who do not align with it. Transgender and gender-expansive people in the U.S. experience profound discrimination in multiple areas of social life. The largest national survey of transgender communities conducted in the United States to date concluded that one-third of respondents experienced at least one negative experience related to being transgender in healthcare settings, such as harassment or treatment refusal. One-fifth reported having to educate providers about their own healthcare (James et al. 2016).

Medical transition is not a single event, but a long and intricate process involving constant exchanges between bureaucracy, people, and bodies. People moving through transition necessarily interact with the minutiae of healthcare bureaucracy and with healthcare staff as they move closer to achieving what they envision for bodies. Every individual's bodily materiality possesses a unique biological history that shapes that body's progression through transition (Coleman et al. 2011; Davis 2014). Thus, bodily materiality is central to understanding the myriad avenues allowing providers and gender-expansive patients to successfully navigate gender-normative clinical bureaucracy.

Rejecting a Cartesian and reductionist view of the body as a bounded and individual entity, I consider bodily materiality to comprise not only physical fleshy matter but the totality of engagements this physical matter can have with the world. The body makes the world as the world makes the body (Davis 2014; Farquhar and Lock 2007, 10). The concept of *bureaucratic encorpment* that I introduce in this dissertation illuminates how bodily materiality shapes gender-normative healthcare bureaucracy just as gender-normative bureaucracy shapes patients' bodily materiality as patients pursue their transition plans. Bureaucratic encorpment, comprised of the combination of words "envelop," "incorporate," and "corporeal," realizes the notion that,

> "The body proper, that discrete, structured, individual myth of a European modernity—begins to disappear, to be replaced by an indeterminate site of natural-cultural processes that is full of possibilities and impossible to finally delimit. Not only is the body not singular, it is not very proper, either" (Farquhar and Lock 2007, 10).

This dissertation traces how healthcare staff and patients' interactions with each other and with gender-normative healthcare bureaucracy shape and are shaped by patients' bodily materiality. Patients' bodily materiality participates in providers' and patients' engagements with gender-normative healthcare bureaucracy. I argue that healthcare bureaucracy shapes patients' abilities to embody gender at the same time gender-normative bureaucratic healthcare practice incorporates—embodies—patients' non-normative gendered embodiments. Beyond the ability to access transition care, the future of optimal transition care depends on responsive bureaucratic health practice that continuously adapts to serve the reality of a heterogeneous patient population. By bringing the body into view as a key participant in bureaucratic practice, each chapter in this dissertation maps out bureaucratic encorpment, the process by which bodily materiality and bureaucracy embody each other, as it occurs in four domains of clinic life. Throughout this work I demonstrate how both bodies and bureaucracy are materialized in practice through their mutual relationship. Outlining this relationship is key to effectively targeting healthcare resources within the context of transition care and beyond.

Providers and patients must successfully challenge many cultural and politico-economic features of healthcare bureaucracy that could otherwise leave patients’ healthcare needs unmet. Addressing a recent call in anthropological theory to turn away from the theoretical impetus of emphasizing people's marginalization and towards identifying how loci of resistance relate to structures that produce inequality (Ortner 2016), I undertook this dissertation research to identify specific cultural and structural factors enabling activist bureaucrats—healthcare providers—and clients—trans and gender-expansive patients—to challenge systems of exclusion.

I conducted fieldwork in two U.S. Midwest clinics specialized to provide gender-affirming healthcare with different organizational cultures: highly bureaucratized outpatient Woodfield clinic and feminist community clinic Glendale. Staff and patients at both clinics constantly interacted with multiple levels of healthcare bureaucracy. These levels included that of federal and state law, of insurance infrastructures accountable to these laws and to corporations, and of individual clinics’ bureaucracies. The U.S. healthcare landscape has experienced sweeping restructuring in the past three decades, including increasing financialization. Coupled with market deregulation, profits have shifted from an emphasis on real assets to managerial practices that prioritize financial assets and activities like investor profits and administrative costs. These new activities necessitate large bureaucracies to manage them (Mulligan 2016). Providers and patients at both Glendale and Woodfield clinics were accountable to consequences of financialization such as auditing as they interacted with layers of healthcare bureaucracy.

In order to understand how providers, patients, and bodies interact with individual aspects of healthcare bureaucracy to achieve satisfactory appointments, it is important to understand how bureaucratic categories are created and maintained. Bureaucratic categories such as those related to race, gender, and citizenship seem natural but embody cultural assumptions. The United States census, for example, contains race categories reflecting the assumption that ethnic groups are biologically distinct. Activists constantly challenge the naturalization of categories that marginalize them, such as when people identifying as biracial successfully advocated for representation in the US census (Epstein 2004; Shilt and Bratter 2015). However, bureaucratic systems are widespread, and challenging naturalized bureaucratic categories is extremely difficult because it requires institutional and cultural resources (Spade 2011). Consider how Molly was forced to relegate gender-related information about Damien to a nondescript note section in his medical record. In the United States, financial restructuring of the healthcare sector to managed care has led to increased bureaucratization and novel techniques to manage new administrative and profit-driven demands of clinical care, creating an array of bureaucratic gatekeeping requirements (Mulligan 2015).

The process of successfully challenging bureaucratic systems is presently poorly understood. Current theory in the anthropology of bureaucracy emphasizes how bureaucrats' implementations of bureaucratic policy serve to naturalize aspects of personhood such as citizenship, race, and gender to the exclusion of people who fall outside these norms (Tuckett 2015; Gupta 2012; van Eijk 2017). This dissertation examines how healthcare staff and patients challenge the naturalization of gender-normative assumptions in practice across healthcare bureaucracy.

In this dissertation, I propose the concept *bureaucratic encorpment* to capture the process by which bureaucratic practice and bodily materiality come to embody each other. Transgender and gender-expansive patients' embodiments of gender are shaped through patients' and providers' embodied interactions with healthcare bureaucracy. In turn, bureaucratic practice is transformed as patients' bodily materiality becomes visible in bureaucratic routines and documents. Bureaucratic encorpment recognizes that bodily materiality is a key site of social practice through which clinical bureaucracy is maintained.

I stress that social scientists' understandings of "street-level bureaucracy" (Lipsky 2010) is an appropriate perspective for understanding how healthcare staff in two gender-affirming healthcare clinics in Iowa with different levels of bureaucratization and financial and cultural resources bring clinical bureaucracy into being through bureaucratic practices like interacting with clinic software and moving through clinic space. Anthropological work on bodily materiality and body comportment, particularly recent feminist new materialist work, offers a lens through which we can observe body materiality as an equal participant in the interactions between provider, patient, and clinical bureaucracy.

The Anthropology of Bureaucracy and Subjectivity

This dissertation draws from anthropological work investigating how individuals strategically navigate healthcare bureaucracy to examine how providers and patients in gender-affirming health clinics are able to challenge gender-normative healthcare bureaucracy in practice. Anthropologists have long been concerned with illuminating the relationship between the state and individuals, most recently by highlighting how bureaucrats' day-to-day duties are responsible for directly implementing bureaucratic policy and regulations into practice, a major focus of the current work.

Scholars continue to draw from Max Weber's foundational work on bureaucracy to investigate how bureaucratization shapes social life in a myriad of cultural contexts, especially when addressing the relationship between bureaucratic policy and practice (Street 2012; Hoeyer

2010; Mckay 2012). Weber listed several defining features of bureaucratization, including an emphasis on efficiency, the presence of specialized roles arranged in a hierarchy, and diligent maintenance of official records (Weber 1947; 1978). He details that the central function of bureaucracy is to homogenize and centralize political power as administrative tasks proliferate. The purpose of administrative upkeep in bureaucracy is to increase the precision and speed of bureaucratic systems and lower the material costs of bureaucratic work, which Weber argued is a reason bureaucracy is often associated with capitalist economic systems (Weber 1978). Inherent in the operationalization of bureaucratic systems is the assumption that bureaucracies are most efficiently governed by reason and calculation as it exerts its control over human beings—it is a rational system free of the emotional and the personal (Weber 1947; 1978). Anthropologists have examined Weber's description of the "iron cage" of bureaucracy in depth, either through considering how bureaucracy creates "red tape" in the form of gatekeeping (Bear 2015, 19) or, especially recently, by elucidating that framing bureaucracy as an "iron cage" maintains an illusion that bureaucracy exists in a binary between rationality and irrationality. Anthropologists have argued that this binary does not accurately reflect social life because it is individuals that realize these policies through everyday practice (Gupta 2012; Bear 2015; Krause 2012).

This dissertation follows the latter interpretation of the "iron cage" of bureaucracy as I consider how those responsible for interpreting and implementing bureaucratic policy close the perceived gap between policy and practice (Lipsky 2010). Bureaucracies can produce cumbersome "red tape," excessive gatekeeping, and conformity to bureaucratic regulations which may exacerbate inequality in the populations they aim to address. However, anthropological literature demonstrates that bureaucrats, responsible for translating policy into practice, manipulate the features of a bureaucracy to prevent the reproduction of structural violence just as they may reproduce it (Brodkin 2012; Buchbinder 2016). For example, Buchbinder (2016) discusses how clinicians in North Carolina following the passage of the Women's Right to Know Act (a bill regulating clinicians' speech about abortion) led some physicians to subvert language policing during appointments, for instance by prefacing the document containing the new language with a disclaimer that clinicians were legally required to offer the new language to the patient.

Lipsky (2010) defines those who mediate between policies enacted by the state and the individual people bureaucracies serve as "street-level bureaucrats." This is an especially appropriate lens through which we can understand bureaucracy to materialize through the actors that bring it into being. Street-level bureaucrats enact policy as they incorporate broader political and social dynamics in their practices (Brodkin 2013). Departing from theorizations of bureaucracy that consider bureaucratic policy in opposition to practice, I consider the healthcare providers in the current study as street-level bureaucrats who respond to workings of state power and connect policy and practice, as the very actors directly responsible for bringing bureaucracies into being through their daily clinical interactions (Ferguson and Gupta 2002).

A specific form of bureaucratic practice, the audit, is a major contemporary focus for anthropologists interested in examining the direct implementation of policy and the exercise of state power, including the translation of healthcare policy into practice as this dissertation does. Audit culture can be defined as culturally understood norms and practices of assessment through which "good practice" and accountability are demonstrated (Strathern 2000; Power 1997). These "rituals of verification" may emerge within relations of power that demand accountability from an individual or organization (Vannier 2010, comment on Power 1997). The audited internalize these norms and judge themselves in accordance with them—creating new forms of subjectivity

(Shore and Wright 2000). In gender-affirming health clinics, providers are accountable to systems that track their activities and movements throughout the workday such as insurance reporting requirements and electronic medical records.

In order for an auditing system to function as a mode of governance, it must assess accountability in some way. Much attention has been paid to the use and (often statistical) measurement of indicators in auditing to fulfill this task (e.g. Merry 2011). Anthropologists and others have explored how statistical indicators are tied to times and places and can produce the very social categories they measure (Randeria 2006). Healthcare staff and patients are constantly audited in clinical time and space—especially in highly bureaucratized clinical spaces. I examine how providers make patients' bodily materiality visible in gender-normative bureaucratic medical technologies such as electronic health records in ways that hasten the realization of patients' transition plans.

The Financialization of U.S. Healthcare

The transitions that characterized the increasing financialization of the U.S. healthcare sector demanded a new routinized mode of efficiently accounting for healthcare profits through audit. This was achieved through quantitative and measureable discrete outcomes of care such as diagnostic codes. This new form of healthcare governance necessitates abstracting healthcare outcomes from patients' embodied experiences in the process of making healthcare decisions financially intelligible for institutions like insurance (Dao and Mulligan 2016; Merry 2011). In the clinic, this abstraction is carried out through providers' use of electronic medical records, digital documents that are directly implicated in healthcare billing through providers' input of discrete diagnosis and procedure codes condensed from the clinical interaction (Hunt et al. 2017).

Financialization is enfolded into the operationalization of managed care in the United States, now the dominant form of healthcare delivery. The shift to managed care in the 1990s transformed the U.S. healthcare system from a patient-centered focus to one in which profitable outcomes are favored (Rylko-Bauer and Farmer 2002). The intent of managed care was to cut healthcare costs and eliminate expensive and unnecessary treatments through careful auditing of service use (Lamphere 2005). However, as Louise Lamphere's work (2005) illuminates, at the level of the clinical interaction the lived effects of managed care can contradict its intended goal, a phenomenon that occurred at both clinic field sites in this study.

Organizational Culture Shapes Patient Agency

The specific organizational culture of any clinic will profoundly influence how providers and patients in that setting bring healthcare bureaucracies into being (Morgen 1995, 1986; Murphy 2012; Nelson 2011). "Organizational cultures" denote the wide range of cultural phenomena, from beliefs to authority symbols like dress, which distinguish an organization (Scott et al. 2003). For example, the organizational work cultures of feminist clinics incorporate cultural values such as women's autonomy and self-care practices to challenge bureaucracy directly (Murphy 2012; Morgen 1995). Similarly, gender-affirming clinics explicitly refuse to reproduce the dominant two-sex two-gender ideology in biomedicine (van Eijk 2014, 2017). In this dissertation I compare how two gender-affirming clinics with very different organizational cultures—a feminist community clinic and an outpatient clinic's audited healthcare bureaucracy—respond to gender-normative bureaucracy as providers and patients incorporate values and missions of these clinics into their responses, leading to various forms of bureaucratic encorpment.

Anthropological theories of biological citizenship are useful to understand how patients constantly draw from gender-normative language embedded in clinic bureaucracies to understand their own gendered embodiment and to challenge the many layers of gender-normative healthcare bureaucracy. Anthropologists have found Foucault's theory of biopower, introduced in the *History of Sexuality Volume 1*, useful to theorize how states employ social techniques to manage populations and individuals, because this exercise necessitated that Foucault specify the relationship between individuals and these forms of state power (Foucault 1990). Foucault considered the body a canvas on which the economy and the actions of the state are inscribed, which brings insight to how bureaucratic practices and discourse shape subjects (O'Neill 1986; Foucault 2008).

Although Foucault's analysis of biopower, widely discussed in anthropology, does not specify how individuals could challenge bureaucratic regulatory structures, succeeding theories like that of biological citizenship acknowledge individuals as agents able to respond to state power. When individuals understand their citizenship as borne from experiences of harm shared with others occupying the same space, this can enable them to impose demands on the state. Such an example of individual agency is evident in Adriana Petryna's (2002) discussion of biological citizenship following the Chernobyl disaster in Ukraine, the ethnographic case in which this concept was first introduced (Petryna 2002; see also Rose and Novas 2004). When individuals form communities around features of biological citizenship, they can create pluralized understandings of dominant truth discourse, including dominant biomedical discourse (Rabinow 1996; see also Kurtz et al 2013). I draw from these more recent analyses of individuals' reactions to state policy to examine how providers and trans patient-participants incorporate dominant medical discourse about gender and sex into their individual plans and desires for medical transition, oftentimes (re)mobilizing these healthcare discourses in conversations to advocate for medical services. The kinds of conversations that occur and the successful reactions that are possible are shaped by clinics' organizational cultures.

Embodying Gender Through Practice

The body has long occupied a place in anthropology, especially medical anthropology, and I draw from theorizations of the body informed by practice theory to demonstrate how bodily practice is lived through bureaucratic practice and vice versa. From early phenomenological analyses to contemporary new materialisms, anthropologists have highlighted the inevitable exchanges occurring between bodily materiality and social life.

The work of Marcel Mauss (1935), which emphasized that culture imprints on the body through habitual training, or habitus, laid the groundwork for a phenomenological approach to the body that anthropologists found useful to explain the coterminous relationship between society and individuals (see also Bourdieu 1977). Building on Merleau-Ponty's (1962) work, Csordas emphasizes the importance of understanding the lived body as the process of engaging in social life, as "the starting point for analyzing human participation in a cultural world" (Csordas 1993, 135).

Theories of body comportment emerging during this time also examined gendered aspects of inscribing culture onto the body. For example, philosopher and feminist Iris Young (1980) details differences between men's and women's bodies in contemporary industrial societies as they move in space with intention to complete specific tasks. She draws a parallel between women's hesitance to reach the full potential of movement (for example, hesitating to use the whole body while throwing an object) and society's conditioning of women through sexist oppression (Young 1980). Such early pieces about gendered body comportment highlighted the importance of examining the dynamic participation of gendered bodily in social life. I draw from this foundational work as I discuss how bureaucratic practice shapes how patient-participants' bodies are able to move through space outside the clinics.

Scheper-Hughes and Lock (1987) substantially contributed to this theoretical momentum of embodiment studies as they put forth a radical reconceptualization of the body in their aim to deconstruct the Cartesian mind-body dichotomy present in Western societies, and especially in biomedicine. The authors reconceived of this dichotomy by instead thinking about it in three perspectives: a body-self, phenomenologically experienced, a social body, and a body politic, or the body as an object of political and social control. This deconstruction of the body served as a new point of departure for medical anthropologists to examine how industrialized states regulate and control bodies and populations, how the body reflects relationships between society, nature, and culture, and how individuals experience their bodies (Scheper-Hughes and Lock 1987). In biomedicine, where bodily materiality is considered as a discrete biomechanical entity circumscribed from the mind and spirit (Farquhar and Lock 2007, 2), introducing these perspectives showcased a novel way for medical anthropologists to examine their own tendencies to adhere to a Cartesian mind-body split and visualize the mind and body as always integrated in both illness and disease.

Scheper-Hughes and Lock wrote the three bodies as they related to three trends of thought prominent in anthropology at the time: phenomenology, structuralism, and post-structuralism. Decades later, however, Yates-Doerr (2017) argued that considering Scheper-

Hughes and Lock’s three bodies in this way ironically serves to reproduce the kind of dualisms these authors wrote against, assuming bounded bodies through which medical anthropologists consider the body as individual, social, and political. The danger of this exercise is that the exchanges between these perspectives are lost to our analysis, creating instead a prescriptive research strategy that “… tells us that there are stable kinds of bodies out there to be studied, and then asks that we fit our fieldwork into this schema” (Yates-Doerr 2017, 152). I follow Yates-Doerr in taking a practice-centered approach to consider how, through situated engagements in clinical context with clinical bureaucracy, bodies are “materialized through practices” (Yates-Doerr 2017, 145; see also Mol 2002).

The development of practice theory in anthropology in the 1980s and the emergence of second wave feminism, which rejected gender essentialism, created the intellectual environment for a theory of gender performativity and the body to emerge in anthropology (de Beauvoir 1952; Rubin 1975). As anthropologists at this time largely focused on structuralist approaches, performance theory represented a welcome departure from this theoretical emphasis as it allowed anthropologists to address questions of individual agency and variability in social systems (Morris 1995). Bourdieu’s (1977) theory of practice stressed repetitious action, and Judith Butler adopted this notion into her later theory of gender performativity (Butler 1990).

According to Butler, our repetitious acts of gender performance always attempt to reach the naturalized ideal of “man” and “woman,” but always fall short (Butler 1990). Butler’s theory of performativity emerges from the very possibility that individual performative acts fail since the naturalization of binary anatomical bodies and gender does not correspond to actual material bodies (Butler 1990). In other words, in reality, bodies do not fit binary categories due to the vast variability of bodily shape and size. Thus, from the beginning, the non-normative reality of bodies opens up the opportunity for individuals to subvert these normative and naturalized gender ideals (Butler 1990; see also Morris 1995). This realization prompted anthropologists to use the “third gender” concept to argue against the naturalization of the binary gender/sex model in the West. Influenced by practice and performance theory, contemporary anthropologists are careful to employ local terminology and understandings of gender and sex difference when conducting fieldwork (e.g. Graham 2004; Littlewood 2002). This anthropological attention to the existing variability of gender performance—and the implication that instances of performance can be tracked ethnographically through practice—is key to identifying how specific aspects of bureaucratic practice and bodily materiality are co-constructed, a central goal of this dissertation.

Anthropology and related fields have since been occupied with examining how components of gendered human experience become naturalized in various cultural contexts and how these naturalized norms exclude other realms of human experience (Rubin 1984; Valentine 2007; Epstein 2017; Plemons 2015). Responding to a recent call in the field to turn from a myopic focus on the marginalization of communities (Ortner 2016), the current project shifts this focus as I demonstrate how providers and patients together actively work against gender-normative hegemonic norms as patients seek medical services to change their bodies.

Agentic Bodily Materiality

Considering bodily materiality as both agentic and shaped through social action opens up the opportunity for us to examine how bodily materiality transforms as it interacts with bureaucratic practice and vice-versa, as I demonstrate in this dissertation. Feminist new materialist approaches attempt to recognize the agency of bodily materiality as it engages with facets of social life. These approaches reframe how agency is understood alongside gender as not merely a performative, discursive practice. New materialist approaches attempt to make visible the vibrancy and agency of bodily matter (Braidotti 2019; Bennett 2004).

Anthropologist Megan Warin (2015) succinctly explains that when scholars speak of the body as agent, they mean that materialist feminism "attends to the ways in which bodies interact with and are radically open to other bodies, different spaces, histories, technologies, and environments" (p. 51). In the current work, I analyze bodies' interactions with bureaucratic technologies and environments, specifically. I am not advocating for a position of biological determinism, in which people are constrained by one of two genetically-prescribed paths of gendered embodiment. On the contrary, I am arguing that there is mutual engagement between body materiality and interventions upon it—features and processes of the body categorized in specific ways in our current time by biomedicine as gendered and non-gendered—and that this relationship can be elucidated by making the participation of bodily materiality available for analysis. New materialist perspectives bring novel insight to questions of transgender identity as they bring the non-linear, diverse, and dynamic trajectory of bodily materiality into view (Siverskog 2015).

Through a new materialist approach that recognizes the sporadic agency of materiality, operationalized through the concept of bureaucratic encorpment, this dissertation investigates how transgender and gender-expansive patients respond to the unpredictability of biological effects of treatments like hormones as bodies are lived in the social and politico-economic contexts of two diverse U.S. gender-affirming health clinics. For people amidst medical transition, the body does not "[stabilize] over time to produce the effects of boundary, fixity, and surface we call matter" (Butler 1993, 9). Bodies in transition are bodies in flux.

Methods

Greentown, Iowa

I carried out this fieldwork in Greentown, Iowa (pseudonym), a town with a population of approximately 70,000. Despite its small size, Greentown houses several LGBTQ-inclusive academic and healthcare institutions, including community cultural resource centers and activities, and the healthcare clinics featured in this research, two of many in the area with an emphasis on LGBTQ healthcare services. The concentration of such resources within a single area and the lack of such resources in surrounding counties flags Greentown as a hotspot for LGBTQ-related resources and activities. The majority of patient-participants in this study travelled from various areas of the state and beyond to receive care, with the average travel time of one hour. Situating this project in semi-urban Greentown challenges traditional political and cultural framings of dualisms like Coast/Midwest (Manalansan et al. 2014; Halberstam 2005; Gray 2009).

Shared Roots

Although the two clinical field sites in this research, Woodfield Clinic, a clinic accountable to a larger hospital, and Glendale Clinic, a small feminist community clinic, differ vastly in clinic organization and financial and cultural resources and histories, both emerged as providers of gender-affirming healthcare services after providers communicated directly with members of the Greentown transgender and gender-expansive community. This was brought to my attention early on in my year of fieldwork when I was approached by Kyle, who heard about my study from a mutual friend and told me they had contact with both Woodfield and Glendale clinics at the clinics' inception of providing transition healthcare services. Kyle requested to meet to discuss their direct observations of these origins with me.

We sat, coffees in hand, while Kyle recounted how a member of the local trans community put together trans healthcare guidelines for Glendale clinic, including definitions of gender and sex challenging the dominant two-sex, two-gender model in U.S. healthcare and guidelines for appropriately addressing transgender clients. Additionally, Kyle had participated in a grassroots community organization that mobilized in the early 2010's to address the local trans community's need to navigate appropriate healthcare services. This organization aimed to both educate providers and mitigate the risk of discrimination as community members sought healthcare services. As it developed, the organization shared specialized knowledge about transition-related healthcare with the community through presentations, including coding practices that more adequately represented gender-expansive patients in medical records. The healthcare staff at Woodfield clinic subsequently incorporated these insights into their clinic practice.

The insights Kyle shared with me reflect a broader and omnipresent characteristic of the historical development of gender-affirming care: the current state of U.S. gender-affirming care must be understood as emerging through the influence of decades of trans activism (Stryker 2008; Meyerowitz 2002). Trans and gender-expansive activists seeking and advocating for appropriate transition care have historically brought their expectations and diverse lived experiences to clinical appointments and broadened healthcare provision to include these experiences. Two of several notable examples include the activism of Lou Sullivan, a gay trans man who during his life advocated for the removal of the prerequisite that trans men seeking transition care identify as heterosexual—the removal achieved in 1994 following his untimely death—and the recent removal of transgender identity as a psychiatric “disorder” in electronic medical record diagnostic coding (Stryker 2008, 120; Lev 2013). Attending to the narratives of trans and gender-expansive patient-participants as this dissertation does provides a window into the expectations these patients had about concrete features of transition care, as recounted directly to providers and outside of the clinical context (Prosser 1998, 4). As I will demonstrate throughout this work, the locus for broad bureaucratic change lies in the repeated, situated exchanges patients have with providers.

Woodfield Clinic

Woodfield Clinic is an ancillary clinic of a hospital located in Greentown. The founding physicians of the Woodfield Clinic launched the clinic in the early 2010s in direct response to discrimination transgender people faced from the U.S. medical system. By constantly participating in outreach initiatives with physicians in various hospital departments, Woodfield providers explicitly hope to spread the clinic’s ethos to the institutions’ other clinics and locations so that patients will not have to travel extensive distances to receive appropriate care. To this end, the providers routinely organize training sessions with providers at the close by hospital and educational workshops.

The clinic is staffed by providers who are specifically trained to serve gender and sexual minorities, including medical assistants, pharmacists, physicians, and nurses. Providers here see patients who travel to Greentown from throughout the Midwest. The clinic uses a specially formatted electronic health record system with fields available to input gender identity and sexual orientation, and wholly rely on these electronic medical records.

The World Professional Association of Transgender Health (WPATH) Standards of Care, recommendations which aim to communicate international professional consensus about optimal transition care, have been broadly incorporated by U.S. healthcare institutions, individual providers, and insurance companies (Coleman et al. 2012; Schulz 2018). Currently, the dominant model of transition care in the U.S. is the diagnostic model, in which the Standards of Care are interpreted such that a diagnosis of "gender dysphoria" and psychotherapy referrals are required to receive access to transition care resources (Schulz 2018). Woodfield providers work within this dominant model, crafting clinical notes that educate healthcare entities outside the clinic about the entailment of transition care and its justification while simultaneously recognizing the variance of patients' gendered embodiments in these notes, as I discuss in Chapter 3.

This clinic has multiple sources of institutional support, reflecting high bureaucratization and specialized staff roles. For example, a provider can seek immediate legal advice to respond to an insurance claim denial based on a patient's gender identity, and notaries are available on-site to notarize letters for patients requesting legal gender marker changes.

Glendale Clinic

Glendale Clinic was founded in the early 1970s, one of the first grassroots feminist community clinics in the United States. Glendale Clinic is a non-profit clinic. The clinic began to offer transition services in the early 2010s, and serves transgender and gender-expansive clients that travel from throughout the Midwest to the clinic to receive hormone medications. The clinic utilizes a combination of paper medical records and standard electronic records and patient portal systems although, as I will discuss, this clinic relies heavily on paper records for patient documentation.

There is low bureaucratization in this clinic; staff often perform multiple roles and there are overall few existing staff members. For example, the main provider at this clinic at the time of fieldwork, nurse practitioner Molly, handled healthcare billing and issues that arose in addition to her clinical role. In the case of an insurance denial for gender-affirming care, for instance, Molly directly called the insurance company to respond to the denial on the patient's behalf. As a community clinic sustained through community donations, Glendale has more unpredictable funding than Woodfield Clinic, but the community support it receives funds clients who demonstrate financial need, which affects how providers and patients navigate similar bureaucratic circumstances such as encounters with the same insurance company.

Participants

A total of 58 trans patient-participants agreed to participate in this study, 36 in Woodfield clinic and 22 in Glendale clinic. The number of participants enrolled in the study reflects the participation rate I observed during preliminary fieldwork at Glendale clinic, and collectively reach data saturation (Morse 1994). Participants were predominately young adults and White, reflecting the ethnic demographics of the population in the region (U.S. Census Bureau 2020). Patient-participants traveled an average of one hour to visit the clinics. In addition, I observed the routine bureaucratic practices (including clinical appointments and scheduling) of 16 total consenting healthcare and managerial staff at Woodfield and Glendale clinics. I use pseudonyms for all participants, locations, and sites described in this study.

Although healthcare staff shifted in and out of the clinics over the course of the fieldwork period, I worked closely with several permanent staff. At Glendale, I spent most of my time sitting with practitioner Molly in her office outside of appointment times, and frequently engaged in discussions across the hall with Sarah, who handled the administrative demands of the clinic. At Woodfield, I worked predominately with head physician Dr. C, physician assistant Janet, and the two respective medical assistants working with them, Serena and Charlotte. On the days I observed clinic scheduling, I spent my time sitting with several schedulers, including Miranda, Alex, and Stacey at Woodfield clinic and Lena and Micki at Glendale clinic. My use of a title for Dr. C. rather than a first name in this dissertation reflects how she was customarily addressed by myself and other staff roles during the clinic day, and reflects the bureaucratization differences between Woodfield and Glendale clinics.

Clinic Site Access

Before I could set foot in the clinic, a months-long process to receive access permission awaited. The length of time needed for access at Woodfield in contrast to Glendale corresponded to the fact that hospital administration needed to create a new specialized role for me to be able to fulfill my research objective of moving around the clinic to observe different staff positions and spend time in the clinic over the course of one year (I made several phone calls to explain why the single visit short-term visitor form was inaccurate for my intentions).

Gaining access to U.S. biomedical hospitals in particular carries its own set of difficulties due to the presence of Institutional Review Boards, clinic site-specific permissions, and national health policy such as the Health Insurance Privacy and Portability Act (HIPAA), which safeguards the privacy of patients' records (van der Gheest and Finkler 2004). The process of receiving permission for access as an anthropologist unfolded quite differently in each clinic, revealing characteristics that define bureaucratized spaces. For example, informed consent forms might make a brief appearance in some fieldwork contexts, and in some cases might even run contrary to maintaining ethics principles with informants (Stark 2012). However, in other fieldwork contexts—particularly bureaucratized ones such as clinics where activities are continuously audited—these bureaucratic documents become embedded in the bureaucracies anthropologists inhabit during their fieldwork. The process of receiving IRB approval for this project largely followed that of ethnographic projects in clinical contexts as I completed HIPAA training and relevant hospital compliances as part of the approval process. However, I argue that the resulting IRB consent form in many ways actually brought into sharp relief the flow and significance of bureaucratic time at each field site in this project, as I discuss in Chapter 2.

Recruitment and Consent

I received approval to conduct this dissertation research from the University of Iowa Institutional Review Board as well as from both clinic sites. Additionally, I completed required HIPAA training prior to observing routine bureaucratic practice in the clinics and appropriately collecting information from the medical records of consenting patient-participants.

I recruited patients to participate through the use of a brochure explaining the study that providers handed to interested patients to read at the beginning of their appointments (see Appendix A for a copy of this brochure). If patients were interested in hearing more, the provider left the room and I entered to discuss the research in more detail, hand them the consent form and answer any questions. Upon reading the consent form, the rate of participation was over 90% at both clinics. Patient-participants may have viewed the study as a vehicle to capture gender-expansive experiences in healthcare. Upon reading through the consent form one patient participant remarked, “Now this is a study that if I don’t participate, nothing will change for this group." This level of enthusiasm was shared by staff as well, who were interested to learn how they could improve their bureaucratic practice.

Observation of Clinical Appointments and Activities

In each clinic during clinical appointments, I observed how consenting providers and patients interacted with each other and discussed gender-related bureaucratic paperwork fields pertinent to appointments—such as gender markers in electronic medical records—to determine how these actors navigated and modified gender-normative bureaucracy in context. Observing the clinical interaction helped me identify why providers and patients considered specific assumptions about gender in health bureaucracy inappropriate and crucial to navigate around in the clinical context. Observation also provided insight about what financial and institutional resources existed in each clinic and how providers and patients utilized these differently, such as the flexible payment plans available at Glendale clinic. I collected observational data on both verbal and non-verbal communication to capture gestures and styles of speaking (Herzfeld 2009). As I realized within the first weeks of conducting fieldwork, non-verbal communication such as gender-affirming buttons pinned to providers' white coats worked alongside verbal communication to communicate broader gender-affirming missions of the clinics (Baker and Beagan 2014).

In addition to clinical appointments, I also sat with providers outside of the clinic rooms as appointments occurred throughout the day to observe routine bureaucratic practice, and observed clinical activities such as scheduling and clinic check-ins, sitting beside schedulers and front desk receptionists to learn how these actors interpreted gender-related fields and features contained in scheduling documents used in these activities.

Post-Appointment Debriefing Interviews

I debriefed consenting patients in one-on-one interviews following my observations of their clinical appointments, in order to gather narrative data about which gender-normative assumptions in healthcare bureaucracy they found inappropriate and targets for change. Ethnographic debriefing involves interviewing an informant about an event that was not feasible to intervene in at the time (Schoepfle and Werner 1999). I conducted semi-structured interviews with informants, asking open-ended questions that allowed patients' understandings of interactions with their gender-affirming providers and with gender-normative medical bureaucracy to emerge. It was important to debrief patients alone, as some patient-participants were more comfortable recounting their thoughts about certain aspects of their appointment when removed from the clinical context.

Debriefing patients about their appointment experiences generates data about patients' perspective of the appointment, including assumptions about gender their providers may be making and that they may feel uncomfortable expressing during the appointment. For example, a patient may consider a particular assumption about gender inappropriate, while their provider may not. The debriefing interview also illuminated how patients understood the meanings clinics conveyed through spaces outside of the appointment room, such as features of the clinics' interiors.

As I debriefed patients after appointments, I periodically asked their providers how they would resolve issues relating to gender-normative medical bureaucracy brought up during these appointments. As it was not feasible to debrief providers after each patient's appointment, I employed a similar debriefing method with providers by asking them between appointments how they understood the meaning and function of gender-normative bureaucratic terms that emerged during those appointments. I designed the questions I asked during interviews according to best practices for conducting qualitative research on intimate topics (LeCompte and Schensul 2010). Debriefing generated a wealth of narrative data reflecting providers' and patients' individual insights about how gender-normative language is used within the clinical context. As the majority of patient-participants traveled from an average of one hour away to visit the clinic, and given that Woodfield clinics were often held in the evenings, I contacted each informant via telephone to ensure uniformity. With permission, I audio-recorded and transcribed interviews from the patient-participants I was able to reach for their interviews (18 at Woodfield clinic and 14 at Glendale clinic). I informed all participants that I had sole access to the research data.

Analysis of Bureaucratic Documents in the Clinic

Since bureaucratic documents represent the practices, regulations, and ideologies of bureaucracies, I consider the bureaucratic document as a gateway to ethnographically examine the seemingly value-neutral cultural assumptions underlying bureaucratic health systems (Hull 2003; 2012). At these clinical sites, documents that indexed broader discourse included electronic health records containing explanations of gender-related diagnostic codes in clinical notes, legal name-change documents handed out to patients, informational brochures for patient-participants' employers, and clinic intake forms, among others. By comparing the information contained in these documents, I was able to identify ways that the documents reflected gender-normativity and noted how providers and patients responded to this ideology in their creative use of these documents. For example, analyzing an insurer's interpretation of a gender-related term and clinical notes together revealed how providers and patients worked around gender-normative cultural assumptions in these documents.

The clinical notes providers write in patients' medical records capture patients' narratives, symptoms, and diagnoses, and provide continuity of communication between providers regarding patient treatment and management plans (University of Washington n.d.). I analyzed the clinical notes providers produced during appointments with consenting patients to collect information about gender-normative assumptions providers made and which were unspoken during the clinical appointment. Clinical notes revealed specific bureaucratic constraints, such as the absence of a pronoun field in the electronic health record, that hindered providers in representing the non-normative embodiment of their patients. Electronic clinical notes travel widely, arriving under the eyes of various audiences such as providers of different specialties, insurers, and pharmacists, as I discuss in Chapter 3. Understanding how providers translated the clinical interaction into bureaucratic health documents clarified how providers addressed gender-normative cultural assumptions in these documents. I collected all clinical notes on-site at respective field sites, recording anonymized data as field notes, and analyzed these field notes in aggregate.

From clinical notes and various circulating bureaucratic documents at both field sites, I recorded field notes about routinized bureaucratic language relating to gender and sex. These ranged from electronic record fields involving reproductive anatomy to pronouns printed on blank clinical training materials and intake forms. I collected only de-identified information from these documents.

Fieldwork Data Analysis and Terminology Rationale

I based analysis of fieldwork data on a grounded theory approach I applied to the data through inductive or "open" coding (Glaser and Strauss 1967). While utilizing grounded theory, the researcher “grounds” themselves in their data to allow patterns of human experience to emerge, and categorizes and labels themes they identify in their data from this approach (Glaser and Strauss 1967). This approach captures how informants actively construct social meaning in context through their narratives that cannot be inferred from pre-established social facts (Whitehead 2005).

For example, in response to dominant two-gender, two-sex ideology in biomedicine, patient-participants often refashioned these understandings to align with their experiences of gender (Edelman and Zimman 2014). The gender-normative understanding of the term “female” as a particular body organization linked to a feminine gender did not correspond to several trans informants’ understandings of the term in their narratives. I recognize that this dissertation is produced at a particular period in time and that language use in transgender and gender-expansive communities changes rapidly, and I have made conscious choices as to the language I use to write about informants in this dissertation. Wherever possible, I reproduce the language informants use for themselves. For example, if an informant uses the term “sex reassignment surgery,” I use this term when discussing this informant’s experiences, even though this term is no longer in mainstream usage (Valentine 2007). Further, understanding trans patient-participants as individuals seeking a variety of medical services, I am careful not to categorize informants under identity labels they have not used for themselves during my observations and interviews. Instead, I have chosen to categorize patient-participants via the services they actually sought at the clinics, such as estrogen or testosterone, and include this basic information with any identifiers patient-participants chose for themselves. Throughout this dissertation, I use the term “transgender and gender-expansive” to capture the variance of gender identities represented in this work. The term “gender-expansive” reflects the notion that the broad existing variance in gender identity expands the boundaries of existing gender norms in a society (Human Rights Campaign 2020). Open coding in the form of in vivo coding, or using informants' own words as names of themes (Corbin and Strauss 2008), captured gender-normative meanings and participants' meanings of gender-related terms in context, making them both available for comparison.

The qualitative software MAXQDA is useful for creating codes from many sources of ethnographic data (Bleck et al. 2014). I open coded observational data collected as field notes and narrative data contained in transcripts by highlighting phrases relating to gender-related language informants discussed. Comparing codes generated from observational data and narrative data emerging from interviews elucidates differences in expectations providers and patients had about appointments, such as when one patient-participant stated that their provider failed to directly address a gender-normative assumption linked to a pap smear during his appointment (Baker and Beagan 2014). I scrutinized data collected from the documents against the codes and subcodes collected from the observational and narrative data, noting relationships between the documents and these other data sources (Boyatzis 1998).

The Anthropologist Embodies Bureaucracy

It was while detailing my own movement through the clinic spaces as an anthropologist that I first recognized how bureaucratic roles and the policies regulating them become embodied and are maintained through both bureaucratic practices and bodily materiality—of my own participation in bureaucratic encorpment. As I discuss below, this phenomenon was especially noticeable in highly bureaucratized Woodfield clinic, where staff attempted to incorporate me into several different existing bureaucratic roles, and was virtually absent at Glendale community clinic, where I was always regarded as an anthropologist.

Throughout my fieldwork, I took copious notes about my own positionality in the clinics and detailed my perceptions of interactions I had with providers and patient-participants. I engaged in a form of autoethnography as I "[critiqued] the situatedness of self and others in social contexts" (Spry 2001, 710). Following Moors (2017), who warns against lumping all discussion of anthropologists' positionality in their fieldwork contexts under the term "autoethnography" at the risk of excluding informants' voices, I want to discuss how my role as an anthropologist, specifically, has been recognized and unrecognized in the fieldwork context. This exercise brought to my attention the ways in which I non-verbally embodied bureaucracy in the roles that I partially inhabited in the clinics since the inception of fieldwork.

Following successful clinic access permission, I had the freedom to interact with consenting staff across positions related to this clinic in fulfillment of my role as a student-researcher (Aberese-Ako 2016). As the purpose of my project was to observe bureaucratic practices across the clinic, I received permission to observe scheduling as well as clinical appointments and staff at the computer desks and offices on the other side of the clinic rooms between appointments.

Although I was legible in administrative paperwork at Woodfield following the creation of my new staff role of unpaid research assistant (Scott 1998), this legibility did not extend beyond this paperwork to the clinic itself. In Woodfield clinic, and especially in the first weeks of fieldwork, circulating health staff often mistook me for a medical student. This was likely due in part to my close proximity to physician Dr. C., who frequently had medical students on rotation with her. However, more peculiar was the fact that even when staff knew of my identity as an anthropologist, some still viewed my position in the clinic as ambiguous and began to extend their role expectations to me. For instance, in the first days of fieldwork providers gave me case presentations (a specialized way of condensing aspects of a patient's medical history pertinent to the upcoming appointment to medical students) prior to appointments I was waiting to attend, despite the fact that I lacked both the writing on my badge and a white coat to mark me as a medical student. Additionally, staff sometimes asked me medical questions (that I would politely decline to answer, stating my lack of medical training). These observations raise interesting questions about the boundaries of specialized bureaucratic roles, especially when other roles' expectations are perceived as ambiguous.

On days when I observed scheduling practices, I sat behind the long desk next to the schedulers on shift. This desk faced the large waiting room of the clinic. In the first weeks of fieldwork, I noticed that I constantly demarcated my role with patients in line, who assumed I was also a scheduler. I did this non-verbally, solely through gestures. For example, as eye contact was a gesture that schedulers used to usher patients into their lines for intake, I purposely avoided it. When patients approached the desk to check-in, I immediately stopped writing field notes so they would not think I was writing about them, in a sense incorporating HIPAA principles of patient privacy into this gesture. Alongside verbal engagement, space, and paperwork, my autoethnographic field notes indicated that gestures represent an additional bureaucratic practice that manages clinic workflow and materializes healthcare policy into practice (Herzfeld 2009). Bodily materiality, in this case body comportment via gesture, brings bureaucracy into being as bureaucratic encorpment proceeds.

Outline of Chapters

In the following chapters of this dissertation I discuss how time, bureaucratic documents, clinic space and architecture, and affect shape how patients embody gender in the two gender-affirming health clinics. These chapters represent enduring sites of interaction between providers and patients and bureaucratic practice in the gender-affirming health clinics. Although all of these features are always simultaneously working together to influence how healthcare staff and patients navigate gender-normative clinical bureaucracy, I have chosen to foreground each in its own chapter to closely examine the role each one plays in shaping how patients embody gender.

The manner in which the clinics manage time differs greatly. In Chapter 2 I discuss how time and temporality manifest in each clinic, and discuss how clinic time, provider and patient time, and bodily or biological time sometimes coincide, and other times do not. Drawing from Munn's (1992) understanding that multiple dimensions of time are lived in practice and Laura Bear's (2014) concept of "time-maps," I discuss how these three temporal rhythms in the clinics come into harmony and disharmony with consequences for patients' abilities to embody their transition plans. In Woodfield clinic, where electronic medical records audit providers throughout their work day, appointments must begin and end at specific times and delays are tracked; bureaucratic time represents a dominant time-map. These conditions coupled with the fact that the gender-affirming health clinic is held only a few times a week influences how patients plan their care. Meanwhile, workflow in Glendale clinic is lax, appointment times are always available, and practitioner and client do not rush through appointments. Patient-participants' bodily materiality is unpredictable—some patients have an allergic reaction to hormone solutions, which delay their plans for transition. Attending to points of disharmony created as these temporal rhythms collide—in some cases eclipsing patients from care—makes visible concrete areas for adjustment in bureaucratic practice.

Although both Glendale and Woodfield clinics are affected by the same healthcare policy pressures and regulations, differences in documents' material forms (Hull 2008) affect how staff and patients address gender-normative clinical bureaucracy, as I discuss in Chapter 3. The electronic material form of Woodfield's medical records enable them to interface with healthcare entities outside the clinic such as pharmacies and insurance companies as part of a broader federal electronic health record standardization initiative, and providers repurpose these widely traveling documents as educational tools that then travel beyond the clinic. Differences in clinics' organizational cultures also affect how providers and patients interact. For example, at Glendale clinic, where hierarchy is purposefully avoided, rapport between practitioner and client is extremely casual and informal, while rapport at Woodfield follows that of a typical provider-patient relationship in a biomedical clinic. In Chapter 3 I show how such differences in organizational culture translate into differences in how providers and patients are able to invoke bodily materiality to navigate and challenge gender-normative language in clinical documents. By refusing to adhere to routinized bureaucratic practices that reproduce gender-normative healthcare bureaucracy, providers at the clinics challenge Foucauldian notions of self-governance (Foucault 1988).

In Chapter 4 I discuss how discursive care practices allow patients to become visible in clinical bureaucracy at each step of their appointments from check-in to check-out and influence patients' abilities to seek future transition care. For many patients, the initiation of medical transition is an occasion to be celebrated, and providers join patients in these celebratory moments. Providers at both Woodfield and Glendale strategically discursively invoked bodily materiality to ensure gender-normative clinical bureaucracy reflected patients' transition plans and to empathize with patients in the face of a political climate that is often hostile to their journeys. In other words, to create positive affects with patients. I consider affect as produced through situated encounters between providers and patients that have variable effects (Stewart 2017; Archambault 2016). Affective responses correspond with bodily materiality; for example, feelings of anxiety contribute to high blood pressure which can skew lab values and limit access to transition care, anxious feelings schedulers try to minimize through bureaucratic practice. I show how positive affects created set the conditions in the present for paths of bureaucratic encorpment that favor patients' transition plans to occur in the future as patients return to the clinics. Providers' consistent efforts to generate positive affects with patients challenge recent understandings of medical professionalism as delinked from care practices in the clinical interaction (Hafferty 1998; Kleinman and Hanna 2008; Craig et al. 2018).

In Chapter 5 I discuss the role that the built environment—clinics' interior aesthetic and architectural features—plays in shaping affect as staff and patients move through the clinics. The materiality of the built environment is designed for a particular purpose but influences providers' and patients' bureaucratic practices in unanticipated ways (Roberts 2012, 2514; Murphy 2016, 443). I devote the first half of this chapter to discussing how Woodfield staff's habitual use of electronic health record software to track staff and patients' movements through the clinic sometimes misrepresented staff's spatial reality with consequences for patients' access to care. As a clinic that also provides abortion services, the interior of Glendale clinic reflects a preoccupation with maintaining security, and clients take notice. By considering the affective potential of the materiality of clinics' built environments, I discuss how patients and healthcare staff react to these built elements as their bodies move through these spaces, creating affective responses that shape patients' willingness to return to the clinics in the future, thus setting conditions for forms of bureaucratic encorpment that embody patients' transition plans.

Through the concept of bureaucratic encorpment I argue that bodily materiality—currently undertheorized in the anthropology of bureaucracy—is a key mediator in the realization of bureaucratic policy in practice. This has profound implications for stakeholders concerned with the operation of bureaucracies, especially healthcare bureaucracies. The insights generated from this dissertation can inform future U.S. federal and state healthcare policy and various actors aiming to improve U.S. healthcare systems, including healthcare professionals and health services researchers. In Chapter 6 I emphasize applications concerning staff's embodied use of healthcare software, the promotion of gender equality in healthcare, and optimal healthcare architecture design. Throughout, I incorporate concrete suggestions patient-participants themselves provided during debriefing interviews for improving future healthcare experiences.

Striving to create paths of bureaucratic encorpment that serve patients' transition plans is key to ensuring patients have a positive long-term medical transition journey. This necessitates that healthcare providers embrace the variability of patients' relationships to their bodies and the variability of bodily materiality. This dissertation serves as a roadmap to reach this goal.

CHAPTER 2: MANAGING COMPETING RHYTHMS IN THE CLINICS

> “’I want a new change, a good change,’ Natalie, who has come in to assess estrogen-related changes in her body, tells Dr. C. ‘I’m considering implants. How big do you think mine will get?’ Dr. C replies that it depends on age and race. She tells Natalie that her breasts will continue to grow, since she’s on estrogen. Natalie insists on finding some way to speed up the process. Dr. C asks Natalie to consider what happens if she has bags in her breasts over time, with gravity. ‘They fall?’ asks Natalie. ‘Yes!’ Dr. C tells Natalie that if she just waits 2-3 years… ‘Look at pictures of the women in your family,’ she says” (Observational fieldnotes, Woodfield Clinic).

Transition is not one single event, but a long-term process involving constant coordination between patients’ bodies, patients’ desired pace for transition, providers’ medical knowledge, and the technologies of gender-normative clinical bureaucracy. Here, Natalie has come into her appointment with a specific vision of how she would like her transition to proceed. However, she does not consider the changes in her body to be happening at a quick enough pace. She hopes that breast implants will help her achieve the look she wants, but Dr. C attempts to dissuade her from this option by insisting that this instant solution will not allow her to achieve what she envisions for her body long-term; if she just waits 2-3 years, her breast size will approach the appearance of those of the women in her family.

In this chapter I illuminate the complicated relationship between the timing of transition and bureaucratic time to demonstrate how the interactions between these temporal representations structure patients’ possibilities to embody their plans for transition. In doing so, I demonstrate how bureaucratic encorpment occurs as temporal representations of bureaucratic and bodily practice constantly engage with each other. Several activities simultaneously occur at any given moment at Glendale and Woodfield clinics: providers and patients are accountable to bureaucratic technology that audits providers in time and space in accordance with broader healthcare policy, and patients embodying unique biological histories circulate through the clinics, bringing their ideal timelines for transition with them. In order to attempt to isolate and describe each of these activities and examine how they relate to each other, I adopt Laura Bear's concept of "time-maps," pairing it with a practice approach to demonstrate how providers and patients' daily practices manage the unfolding of competing temporal constraints in the two clinics and carry consequences for patients' gendered embodiment.

I answer Laura Bear and colleagues' call to move beyond simply describing representations and practices of time to "track how these produce social rhythms and follow the relationship of these rhythms to each other" (Bear 2014, 19). To do this, I extend Bear's analysis by identifying the agency of bodily materiality in transition as a rhythm in constant conversation with the rhythms of bureaucratic time and providers' and patients' plans for transition. I examine how conflicts and harmony generated as these rhythms collide shapes patients' gendered embodiment just as patients' embodiments shape the unfolding of bureaucratic time in each clinic, detailing how bureaucratic encorpment occurs at the temporal level. Bureaucratic encorpment, as I detailed in the introductory chapter, is the mutually constitutive embodiment of bureaucracy and bodily materiality.

Anthropological Theories of Time

Anthropologists have long been interested in specifying the nature of time, but a theory that centers individual practice has only recently been proposed. Grappling with the inescapability of temporality in the midst of the reflexive turn of the 1980s, anthropology and related disciplines interrogated how scholarly theorizations profoundly shaped conclusions of ethnographic inquiry (Fabian 1983, see also Frankenberg 1994). For example, critiques arose against presenting ethnographic accounts as if they occurred in the present, framing field sites as if they were unbounded by time. In addition, critiques encouraged anthropologists to consider the vast array of existing ways of experiencing time that departed from the Western notions of progress coloring many prior works (Fabian 1983). The realization that a plurality of ways of experiencing time existed prompted anthropologists to deeply interrogate the characteristics of these nuances.

Theories of temporality grounded in practice emerged in efforts to capture the minutia of people's experiences of time across social contexts. Munn's (1992) detailed analysis of anthropological theorizations of time tracks the struggle of defining the relationship between individuals and conceptions of time, key in outlining how practice interfaces with temporality. While discussing the link between time and practice, Munn argues that Bourdieu's attempt to unify the temporal and the spatial falls short of situating individual action, with obvious ramifications for how we as anthropologists conceptualize the connection of temporality to space, individual, and action through a practice-oriented approach (Munn 1992, comment on Bourdieu 1990).

Munn responds to the heterogeneity and shortcomings of anthropological approaches to time by offering an understanding of "temporalization" that more clearly centers everyday practice. She states that people are always imbricated within multiple dimensions of time—understandings of sequences of time and of past-present-future relations, for instance—and that at any given period, certain facets of these dimensions come to the attention of actors forming relationships between themselves and these temporalizations, while others remain unacknowledged. Importantly, she notes that these multiple dimensions are constantly “lived or apprehended concretely via the various meaningful connectivities among persons, objects, and space continually made in and through the everyday world” (Munn 1992, 116).

Laura Bear, in an effort to outline a theory of modern time available to ethnographic inquiry, refines Munn’s analysis to account for lived experience. She argues that the act of working within and on time involves “an encounter with the material world, the limits of the body, multiple tools, and co-ordinations of diverse rhythms and representations,” (Bear 2014, 20). In order to translate Munn’s more abstract analysis into concrete acts that can be readily examined, Bear draws heavily from anthropologist Alfred Gell, who introduced the model of “time-maps.” Gell argued that humans create representations drawn from their personal experiences and that these representations always have only a partial relationship to the passage of non-human time (Bear 2014, comment on Gell 1992). Expanding on Gell, Bear notes:

> “Time-maps will vary in the degree to which they mimic the other of non-human time or human time experiences. For example, technologies of time such as navigational devices will be closely tied to non-human forces. Historical records and personal mementos, by contrast, can improvise freely with both the flux of life and experiences of before and after, largely unconstrained by non-human time” (Bear 2014, 16).

Bear knits together this notion of time-maps with Marxist political analysis to develop a more holistic theoretical lens that offers the ability to examine how time-maps are organized hierarchically, how they come into tension with each other, and how these orderings produce additional interacting social rhythms (Bear 2014). I adapt Bear's approach to examine the often discordant suite of interacting rhythms occurring in Glendale and Woodfield clinic, rhythms providers and patients constantly attempt to manage.

To demonstrate how bureaucratic encorpment occurs through temporal engagements, in this chapter I specify the impetus of bodily materiality, characterized by the time-maps unfolding as bodies act in accordance with existing biological histories. I demonstrate how these bodily time-maps constantly interact with bureaucratic time-maps; that is, how bureaucratic encorpment occurs as bureaucratic and bodily time mutually constitute each other through providers' and patients' situated engagements with gender-normative healthcare bureaucracy.

Recent anthropological work on chronicity and illness has investigated how chronic conditions such as cancer, HIV, and infertility interface with gendered embodiment and corresponding social gender expectations across cultural contexts (Manderson and Smith-Morris 2010; de Klerk and Moyer 2017; Stansbury et al. 2003). Considering bureaucratic encorpment as an ongoing process grounded in practice allows for fine-grained analysis of the spontaneous reactions bodily materiality might have to specific biomedical interventions, and the direct changes that occur in gender-related bureaucratic practice in response to these bodily reactions.

Pharmacies, for example, suspend injectable testosterone in either cottonseed or sesame seed oil. Immediately after a patient administers their injection, they might experience a localized allergic reaction to one of these oils in the form of a rash, as some of the patient-participants did. I consider such reactions to be produced by bodies' unique genetic and immunological histories that are shaped by patient-participants' actions (Davis 2014; Feuille and Nowak-Węgrzyn 2016). Demarcating such bodily reactions allows me to examine how the time-maps bodily materiality creates come into tension with concurrent time-maps like those produced by clinical bureaucracy and those shared by providers and patients. For patients experiencing dermatological reactions to particular hormone suspension oils, the only option might be to choose a different route of administration that avoids an allergic reaction, such as the testosterone gel, which releases testosterone into the body at a slower rate and may not be covered by insurance, as I will discuss. Coverage issues can create delays for patients' transition plans, consequently shaping how patients are able to embody gender vis-a-vis their transition plan in that moment.

Bear's incorporation of Marxist political analysis to explain the hierarchical layering of time-maps is likewise helpful for illuminating how actors reconcile tensions of power between time-maps (Bear 2014). Here, I identify hierarchy between time-maps to emerge as providers and patients attempt to bring competing time-maps into synchronicity with bureaucratic time-maps. In both clinics, for example, providers and patients covered by state insurance are subject to shifts in broader healthcare policy, such as the lawsuit brought against Medicaid by the ACLU in the middle of the fieldwork period. This appeal challenged an administrative code governing Medicaid in Iowa that framed transition-related surgeries as cosmetic and under the category of plastic surgery, preventing patient-participants from receiving approval for transition-related surgeries such as mastectomy (breast removal) and vaginoplasty (construction of the vagina) (Crowder and Nozicka 2019). Like patients' private insurance plans, such broader policy decisions create particular time-maps that come into tension with patients' own plans for transition timing, but that providers and patients are required to adapt to. Thus at any given time multiple time-maps are interacting with each other with different levels of influence upon one another. In this chapter I will illuminate these layered interactions by examining providers' and patients' concrete daily interactions with gender-normative clinical bureaucracy, bureaucracy characterized by the auditing of clinical activities and providers' and patients' accountability to these audits and to healthcare policy.

Although multiple time-maps are interacting at any given moment, in order to investigate the fine detail of how these time-maps interface and thus how bureaucratic encorpment occurs as a temporal process, it is necessary to attempt to isolate and elucidate one at a time, so that we may "examine dominant representations of time and the social rhythms, conflict, mediation, and heterochrony that unpredictably emerge in relation to them" (Bear 2014, 6). I approach this project by organizing this chapter into four major sections reflecting four prevalent time-maps occurring at Glendale and Woodfield clinic: distance to and from the clinics, "bureaucratic time" including auditing and policy constraints and role-related delays, provider and patient time exemplifying these actors' transition goals, and body materiality.

Outline of Sections

I devote the first part of this chapter to illuminating how distance—that is, the geographical distance from patients' homes to the two clinics—creates time-maps that alter patients' experiences of time with the two clinics before they even set foot in them. On average, patients traveled an hour to reach either of the clinics. Arriving at the clinic on time demands several acts of careful coordination; patients must take off work and arrange rides to and from the clinic, taking note of weather forecasts on the respective day. Additionally, FDA and insurance requirements for updating testosterone refills (but not estrogen, as I note) require patients to re-check lab values periodically before their providers are able to renew their prescriptions. In order to prepare for blood draws, patients have to time their last testosterone injection precisely so as to not skew lab values on the day of the appointment. They must also fast before the appointment. These acts of preparation before arriving at the clinic create time-maps that come into tension with the bureaucratic timing demands of lab draws, the length of time allocated per clinical appointment as required by clinic auditing mechanisms, and patients' ideal timing for hormone administration (typically every 1-2 weeks for injections). I will discuss how providers attempt to manage these tensions while working within the clinics' bureaucratic time constraints.

In the subsequent section I outline the kinds of time-maps that features and technologies of a clinical bureaucracy create, and discuss how providers at both clinics attempt to adhere to these dominant time-maps. I discuss the importance of staff role distinctions and the time representations they produce in the two clinics, focusing on the staff in Woodfield clinic, which features a proliferation of hierarchical staff roles. Physicians, physician assistants, medical assistants, and nurses each have particular tasks assigned to them and cannot perform tasks of another's role. These role boundaries impact when transition surgery letters can be signed and when patients can be scheduled for appointments. All Woodfield staff are audited by electronic health records (EHRs) in space and time, ensuring that bureaucratic workflow proceeds as planned throughout the workday. These time-related auditing constraints sometimes conflict with providers' and patients' goals for appointments. Although Woodfield's omnipresent auditing constraints are absent in Glendale clinic proper, healthcare policy and insurance requirements are not, and the Glendale practitioner accommodates these constraints by communicating with insurance companies directly to bring patients' transition timing goals in line with these dominant time-maps.

The transition timing plans patients envision for their bodies are as diverse as patients themselves. Some patient-participants wish to take hormones only until they achieve their desired appearance while others seek particular surgeries without taking any hormones. Providers at Woodfield and Glendale clinic work to meet these transition goals, but they also draw from their clinical knowledge about transition-related care to manage patients' desires against ways in which patients' existing habits sometimes negatively interact with hormone administration. While testosterone and estrogen are safe to take during transition, they must be taken at specific doses and do have contraindications, such as an increased risk for blood clots in people who smoke. In this section I discuss how providers negotiate hormone administration with patients vis-a-vis these risks, encouraging patients to eliminate risk factors in order to increase their hormone dosages to meet patients' desired transition timing.

In the final section in this chapter I discuss how bodily materiality creates its own time maps that can become discordant with provider and patient transition goals and clinical bureaucracy. Bodies can react negatively to methods of hormone administration as discussed above, or the effects of transition may occur at a faster or slower rate than the timing patients desire, as in Natalie's case. The timing of bodily change can come into tension with clinical bureaucracy amidst surgery delays under insurance denials. I discuss here how providers and patients manage such bodily time-maps within the clinics' bureaucracy.

Mapping the Clinic Commute

The majority of the patient-participants traveled at least one hour from their homes to attend their appointments at Glendale and Woodfield, with a few participants traveling 5 hours to the clinics. This substantial geographical distance creates time-maps that structure the workflow inside the clinics—even before patients reach the front desk. These geography-related time-maps can come into tension with routinized bureaucratic practices in the clinics as delays are created due to traffic, bad weather, or failure to secure appropriate transportation to appointments. I discuss here how providers and patients attempt to manage these disruptions to align delays with time-maps that favor patients' ideal transition pace, influencing how bureaucratic encorpment proceeds.

Prior to starting hormones or receiving pre-authorizations for hormones, patients must get labwork done to make sure existing levels are within normal ranges. Patients can either have labs done locally near their homes prior to arriving at the clinics and fax the results in, or get them drawn at the clinics during their appointments. Having blood drawn demands preparation days before showing up at the clinic. Patients must fast before they get their blood drawn and, if they are already taking hormones, need to time their last hormone injection in order to ensure that resulting testosterone lab values do not read abnormally high. In order to receive their testosterone prescriptions in a timely fashion, the patient will ideally arrive at the clinic having not yet administered their last hormone injection, and have fasted. This is the time-map that synchronizes with those that represent routinized bureaucratic workflow in the clinics. However, geographical distance can disrupt this ideal time-map in profound ways.

For some participants, the requirement to fast prior to appointments precluded them from receiving timely transition care. After taking testosterone injections for 7 months, Brett spent a year homeless and car-less, and thus ceased his injections for one year. He came in for his appointment at Glendale to have Molly clear him for another testosterone prescription, the mid-year appointment required by his insurance. Molly looks through his chart. "Ok," she says. "I'll have to get 6 month labs, right?" She tells Brett that he will get his labs done and then talk on the phone after his appointment. "Then, if everything's ok, I'll call you in" (i.e. she will renew his testosterone prescription). Brett interrupts Molly. "I can get labs drawn locally," he says. He explains that he has a health condition that in the past has interfered with testosterone and that he needs to monitor, and has arranged to get labs drawn at a hospital local to him that he will then send to Molly. Towards the end of the appointment, however, Brett reconsiders, telling Molly that he'll get his blood drawn later. He mutters that he can't make it without food for the hour and a half drive home. Molly quickly replies that there are openings at Glendale the following Monday. "I don't have Monday off," Brett replies. Molly tells Brett that any decision he makes is fine. "Whatever works for you, as long as you don't pass out at the wheel," she says.

Brett's experience managing the time-map created by geographical distance alongside seeking hormone renewal mirrored that of several patient-participants' who lived far from the clinics. In Brett's case, his existing health condition necessitated he complete his labs at a local hospital away from Glendale, which Brett then had to manage alongside the time it took to reach Molly for his mid-year appointment and drive home again. The consequence of managing these different time-maps for Brett was that he could not bring these time-maps into alignment with the time-map that would allow him to receive a testosterone prescription as soon as his labs were completed at his local hospital. Instead, the time-map created by his local hospital to fast his body and to assess his unique blood condition conflicted with the time-map created by the drive to and from Glendale clinic.

Other patient-participants experienced issues juggling geographical distance separating them from the clinic and the hope that they would receive their transition care in the timeframe they desired. For example, Jake, who also attended an appointment at Glendale, turned to me after Molly briefly left the clinic room to refill his "script" and said that his local pharmacy sometimes failed to text him to let him know his testosterone prescription was ready to be picked up. He has nine days to pick up his vial before it expires. "And it's kind of a drive. It's hard enough" he says. Moe, also a Glendale clinic patient-participant, usually arranged to ride with a friend to attend his appointments. He acknowledged the time strain geographic distance caused this way:

> "Because it's a distance away like that, it takes some… I have to work my job around it and hope that nobody's going to need me. And I have to hope that nothing crazy is happening with construction or something out there so I can get back in time for work and have to hope that there's no accidents on the highway, and there's just a lot of variables when you suddenly have to travel so far for a doctor's appointment. Especially when you have other shit that you have get back to do in the end" (Debriefing interview with Moe, Glendale clinic).

For patients like Moe who do not have access to a car, the necessity to secure transportation over the long distance to appointments represented an additional factor that impacted the relationship between time-maps occurring inside and outside the clinics. Maya, a patient-participant attending Woodfield clinic, came into her appointment with her mother, who was also her ride there. Maya was excited to learn that she would be able to get her legal name changed. After a pause Janet commented that Maya's mom is here for support, but that a lot of people don't have that. "That's really sad when you say it," Maya says. "It's true," Janet replies. Later during her phone interview, Maya mentions that her mom asks to attend every appointment with her, in support of her. I ask her if the distance to the clinic affects the planning process with her mom and she replies,

> "Yes it definitely affects things. My mom is a *very* busy woman. With her normal work, she's a rescue… she does so much stuff that it's always shoehorning these appointments,

> but she does it ‘cause she loves me. So yeah, that’s why I say I have an excellent support system” (Debriefing interview with Maya, Woodfield clinic).

I asked Maya what she meant by “shoehorning” appointments, and Maya said, “You somehow make time.” She told me that she missed a couple of appointments because her mom received calls about dogs that she needed to pick up. “And she’s a hero to those dogs so she drops everything to rescue the dog.” Maya’s attendance at her appointment is predicated, then, on the time-map her mother’s job creates. Important to note here is that economics—the means by which a patient is able to travel to the clinic—is one of many factors that might influence patients’ commute. For Maya, her mom’s support at appointments carried emotional significance for both Maya and her mom. Complications that sometimes arise as this time-map collides with that of the clinic’s appointment workflow still allow Maya to attend most of her appointments when these time-maps come into harmony. Patients who have no personal means of transportation and no support system cannot attend the clinics at all.

When time-maps created by geographic distance clash with clinic time-maps that synchronize with patients’ transition plans, healthcare providers at Glendale and Woodfield clinic manipulate several aspects of routinized clinic workflow—aspects directly interacting with distances travelled—to make these time-maps congruous. Providers at both clinics manipulate bureaucratic documents, pharmacy supplies, and financial plans to make it easier for traveling patients to receive their care as close to the day of their appointments as possible. Providers not only address the common abovementioned issues with prescription pickup timing, which involves coordinating with pharmacies outside of the clinic, but they also assist patients in bringing clinics’ workflow time-maps into synchronicity with patients’ bodies.

Because it is considered a controlled substance, healthcare providers must renew testosterone prescriptions every six months under FDA regulations—or sooner under certain insurance plans like UnitedHealthcare community plan. This requires that patients schedule appointments to have labs assessed with their provider within these timeframes. While testosterone falls under this FDA requirement, providers do not have to preauthorize estrogen and it is not nearly as regulated. Sometimes, providers' preauthorizations take time to be approved under patients' insurance, leaving patients—who have already been instructed to prepare for labs by coming in a week out of their last injection—without their testosterone prescriptions.

At Woodfield, the pharmacy is located in the same building as the clinic. After I heard Janet tell a patient to come back up to the clinic if his insurance did not cover his testosterone and asking her why she told him that, she responded that health staff at Woodfield show patients how to inject themselves with their first dose during the clinic appointment, discussing with the patient proper technique of injection—which involves many steps—and appropriate injection sites. One effect of this demonstration dose is that the shot lasts about two weeks in the body, giving patients' insurance enough time to approve the preauthorization. "That way, they won't have to go home with nothing," she said. Through this initial demonstration dose, Woodfield providers are able to synchronize distance- and policy- related time-maps to patients' ideal time-maps for transition.

Both Glendale and Woodfield clinic manipulated aspects of the clinic bureaucracy to manage distance-related pharmacy delays that conflicted with patients' transition plans. These manipulations structured whether bureaucratic encorpment occurred in such a way that patients' transition plans were realized. Woodfield providers took advantage of the location of the pharmacy by advocating to make patients' injection needles free of charge and arranging for patients to pick up prescriptions in the building. The pharmacy is also able to directly mail testosterone vials and needles to patients who live out of town as soon as prescriptions are approved. The package usually arrives in two days.

At Glendale, staff softened the impact of financial strain on patients who did not have insurance or who faced unexpected bills during the testosterone timeline mandated by the FDA. One Glendale patient called the clinic in tears after their provider in another state erroneously ordered extra labs to check hormone levels in addition to six month labs, leaving the patient with a $300 bill. Administrator Sarah immediately put the patient under Glendale's flexible payment plan to take care of the bill over a six-month period, rather than upfront. Both clinics were also forgiving when patients "no-show'd;" at Woodfield clinic, Dr. C refuses to fine patients for failing to show up for appointments. Thus, by manipulating time-maps within the clinics to account for the long distance most patients travel, providers are able to align time-maps created by broader policy and insurance requirements to realize the ideal transition time-maps of their patients.

Breaking Role Boundaries to Manage Time

The organizational culture of Woodfield and Glendale clinics influences how healthcare staff and patients manage time-maps that conflict with patients' goals for transition, contributing to the ways that bureaucratic encorpment unfolded. Woodfield is structured like a typical biomedical clinic bureaucracy, with a proliferation of hierarchical staff roles, auditing technologies, and documentary practices, while Glendale clinic purposely refuses such hierarchy and surveillance (Weber 1947, 1978; Murphy 2012; Morgen 1995). The necessity to maintain hierarchical and distinct roles at Woodfield impacted how time was managed at this clinic. Each role at Woodfield entails specific tasks that only a person in that role can perform (as the anthropologist quickly learned on the first day of fieldwork when I asked if I could help out with clinic tasks). These task distinctions created time-maps that coincided but also sometimes conflicted with the ideal time-maps patients envisioned for transition.

Some patient-participants who saw Janet for their appointment and needed signed letters for approval to legally change their birth certificate gender marker had their plans put on hold due to the boundaries of her staff role. To get these letters, the provider must document “permanent changes” on the body, such as breast tissue growth for patients taking estrogen and voice changes for patients taking testosterone, and compose a signed letter listing these changes. Successfully changing one’s birth certificate gender through the signed affidavit clears the patient to then update their health records with the new gender marker as well as other basic legal documents such as drivers’ licenses and passports. During appointments, Janet informed all of these patients that she could not sign these letters, only someone with an MD (like Dr. C) could. Unfortunately, not all staff were aware of the tasks Janet was allowed to perform. One afternoon, I overheard Janet sharing her frustration with a nearby medical assistant in the staff room. Apparently, someone at the front desk had scheduled a patient who wanted a gender marker change with Janet, but had not realized that PAs are unable to sign affidavits. Janet sighed; this is the second time this had happened in the past week. The scheduling staff’s confusion over Janet’s role specifications potentially produced a time-map that delayed the patient’s timeline for transition. This particular role boundary is further complicated by the fact that Dr. C had fewer scheduling spots per clinic day available to fill with appointments.

As mentioned previously, the same software that displays electronic medical records also audits healthcare staff in real time throughout the workday. As I will discuss extensively in Chapter 5, this clinic-wide software not only audits staff in real time but also staff and patients’ positions in space. Inside the staff side of the clinic, there is a large patient board displaying this software that everyone looks at as the day progresses. The display lists the status, clinic rooms, patient names, gender markers, and short descriptions of each clinic visit. One of the features of the software is to ensure front desk staff check patients in on time and document the time patients sit in the clinic rooms before providers enter to see them. The software tracks staff's task completions visually through an array of colored flag icons that maintain the flow of the clinic. For example, if an icon next to a clinic room number on turns red, it signals to clinic staff outside the room that the patient has been waiting in the room for more than 15 minutes. Throughout the day staff must orient their role-specified clinical activities to align with this dominant auditing time-map, but at times this map came into conflict with the time-maps providers and patients created in clinic rooms during appointments. This necessitated that some staff step out of their roles to ensure clinical activities adhered to this dominant auditing time-map.

One very busy afternoon at Woodfield, I had just finished consenting a patient-participant and walked out of the clinic room to the staff area when I noticed one of the medical assistants (MA), Sandra, looking at the patient board intently, then looking back at the closed door to the clinic room where Dr. C was in with a patient. She looked back and forth between the board and door several times. "Ok," she finally says to the staff within earshot. "I'm gonna beep her." A minute later, I watch as Dr. C emerges from the clinic room with her back to us, waving goodbye to the patient. I ask Sandra if she beeped Dr. C to give her an excuse to get out of the room. "Mhmm," Sandra replies.

MAs, who are responsible for checking patients into clinic rooms and taking vitals, frequently also performed the task of moving clinic workflow along, especially on clinic days with patients scheduled to or past capacity. Watching the overhead board for red flags, MAs would peek into the rooms of patients, apologize for the delay, and explain the current task Dr. C was completing, such as, “I’m waiting for her to sign your labs,” or “she’s almost finished with the patient right before you.” MAs communicated with patients prior to their appointment arrival as well. One MA explained that she gave patients with a history of lateness “fake arrival times” (earlier than their actual time) and encouraged patients to narrow down their issues to just one per visit. Although unable to step into the boundaries of a physician’s role, MAs stepped out of their own, manipulating bureaucratic technology and reaching out to patients outside of appointments to conform their time-maps to the dominant auditing time-map of the clinic.

It is worth noting that my own presence at Woodfield clinic—specifically, the necessity to consent patients before appointments—sometimes interfered with staff’s efforts to coordinate clinic practice with auditing time constraints. On average, patient-participants spent seven minutes reading my IRB consent form between the MA’s exit and the physician’s entrance into the room. Sometimes, patients spent a longer time reading the form and Dr. C would enter the room before patients could complete the consent. In one case, Dr. C came into the room to begin an appointment with a patient who had not yet finished reading the consent form, and this patient was disappointed that she could not sign the form in time to participate. Such activities suggest that while performing their own roles, anthropologists become incorporated into the bureaucracies they study and their corresponding time-maps, a phenomenon I discussed extensively in the introductory chapter.

One Provider, Many Time-Maps

The proliferation of distinct hierarchical roles apparent at Woodfield contrasted with the situation at Glendale, where a handful of staff performed several roles. Molly, the sole practitioner while I was completing fieldwork, coordinated several aspects of client care, from providing care to personally connecting with pharmacies to billing. Molly seemed grateful when students rotated through the clinic. As she watched a nurse practitioner student run a test in the clinic's small test room, Molly once leaned over to me, whispering, "Students are wonderful. They just come in and… do my job." At Glendale, there is no boundless software auditing staff and patient workflow. Appointment spots rarely fill up during the week, and Molly spends a variable amount of time with each client, depending on their care needs. I also never felt any time pressures during the consent process. Just like at Woodfield, clients can receive hormone prescriptions and have letters notarized for surgery when irreversible bodily changes appear. However, at Glendale, complying with the time-maps of broader healthcare and insurance policy highlights that the responsibility for harmonizing patients' time-maps with these dominant maps lay with the same person who had the most contact with clients.

When clients were not sure which pharmacy to send their prescriptions to, Molly tracked down the client's pharmacy if the client was unable to give her their pharmacy's phone number. She also communicated directly with insurance companies if they raised questions about something she wrote in an encounter form for a client that did not conform to the plan's gender-normative terminology. She repeatedly called UnitedHealthcare, the federal community plan that requires clients to complete labwork every three months, to complain that the plan should follow WPATH (World Professional Association for Transgender Health) guidelines, the most agreed-upon standard of care among health professionals (Coleman et al. 2011). "But they use Endocrine Society's standard of care for 60-year-old men instead. I've tried to tell them countless times. They don't care," she told me once. Requiring patients to adhere to Endocrine Society's standard of care forces patients to coordinate their time to attend appointments every three months, which conflicts with the FDA's requirement for patients taking testosterone to complete labwork every six months. As stated above, such delays can disrupt patients' abilities to secure transportation and prepare for labwork in ways that satisfy patients' plans for transition.

In order to keep clients accountable to the FDA six-month labwork requirement for testosterone, Molly tells each client to call the clinic as soon as they notice they are on their last refill to set up an appointment. She recited the same phrase to each client: "Poor planning on your part is not an emergency on my part." She usually followed up this phrase by telling clients that she will work with them if "stuff happens" and the clients cannot make it to the clinic due to travel issues, but will be less forgiving with repeat no-shows. In bureaucracies with very low differentiation of specified tasks, then, a select few people may be tasked with coordinating multiple, simultaneously occurring time-maps.

Managing Patients' Transition Plans

Medical transition means something different for every patient. For one patient, transition might only entail taking hormones for a short period of time until they achieve the desired bodily changes, while for another it might mean seeking a particular transition-related surgery such as mastectomy while taking no hormones at all. Additionally, testosterone and estrogen achieve different bodily changes at different rates, and their activity in the body sometimes negatively interacts with patients' existing food habits and lifestyles (Cavanaugh et al. 2015). Providers must balance patients' lifestyles and hormone administration on one hand, and patients' ideal timing for transition on the other. Woodfield and Glendale providers did this largely by bargaining with patients, telling them that they will increase hormone dosages on the condition that patients reduce or eliminate lifestyle habits that have the potential to cause poor health outcomes when continued with hormones such as blood clots.

Smoking while taking either estrogen or testosterone is associated with a higher risk of experiencing venous thromboembolism (VTE), a condition wherein a blood clot forms in a vein and then either manifests in deep-vein thrombosis or a pulmonary embolism (Wierckx et al. 2012). Given this risk, providers either prescribed a low dose or refused to prescribe hormones altogether to patients who smoked. Taking a lower dose of either hormone corresponds to slower changes in the body over time, a phenomenon undesirable to most patients. In order to reduce or eliminate risks of hormone complications, providers bargained with patients, telling them that eliminating smoking would allow them to prescribe hormones at a dosage that would synchronize with the pace of transition patients desired.

Such an exchange occurred at Woodfield between Dr. C and Zinnea, who had come in to get her hormone levels checked. During the appointment, Dr. C told Zinnea that she needed to get to 2 years of breast growth on estrogen before Dr. C could add progesterone, a hormone that assists in giving breasts a rounded shape. But, Dr. C said, she can send for spironolactone and finasteride. Dr. C explained that these medications work together to block the testosterone Zinnea's body is currently making. "The more I can control the heart risk, the more I can go up on estrogen," she tells Zinnea. "You have to lower smoking; the more you stop the faster I can increase estrogen." "I'm thinking of quitting," Zinnea replies. Dr. C tells her that quitting is the right thing to do, because smoking (including secondhand smoke) increases stroke risk and blood clot risk.

This dialogue between Dr. C and Zinnea illustrates how providers typically approached this practice of bargaining patients' desire for an ideal transition time-map against lifestyle habits that could interfere with the hormone levels needed to achieve this ideal pace of transition. In addition to smoking cessation, providers at both clinics also bargained the realization of ideal transition time-maps against conditions such as obesity and high blood pressure. As these conditions likewise raise the risk for VTE when interacting with hormones, providers encouraged patients to reduce their salt intake and eat foods with a low glycemic index before raising hormone dosage. Managing healthcare needs alongside patients' transition timelines represented an additional factor that shaped how bureaucratic encorpment proceeded in the clinics.

Agentic Bodily Time-Maps

At times, patients' ideal pace for bodily transition clashed with their bodies' own time-maps emerging from patients' unique biological histories (Davis 2014). The agency of patients' bodily materiality in these cases likewise influenced how patients were able to embody gender in accordance with patients' transition plans. Providers and patients needed to adjust for these time-maps within clinical bureaucracy, impacting how bureaucratic encorpment proceeded. As mentioned above, allergic reactions can occur from injections with testosterone suspended in particular oils, which providers and patients then have to work around to approach patients' desired transition time-maps while trying to synchronize these time-maps with bureaucratic ones. One solution for this rather common issue was that patients taking testosterone injections could switch over to another form of administration such as the gel or patch. However, bodily changes under these other routes of administration are slower, and these other forms might not be covered by insurance. For instance, Brett's insurance, UnitedHealthcare community plan, covers injections but does not cover these other forms. Starting testosterone again after a one-year hiatus left Brett in a state of confusion over what was and was not covered under the Medicaid plan. As he shared his thoughts with me later about how he was going to address the oil composition issue, Brett elaborated that the solution of switching from one form of testosterone to another involved a great deal of personal maneuvering within gender-normative clinical bureaucracy:

> "Before I add anything else to the mix I wanna make sure that Medicaid's actually gonna cover it, because if they're not then I might as well see if I could do the gel or the patch. Since I'm gonna be paying out of pocket anyways I might as well get what *I* want. And so that's kind of been where I'm at, just advocating for myself and trying to figure out like, 'Well if I can get myself on T long enough to feel better inside my own body then it'll be much easier to advocate for myself.' So there's some things like attempting to change my name or trying to get my gender marker changed, or just dealing more directly with things like picking the right compound. I feel like I'm putting it into the basket, putting it off to the side, and so I feel a little bit better. But given that I'm having a reaction to the cottonseed oil, before I go to the pharmacy next time, I'm gonna call Glendale" (Debriefing interview with Brett, Glendale clinic)

From Brett's explanation, we can discern the complex interplay between bureaucratic, personal, and bodily time-maps. Brett discusses the importance of taking testosterone long enough to get him to the point of feeling comfortable enough to advocate for his care on his own behalf. Examining this conversation through the lens of time-maps, Brett strives to bring the time-map of his body into harmony with the pace he envisions his body to take. Once Brett's priority to synchronize these two time-maps is completed, he will then set about synchronizing these maps with bureaucratic time-maps for legal gender marker changes. As he continues talking about his plans, it is clear that Brett must manage several particularities of gender-normative pharmacy bureaucracies, whose time-maps delay Brett's ability to have his testosterone appropriately compounded or switched out.

> "The pharmacy didn't seem to know who I should contact. And this happens a lot, where like I need to get it compounded somewhere else and because all of these different groups aren't used to dealing with transgender people in the first place, they sort of panic when I ask for anything specific and they'll be like 'I don't know who you should talk to.' And so, so it's all on me to figure it out. And so what do I… do I just start calling random pharmacies hoping that I talk to the right person? [laughs] You know? How do I even find out who compounds it? So, I'm gonna call Molly and see if she can at least point me in the right direction" (Debriefing interview with Brett, Glendale Clinic).

Whereas Brett's difficulty navigating gender-normative pharmacy bureaucracy primarily delayed his plans for transition, patients' insurance plans sometimes conflicted with patients' planned timelines for transition with negative direct consequences for bodily materiality. Emma, a Glendale client who came in to increase her estrogen dosage, shared with Molly that she planned to have an orchiectomy soon as she had been experiencing testicular shrinkage that was causing her pain. Emma tells Molly that her insurance is good for the most part, but it does not cover anything related to "sex change." "You have to be careful," Molly immediately replies. "How to word it—you need to understand their terminology." Molly tells Emma (as she has told many clients) that insurance companies are always looking for keywords. Perhaps her insurance would cover her transition care under "sexual transition," instead of "sex change." "Ooh," Emma says. "So they might cover it under 'sexual transition.' I'll call in about that." I asked Emma later what she thought about this new information and she prefaced her response by informing me she had some prior familiarity with how insurance works, and continued,

> "Everything that you do boils down to the letter of what is written. You know, sex change is a very interesting diagnosis to put because sex change is not medicinally nor psychologically recognized… But what she was saying is that 'it depends on the diagnoses that I give you. If I say it's gender dysphoria it won't be covered. But if it's due to…' Which is true, this is actually true… Full disclosure, so my testicles tend to get quite sore for a multitude of reasons… And also with the way that I walk—I walk in a very feminine gait now and I put a lot of practice and time into how I walk—well, that keeps my thighs very close together which creates a lot of friction and a lot of rubbing and it causes *a lot of pain.* And so if it's written as a medicinal necessity just due to pain or I don't know what she would write it under, I'm not in the medical field but that could be covered. Whereas the exact same surgery due to dysphoria would not be" (Debriefing interview with Emma, Glendale clinic).

Emma's explanation illustrates the discordant relationship between the time-map of her insurance policy marked by delays due to specific terminology requirements, that of her own plan for transition which included plans for an orchiectomy, and the time-map of a body experiencing testicular shrinkage. Emma's insurance policy rejects certain terms for coverage of transition care—either "sex change" or "gender dysphoria." The process of spending time to figure out which keywords are correct potentially conflicts with Emma's bodily time-map as her body changes during transition. The bodily pain this insurance delay contributes to is further exacerbated as Emma performs her gender. In other words, the failure of insurance to embody Emma's bodily materiality due to unmet terminological requirements translated into a difficulty for Emma to embody what she envisioned as a feminine body comportment.

Conclusion

At Glendale and Woodfield clinics, several temporal representations simultaneously occurred and either harmonized or conflicted to lead to a particular manifestation of bureaucratic encorpment in the two gender-affirming health clinics. Providers and patients must coordinate patients' ideal plans for transition against dominant bureaucratic technologies and against patients' own bodies. In this chapter I have isolated and described how this coordination individually shaped patient-participants' abilities to realize the ideal plans for transition they had for themselves and in turn shaped bureaucratic practice, culminating in discernable paths of bureaucratic encorpment. Utilizing Bear and colleagues' conceptual tool of "time-maps" to analyze providers' and patients' daily interactions with gender-normative clinical bureaucracy, I have shown how factors such as the distance a patient must travel, bureaucratic roles in the clinics, and providers' accountability to healthcare policy directly structured patients' abilities to align their desired transition timing with their bodies. Attending to these time representations individually outlines the contribution each has in shaping possibilities for patients to achieve gendered embodiment they consider ideal. By investigating how power is distributed among these time-maps we can begin to identify specific points of disharmony and target resources to eliminate social inequalities produced by these areas of temporal friction, such as clinic access issues arising from travel distance. Outlining the previously unexamined role of bodily time-maps as I have done here further refines this effort.

Transition is not a single, discrete event but a long-term process each individual experiences differently. As I detail in the final chapter of this dissertation, attuning to the unpredictable variability of bodily responses to particular features of bureaucratic practice reveals the creative possibilities of embracing rather than fearing uncertain futures, central to current theoretical discussion in the fields of anthropology and of design (Pink et al. 2018). Instead of viewing uncertainty as threatening—as something to avoid—anticipating the emergent and unpredictable effects of constantly interacting bodily and bureaucratic temporal representations gives us space to carefully track how the parameters of each representation shift and change in relationship to others and harmonize in ways that produce positive outcomes for patients. Centering uncertainty as an inevitable feature of bureaucratic and bodily practice similarly allows us to understand how technologies like electronic medical records are actively repurposed toward innovative ends that favor gender non-normativity, as I will discuss in the subsequent chapter.

CHAPTER 3: REPRESENTING THE GENDERED BODY IN HEALTH DOCUMENTS

Today at Woodfield, I'm attending appointments with Janet, the physician assistant. The first patient I consent is college student Matthew, who has come in for a follow-up appointment to check his lab levels so he can get a testosterone refill. Janet asks how he's doing and he smiles and responds that he recently overheard his mom tell one of her coworkers that she has two sons. Janet is happy to hear this.

We leave the appointment room and Janet enters another appointment while I take a seat in the staff area. Soon after, one of the medical assistants (MA) asks me if I knew whether Matthew needed a doctor's note for school. I'm caught off guard that she'd asked me and told her I didn't remember that being discussed during the appointment. She recalls that he does need one. The MA sits next to me and starts working on a template in the electronic health record (EHR) software for Matthew's doctor's note. She completes the note, prints it out, and walks out to the waiting room to hand it to Matthew. As she walks back into the staff room she realizes that she had left his 'dead name' (name given at birth) in the letter, as it had automatically populated in the template. Another MA, Sandra, stood nearby, and I overhear the MA discussing the situation with her, visibly upset. "I'm gonna go out and say something," the MA says. She disappears out into the lobby again, then comes back, agitated, and says that Matthew has left. Sandra says, "just call his cell phone." The MA does so. I overhear her side of the phone conversation as she sits next to me. "I didn't realize the computer entered the assigned name before I printed…" The MA seems to relax as she listens to Matthew's reaction on the other line. "Alright," the MA says. "I just wanted to check and make sure" (Observational field notes, Woodfield Clinic).

In this chapter I examine how bureaucratic encorpment occurs through the use of a ubiquitous U.S. bureaucratic health document—the medical record—as providers work to represent patients' varied gendered embodiments in this gender-normative bureaucratic document to meet patients' healthcare needs. In 2009, a federal initiative to standardize electronic health records (EHRs) in medical practices took off with great success; 96% of non-federal acute care hospitals have implemented this technology at the time of this writing (ONCHIT n.d.). An ultimate goal of the EHR is interoperability—facilitating the communication of patient data across healthcare institutions (Steinbrook 2009). Language in the technology is standardized via the presence of a set of available diagnostic codes. A drawback of this standardization for interoperability, however, is that, through their use, EHRs translate complex patient lives into discrete, simplified data points to be tracked. During this process, patient bodies are "abstracted from real time, actual location, and social space" (Lock 1993, 371; see also Merry 2011). Additionally, EHRs function as surveillance tools, monitoring how patients' health changes, which carries consequences for insurance coverage (Ruckenstein and Shüll 2017).

Built into the medical record is the cultural assumption that gender is static and follows the dominant two-sex, two-gender model (Fausto-Sterling 2000). In gender-affirming health clinics, providers must interact with medical records to provide healthcare for patients who are in the process of changing a standardized indicator in a record that is not understood to change: gender. Indeed, the two possible gender markers M and F cannot be changed in the EHR without an affidavit (a court order). Providers at Glendale and Woodfield clinic engage in several practices to ensure that patients' complex gendered embodiments are represented in medical records, and these daily practices structure how bureaucratic encorpment unfolds in ways that serve or do not serve patients' transition care needs as providers and patients engage with these documents. The opening vignette with physician assistant Janet and patient Matthew provides a glimpse into the constant bureaucratic practices providers must participate in to actively notice and challenge existing gender-normative language in healthcare documents.

Observing how providers purposefully challenge language in EHRs in situ complicate often-discussed notions in anthropology such as Foucault's concept of "technologies of self," which relies on the idea that the possibility of surveillance rather than surveillance itself engages subjects in self-discipline as they police their own behavior in light of broader modes of governance (Foucault 1988). However, I show that in gender-affirming health clinics—established to provide healthcare for patients whose gendered embodiments often do not correspond to dominant biomedical discourse—providers specifically refuse to internalize particular practices of self-governance vis-à-vis the EHR that uphold gender-normative assumptions about patients' health and bodies. In fact, adhering to routinized engagements with the EHR actually served to negatively impact the very patient population the clinics emerged to provide healthcare for. In this chapter I discuss how providers' and patients' intentional situated engagements with bureaucratic clinic documents created paths of bureaucratic encorpment that affirmed patients' gendered embodiments in the two clinics, and conversely, I detail how routinized engagements with these documents in clinics unfamiliar with transition care led to trajectories of bureaucratic encorpment that did not incorporate diverse gendered embodiments.

In cases where they cannot represent non-normative gendered embodiments in healthcare documents, providers manipulate existing gender-related language in the EHR to ensure patients receive appropriate transition-related care within the clinic. As the opening vignette indicates, providers were explicitly careful not to allow the reproduction of gender-normative language in this healthcare technology just as they were accountable to automated features of the EHR that interfered with this goal. In this chapter I provide a brief history of the emergence of standardized EHR technology and examine the complex exchanges between the clinical record and providers' clinical practices, detailing how this document structures possibilities of gendered embodiment at the same time providers and patients actively modify the technology through bureaucratic practice. I focus on four common domains wherein providers worked to make visible patients' shifting embodiments in the medical record. By manipulating existing digital fields in the EHR, providers were able to directly represent non-normative gendered embodiment in the medical record. When direct manipulation of fields was not possible, providers interpreted polysemic terminology in insurance plans, which led to coverage for patients without directly challenging insurer's understandings. In comparison, I discuss how providers' privileging of existing gender-normative language in EHRs carried social consequences for patients, an unfortunately frequent occurrence as patients recounted visits to clinics that were not specialized to provide transition care. In the final section of this chapter I outline practices in which providers strategically utilized patients' bodily materiality in paperwork to ensure patients received appropriate care. These four domains highlight limits and possibilities toward broad-scale change in EHR technology through bureaucratic practice, and demonstrate how language in the EHR and associated bureaucratic constraints for transition care structure patients' possibilities of gendered embodiment. In other words, these domains demonstrate how providers work to represent patients' gendered embodiments in healthcare documents, creating paths of bureaucratic encorpment that address patients' healthcare needs when their actions succeed.

The materiality of bureaucratic technologies, specifically the ways different material forms enable particular kinds of interactions while foreclosing others, is paramount to examine in order to understand how situated bureaucratic practices bring healthcare bureaucracy into being

(Hull 2008; see also van Eijk 2019). Electronic and paper medical records enable different kinds of engagements and are read by different audiences. I demonstrate how providers inscribe gender-expansive patients' bodily materiality within electronic and paper documents in ways that achieve access to transition healthcare for individual patients, but produce variable wider spread consequences for gender-normative healthcare bureaucracy.

The Emergence and Effects of EHR Standardization

In 2009, the U.S. American Recovery and Reinvestment Act provided financial incentives for providers to adopt standardized health information documents such as EHRs with the intended goal to increase interoperability between U.S. healthcare practices (Steinbrook 2009). Discrete diagnostic codes embedded in EHRs index diagnoses and provide reference for providers writing up clinical notes. Some 140,000 codes encompass what are called ICD-10CM and ICD-10PCS systems, which comprise a set of codes that reflect reasons for clinical visits and diagnoses and a set reflecting procedures and services performed at the visit, respectively (CDC 2020). As with the broader goal of EHR adoption, these standardized codes are meant to make it easier for providers, EHR software, and healthcare institutions to communicate using uniform terms.

However, in contrast to other Western countries that have implemented EHRs, in the United States individual providers, private and group providers, hospitals, and long-term care and ambulatory centers are constantly in competition with each other and have different levels of financial resources. This circumstance interferes with the federal goal to standardize electronic health technology (Anderson 2007). This disparate landscape is apparent at the two field sites; while Woodfield clinic has adopted one of the nation's most widely used EHR software packages, at Glendale providers primarily rely on paper medical records to document appointments, copying details of these appointments into a less widespread but cheaper EHR software. This discrepancy in technology adoption influenced the abilities of providers at the two clinics to represent patients' gendered embodiment in clinics' bureaucracy. For instance, Woodfield clinic's EHR's quality auditing feature necessitates that Woodfield providers document clinical activities according to specific documentation requirements of the EHR that connect to billing, which include fields that link specifically to M and F gender markers. These requirements created constraints as Woodfield providers attempted to integrate patients' gendered embodiment into this technology. Failing to represent patients' embodiment in EHRs and instead prioritizing existing EHR language at times led to a dismissal of patients' subjectivities, contributing to the depersonalization of the patient in healthcare in favor of health technology standardization (Timmermans and Almeling 2009). This was apparent as patients recounted to Woodfield and Glendale providers their unsatisfactory appointment experiences at clinics unfamiliar with transition healthcare, as I will discuss in this chapter.

In medical records, providers must relate patients' diagnoses to appropriate codes with extreme precision. For example, for the 120 ICD codes that link to diabetes, providers must specify the type of diabetes, details about diabetes complications, and whether the patient is receiving insulin for the codes to be accepted for billing (Hunt et al. 2017). Although ICD codes for conditions like diabetes are consistent, it quickly became apparent during my fieldwork that diagnostic codes relating to transition care were much less so. These dissimilarities reflected insurance companies' varied understandings of what transition-related care entailed. Providers at both Glendale and Woodfield clinic employed creative coding strategies to ensure coding appropriately reflected patients' gendered embodiments and trajectories for transition, at times utilizing these inconsistencies, as I will demonstrate in this chapter.

Given the large breadth of gender-normative language contained in the EHR, it is crucial for providers to build strong rapport with gender-expansive patients in order to accurately represent their gendered embodiment in these records. However, literature examining providers' use of EHRs in the clinic have repeatedly suggested that EHR use preoccupies the provider's time reserved for the appointment, leading to reduced rapport with the patient (Dillard-Wright 2019; Kazmi 2014). As demonstrated through the experiences patients recounted with past providers in this chapter, when providers privilege existing gender-normative language in medical records over accounting for patients' existing gendered embodiment, or are unable to challenge this gender-normative language, these practices can directly lead to denial of health services for patients, leading to paths of bureaucratic encorpment that constrain possibilities for gendered embodiment.

Studies of the implementation of EHRs, or its "meaningful use," overwhelmingly examine *whether* providers are incorporating the technology into medical practice (e.g. Declerck and Aimé 2014; Jones et al. 2014), but studies analyzing *how* providers and patients actively interact with the technology to understand the specific processes that lead to success or failure of its adoption are few (Sangaramoorthy and Benton 2012). Observational ethnography in gender-affirming health clinics reveals both the specific gender-normative assumptions underlying EHR technologies as well as the everyday practices providers and patients employ to challenge these assumptions when they clash with patients' non-normative embodiments. Examining providers' and patients' engagements with EHRs allows us to understand how people implicated in systems of enumeration in health "experience and identify with the categories that emerge alongside and in tandem with techniques of enumeration" (Sangaramoorthy and Benton 2012, 288). Health technologies like EHRs shape patients' possibilities for gendered embodiment just as providers' and patients' interactions with EHRs reconfigure the governance of this technology (Sangaramoorthy and Benton 2012). This mutual relationship illustrates the process of bureaucratic encorpment at the level of the bureaucratic document as providers and patients work to mediate the co-construction of bureaucratic practice and bodily materiality in ways that meet patients' healthcare needs.

Below, I detail how providers engaged in several consistent practices that directly challenged the gender-normative assumptions of language embedded in the EHR, which they then mobilized to travel beyond the clinic by taking advantage of the interoperability mandate of the technology's standardization. Woodfield's EHR has incorporated a field for patients' preferred names, but at the time of fieldwork there was no default field to represent patients' pronouns of use or history of transition care. Providers utilized existing features of the EHR to make pronouns visible to healthcare staff within and beyond the clinic, organized columns on the patient board to list patients' preferred names ahead of their legal names during the workday, and created their own templates to represent patients' histories of transition. Utilizing the record's free note section, Woodfield providers took advantage of the EHR's capacity to travel beyond the clinic, refashioning it as an educational tool that became visible to other providers, billers, and pharmacies as these other entities received patients' records. Through these practices, providers were able to directly modify EHR terminology to account for patients' shifting embodiments, and bureaucratic encorpment thus proceeded in a way that represented patients' transition plans.

In the following section, I outline how existing language in the EHR created different understandings of gender for providers and insurance companies as providers interacted with gender-related language in this technology. As mentioned above, insurance plan language relating to gender-affirming surgery varies widely. Interpreting which terms to use to code for diagnoses related to transition care to match insurer's understandings was often a trial-and-error process for providers, and Woodfield and Glendale providers navigated communication with individual insurance companies differently in light of clinics' existing institutional resources. In some instances, providers were unable to negotiate with insurance companies or code in a manner that reflected the patient's embodiment or health service needs. These cases occurred predominately when gender markers in the EHR, which patients cannot legally change without an affidavit, either continued to list the gender marker reflecting the transitioning patient's assigned sex or did not contain additional context to signal patients' transition process. Failure to change EHR gender markers had the potential to lead to drastic and even life-threatening consequences for patients when patients faced denials for gender-related care. In these cases, bureaucratic encorpment unfolded such that patients' gendered embodiments were overlooked as gender-normative language in the EHR remained intact, interfering with providers' abilities to fulfill patients' healthcare needs.

In the subsequent section I discuss consequences that occurred as providers at clinics unfamiliar with transition-related care complied with gender-normative terms in the EHR as part of routine bureaucratic practice. Providers at both clinics purposefully attempted to avoid engaging in this practice and thus here the practice was rare. However, the stories patients recounted to providers and later in interviews regarding negative experiences at past clinics brought into sharp relief the effects that privileging gender-normative EHR language through routinized bureaucratic practice had for patients at clinics unfamiliar with non-normative gendered embodiment. Patients' experiences further highlight the centrality of the medical record as a key mediator between providers and patients' access to transition care and an essential object in the creation of paths of bureaucratic encorpment that serve diverse gendered embodiments.

There are several ways that providers interpreted the body materiality of gender-expansive patients and translated this interpretation into the medical record to ensure care for patients and affirm patients' plans for transition care. In the final section of this chapter I describe two of the most common ways this occurred. The first, the physical exam, was a procedure providers performed to determine whether "permanent bodily changes" existed in the body for approval for transition-related surgeries. Providers also strategically encouraged patients to use focused conversation with surgery letter-writers that harmonized patients' need for transition care into terms that matched insurance companies' understandings of medical necessity. These strategic bureaucratic practices created avenues of bureaucratic encorpment that simultaneously met federal requirements for changes in legal paperwork and hastened patients' access to desired transition healthcare.

Communicating Patient Embodiment Through the EHR

I am sitting in the health staff waiting area of the Woodfield clinic, or "pod," as the staff called this area. The pod is an area filled with a row of computers where staff sit between appointments, documenting appointment visits throughout the day. In the pod, staff usually signal the computer they intend to sit at by placing coats and bags on the chair. On this day, Woodfield clinic had several visitors here to shadow Dr. C. during the day's clinic, including a facial surgeon who told me she had come down to the clinic to learn more about it, and a gynecologist. Across the room Dr. C. explains the process of gaining access to shadow the clinic to a visiting resident and doctor. Because Woodfield attracts many health professionals who are interested in learning about the healthcare of gender and sexual minorities, the process of gaining access to shadow in the clinic is quite long.

Dr. C. is not the only staff showing the visitors around the clinic; the MAs show the visitors the various ways this clinic is different from what they are used to. Today I am sitting at a computer station between the gynecologist and a visiting nurse practitioner who works in the larger adjacent hospital. One of the MAs comes by our stations to show us where preferred pronouns go in a patient’s chart on her computer. She opens a drop-down menu on the front of the chart displaying a series of possible pronouns, and I see “she/her,” “they/them,” and “other” on the list. I ask if this is a template available in the EHR by default and the visiting nurse practitioner replied that it is a “smart phrase:” a template that providers can construct, save, and paste later when needed. She says that smart phrases make charting faster and easier. The MA nods in agreement and explains that all providers who have contact with a patient can see these templates. There is yet no existing section in the EHR for pronouns, however. The MA shows us where providers can find a patient’s pronouns on the chart, for now. She moves her mouse to a bright yellow bubble next to the patient’s name with the letters “FYI” on it. This bright bubble stands in in contrast to the dark background of the record. She clicks on the bubble, revealing the patient’s pronouns. I notice that the pronouns are placed strategically right next to the patient name in the bright FYI icon that is easily visible and impossible not to pay attention to—this is the same section that holds any alerts about the patient providers might need to be aware of before going into an appointment.

Woodfield providers have created several templates in addition to the pronoun section. Staff created two "smart phrase" templates that they can paste into the notes section of the patients' clinical records. The first template is titled, "Transgender Information" and contains the following fields that providers fill in to describe the patient's transition history as they complete clinical notes:

Transgender Information
Sex assigned at birth:
Current legal sex:
Gender identity:
Preferred name:
Preferred pronouns:

When a clinical note detailing the patient's appointment is opened, this template appears at the very top of the note. These categories capture information that cannot be expressed by the static "F" or "M" gender marker in the EHR alone. The "sex assigned at birth" makes the provider aware of the likely presence of particular organs corresponding to the biomedical designation of a body as male or female, and the "current legal sex" is included to denote any legal gender marker change, which carries implications for insurance coverage. Additionally, the template's inclusion of "current legal sex," which is represented simply as the gender marker "M" or "F" in the record, makes the viewing provider aware that the listed gender marker may not denote the patient's sex assigned at birth. This template thus does dual work of representing the patient's gendered embodiment while clarifying the relationship between the record's gender marker and the patient's embodiment, challenging its existing gender-normative meaning. Dr. C. explained that she specifically pastes this template into the clinic note section of the EHR because this way the patient's primary care provider will be able to see it immediately "and know exactly how the patient wants to be called."

Woodfield providers strategically include an additional template that circulated to pharmacies and insurance companies. As I began completing analysis of consenting patients' clinical notes, I noticed that I was reading the same large block of text over and over again with each new record, alongside notes specific to each patient's visit. The block of text read:

> "Previously discussed: Gender Dysphoria (302.6). Discussed AMA[1] 2008 position statement supporting the sage and effective care of transgender patients as medically necessary. Same position is taken by APA[2]. AMA recognizes WPATH 2011 as the best standards for the care of gender non-conforming people. We reviewed with patients guidelines to obtain psychological evaluation and support and to optimize medical care to decrease risk associated with Gender Dysphoria. Speech therapy and laser hair ablation are a part of gender transition supportive care. Surgical care was discussed. At this time, to qualify for gender supportive surgery, patient should be on hormones and living in current gender identity for at least one year and having the support of 2 different mental health therapists. At this time patient is not ready to pursue surgical management but may consider. Patient would like to continue necessary hormonal treatment for Gender Dysphoria."

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[1] American Medical Association

[2] American Psychological Association

“Why is this paragraph in here over and over again?” I asked Dr. C. It did not make sense to me for healthcare staff specialized in gender-affirming healthcare to arbitrarily detail the positions of national medical associations such as the American Medical Association and the American Psychiatric Association in a patient’s medical record, nor signify that “speech therapy and laser hair ablation are a part of gender transition supportive care,” unless these statements were meant for an audience beyond the clinic. My suspicions were correct. Dr. C. explained to me that when the clinic first opened, insurance companies constantly denied tests for transition-related care, so she created this smart phrase to intercept these denials. “It’s a phrase on every trans patient’s notes,” she said, looking over my shoulder at the screen. “It’s also for liability,” she adds, explaining that the FDA has not yet approved estrogen and testosterone as treatments—“because clinical trials require thousands of participants” she says.

Taking advantage of the EHR’s journey as it arrives under several sets of eyes, Woodfield providers transformed these documents from their original function into tools that both inscribed patients’ shifting embodiments and educated providers, insurance companies, and pharmacies about medical associations’ supportive positions regarding transition-related care (American Medical Association 2008; American Psychological Association 2015). As I was looking through the records, an MA, Sadie, commented that a different clinic she was working at learned what preferred pronouns were from a patient’s record displaying the transgender information template. The above examples illustrate how providers actively utilized EHR software’s existing interface features such as bright alert buttons, customizable templates, and interoperability to make visible patients’ shifting gendered embodiments in this bureaucratic document. These bureaucratic practices translated to forms of bureaucratic encorpment that represented patients’ gendered embodiments in Woodfield’s clinical bureaucracy—and clinical bureaucracies beyond.

At Glendale, staff primarily relied on paper records to record clinic visits, and the kinds of notes recorded in these documents hinted at their home within the clinic's walls. These notes, written by practitioner Molly, were often succinct and written in cursive. Scribbled in the available sections on the appointment sheets, the notes stated things like, "Reason for visit: trans yearly," "Wanting refill on estrogen therapy, spironolactone, and estradiol," "Assessment: labs collected," "Additional data: goes by [patient's name of use]." At Glendale, a separate sheet existed that simply listed ICD diagnoses and services with checkboxes alongside them that Molly ticked off for billing at the end of the visit. The way the clinic notes were written seemed to imply that they had a very small intended audience. While keeping paper records inside the clinic offered some freedom to represent the variety of gender-expansive embodiments within these documents, the simplicity of the diagnoses and services sheet, and the fact that it was stored separately from the appointment sheet, may have shifted the labor required to justify the clinic's choice of healthcare services to entities outside the clinic such as insurance companies onto Molly, as discussed in Chapter 2.

Providers' bureaucratic engagements with medical records at the two clinics demonstrate how medical records' material form both facilitates and constrains providers' abilities to represent patients' shifting gendered embodiments in this ubiquitous gender-normative bureaucratic health document (Hull 2008), leading to different forms of bureaucratic encorpment. Existing clinical technology impacts the co-construction of bureaucratic practice and bodily materiality as features of this technology—whether digital or paper—permit different kinds of interactions within and beyond the clinics' own bureaucracies.

Covertly Bridging the Gap Between Clinics and Insurers

Medical records mediate communication between providers and insurers, and questions of insurance coverage are an ever-present feature of clinical appointments. Working in the space between policy and practice (Ferguson and Gupta 2002), providers engaged in practices in the clinic that ensured patients received appropriate transition care, even though these bureaucratic practices sometimes did not result in visible changes to gender-normative terms in the EHR that communicated with insurance companies. Providers at both clinics often expressed frustration with predicting month-to-month changes in insurance coverage, both for services generally and for transition care specifically. One Woodfield provider made her thoughts clear during one visit as we had just left a patient appointment towards the middle of my fieldwork, after she and I had built some rapport. She discussed the load that working with insurance companies put on her and other staff. In a frustrated tone, she spoke about many things that irritated her about insurance, for example that it is a pain to adjust from month to month for things insurance covers one month but not the next, like over-the-counter allergy medicines, which used to be covered by insurance in the past. "We become lackeys, and I don't want to play that game. *We* have to jump through the hoops."

The precision required to code clinic visits correctly for insurers demanded that providers choose exactly the right codes to avoid coverage denials. As stated above, insurers' understandings of transition-related terms sometimes greatly differed from providers'. However, providers did not challenge these disparate understandings and instead utilized the polysemy to ensure patients received appropriate care. Providers' interpretations of these polysemic terms led to paths of bureaucratic encorpment that allowed patients to receive appropriate transition care through clinics' bureaucracies, although these practices did not lead to direct change to gender-normative bureaucratic terms. To demonstrate how this process unfolded, I detail here Glendale practitioner Molly's discovery of such term discrepancies and how she resolved them, a story she never hesitated to share with clients.

Molly routinely recounted the "sexual transition story" (as I came to refer to it shorthand in field notes) to clients as a way to emphasize that insurance companies "are just looking for keywords" to determine whether to cover transition-related care such as hormones. I first heard the sexual transition story during preliminary fieldwork two years prior, when Molly told a client she contacted an insurance company after they refused to cover hormones for the client. The insurance company told her the service would be covered when she coded for the term "sexual transition." The approval of the term "sexual transition" is interesting here. Molly seemed to have overlooked the label "sexual transition" as appropriate because she interpreted the diagnostic label to code for transition-related surgery, but not hormone replacement therapy (HRT), which patients can take as long as desired without electing surgery to change their bodies. The patient's insurer interpreted the same label to include HRT *and* surgery, an understanding that naturalizes gender-normative assumptions since "surgery" is still generally understood to align a feminine or masculine gender to one of two distinct sexes (Richards et al. 2016). By interpreting the code this way in clinical practice, Molly was able to represent clients' non-normative embodied experiences of gender in the medical record to ensure coverage for hormones, even though she did not directly challenge the code. For Glendale staff, advocating for hormone coverage for clients was more important than directly challenging insurers' understandings of codes. "It doesn't matter how hip their language is," administrator Sarah said when I later asked if practitioners ever contest the meanings of insurers' terms. "We do what is needed for the client."

Both Glendale and Woodfield providers strategically coded for transition-related care in order to ensure patients received the appropriate care and did so in safety. The most prominent practice in Woodfield clinic was to code transgender and gender-expansive identity not as “gender dysphoria,” the diagnosis code used to signify transgender and gender-expansive identity under the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Dreschler et al. 2012; Lev 2013), but as “endocrine disorder,” which frames gender-expansive patients’ needs as a hormone incongruence in need of alleviation. I first became aware of this use when I overheard Dr. C. mention to a visiting nurse practitioner that “endocrine disorder is a more global term while gender dysphoria kind of outs the patient.” At Glendale, Molly made a similar comment when she pointed to the form of listed diagnostic and service codes and described “endocrine disorder” as “all-inclusive billing.” Utilizing the code “endocrine disorder” represented another instance in which providers at both clinics strategically used existing terminology in medical documents in service of patients’ non-normative gendered embodiments (Riles 2006; Hull 2012; Buchbinder 2016). Providers’ use of the term “endocrine disorder” mirrors advocacy suggestions to use this term to code for transition care (Project Health, n.d.).

Despite not leading to visible changes to existing gender-normative terms in the medical record, providers at both clinics—acting as street bureaucrats—subvert this terminology by interpreting it in ways that lead to the appropriate provision of healthcare to gender-expansive patients, demonstrating the importance of considering the operation of state power not only from the top-down but also “from the bottom up and middle out” (Buchbinder 2016: 774; Ferguson and Gupta 2002). In the cases above, providers creatively perform clinic terminology in medical documents in ways that might leave gender-normative terms intact but that appropriately meet patients’ transition healthcare needs (Buchbinder 2016: 781). The availability of clinic resources and the interactions they afford—such as digital interoperability versus paper records—shapes providers' abilities to address this gender-normative terminology. Considering the impact of specific clinical resources and motivations that afford and constrain avenues of bureaucratic encorpment serving patients' varied transition goals generates an understanding of how to recognize and reproduce these paths in future appointment encounters.

The Limits of the Gender Marker: Lisa's Story

There were times providers were unable to ensure transition-related care was covered under insurance. This occurred when insurance companies considered certain healthcare services inappropriate vis-à-vis patients' listed legal gender markers. For example, insurance companies often questioned why patients were seeking a breast exam under an M gender marker, or a prostate exam under an F gender marker. Glendale patient-participant Lisa's experience with her insurance illustrates the serious consequences arising when insurance denies transition care while adhering to the dominant notion that there exist only two kinds of gender experiences statically linked to two distinct kinds of bodies (Fausto-Sterling 2000).

Lisa came in for an appointment at Glendale for a breast exam. She apologized for missing her first appointment due to a pest invasion in her home and completed her exam. Then, the nurse practitioner student working with Molly that day asked if Lisa has had "bottom surgery" (i.e. orchiectomy and/or vaginoplasty). Lisa's face falls and she replies, "No. I have a testicular cyst. It's the insurance—they've been delaying it. They need a letter from psychiatrist to prove that I'm mentally sound to have it removed. Now it's so bad that I need an orchiectomy." "I don't fit their codes," she says. Molly responds by telling Lisa the sexual transition story. "You have to match the words they're using," Molly says. "Well, they changed me in the state system and now they say I'm female. But now I can't have testicles..." Lisa continues, explaining to Molly and the nurse practitioner student that her insurance only covered surgery with a surgeon located 4 hours away from her. She was not pleased with photos of this surgeon's past work. Additionally, Lisa spoke about how, in order to receive the psychiatrist's letter required to get bottom surgery approved under her insurance, "you have to pretend really hard—I have to wear girly stuff," a clothing style very unlike her own. All of this document gatekeeping led to a delay in the removal of her testicular cyst so lengthy that Lisa decided to pursue bottom surgery and have the cyst removed simultaneously. Later during the interview, I asked if Lisa were willing to share the details of what happened with her insurance, why she was denied. She replied,

> "So what ended up happening was that I discovered a lump probably about 9 months ago now and I went in to get a test done because… cancer runs in the family and I was panicking over it. And insurance was just dragging their heels, like not wanting to pay for any of the tests or results or anything and I finally asked, "What is your guys's problem? This is a health issue. And they're like, 'Well we have you listed as female in the system and females don't have testicles so you can't have a testicular cyst.' And I said, 'Well, I'm trans. You can't just decide that I don't have something simply because you mark me down as female in your system…'" (Debriefing interview with Lisa, Glendale Clinic)

Lisa continued, discussing how she saw a urologist who suggested she should go ahead and pursue gender-affirming surgery instead of simply getting her cyst removed, but she told him that she did not have any psychiatrist letters she could present for surgery approval. She then traveled hours away to a clinic that also did not cover her cyst removal surgery and came back to the urologist, who tried submitting her cyst removal claim to insurance, who denied it again. Meanwhile, the cyst had been growing, and Lisa's urologist agreed that an orchiectomy would also remove the entire cyst. "Because now," Lisa says, "You know, cutting the cyst off is pretty much like removing most of what's there."

> "And they've been denying that as well. So I have been hit with five different medical bills in regards to it… I couldn't afford to pay all these tests that were medically necessary 'cause the insurance is refusing due to the fact that they have me listed as female. And that's pretty much the only reason why they're refusing to budge on it. So they finally said well we'll think on it if you go to get a letter from a psychologist proving you're mentally fit to have this surgery done. Because they consider an orchiectomy on a trans person to be uh, cosmetic. And that's pretty much what I've been dealing with" (Debriefing interview with Lisa, Glendale Clinic)

I asked Lisa what she meant when she told Molly during her appointment that she "didn't fit their codes." I asked her if this related to the fact that she was now legally listed as female in her medical record, and she said "yes," but she clarified that every time providers tried to frame her need for the surgery as transition-related, her insurer would immediately request letters from a psychiatrist to approve the surgery:

> "...If I was a cis male and had this exact problem this would already be removed within the first couple of months of me having the problem. But since they didn't have the

> coding for it they just automatically kept denying me outright without giving it any thought… They've even tried to submit it as if I was a guy just to get it approved and that was denied too. The problem is if I get changed to an M in the system for my sex then they won't allow me to get breast exams and stuff and I have to have those too. So it's kind of a catch 22 'cause I have to have both male and female checks done to me and they're basically saying I can have only one or the other" (Debriefing interview with Lisa, Glendale Clinic).

Clearly, the insurer's gender-normative understanding of Lisa's "F" gender marker completely eclipsed Lisa from the preventative gender-related care she needed, and her gendered embodiment was disregarded in the process. This was a case that Glendale providers were unable to resolve at the time. Lisa's "catch-22" arose from the fact that despite taking the legal steps necessary to change her legal gender marker in the EHR, her new gender marker "F"—and the gender-normative assumptions underlying it—remained unchallenged. Without attempts to challenge the gender-normative assumptions underpinning both F and M gender markers, Lisa's non-normative gendered embodiment—which demands an amalgam of reproductive preventative care—became invisible to her insurance. The path of bureaucratic encorpment created by the difficulty to challenge these gender-normative gender markers caused serious healthcare delays for Lisa.

At Glendale and Woodfield, where providers are specifically trained to navigate known bureaucratic barriers to patients' healthcare, providers always tried to challenge gender-normative language in medical documents during my fieldwork. There were, of course, cases in which these efforts were unsuccessful, such as the ethnographic example presented in the introduction, or when pronouns of use were not easily visible on the front of a medical record at Glendale and led staff to misgender a client. The negative experiences patients had at past clinics surrounding the use of medical records far outweighed these cases and appeared consistently across patient-participants. Several patients at both clinics mentioned their negative prior experiences with providers. Often, this occurred when past providers did not challenge existing gender-normative terminology in medical records during appointments, instead adhering to routinized bureaucratic engagements with healthcare documents. Relying on existing gender-normative language in bureaucratic health documents such as the medical record instead of considering this terminology alongside patients' bodily materiality creates forms of bureaucratic encorpment that lead non-normative gendered embodiments to be overlooked. Drawing from observational notes and interviews with patient-participants, I outline co-interactions between bureaucratic practice and bodily materiality that created such paths below.

Many patient-participants recalled these negative past experiences during their appointments at the clinics. For example, as Dr. C. was putting in an order for a medication for Samantha, she paused in amusement and told Samantha that "It [the EHR] gave me a warning for the medication to make sure you're not pregnant." "They ask me every time at the hospital and I'm like, 'Bless your heart,'" Samantha replied. When they see an F gender marker in their records, staff at non-specialized clinics might ask gender-normative questions, like when the patient's last period was, and the patient must clarify that they do not have periods. I asked Lisa what she meant when she stated that Glendale clinic was trans-friendly, and her understanding of trans-friendliness involved the use of language that did not preemptively assume gender normativity:

> "A lot of the language they use just doesn't assume. Cause I have had issues at other doctors' offices where they consider sex and gender to be the exact same thing. And actually [laughs] I had this happen recently where I had the blood work done she requested at a lab place and the place actually has me marked down as male and one of the nurses ended up calling me "sir" after seeing that. Cause they didn't have anything to indicate that I was female" (Debriefing interview with Lisa, Glendale Clinic).

Samantha's and Lisa's experiences highlight the consequences arising when bureaucratic practice does not consider patients' existing gendered embodiments alongside medical records. In these cases, bureaucratic encorpment progresses in ways that privileges routinized bureaucratic practices—that is, those bureaucratic practices within the clinic that leave gender-normative terminology in these documents unchallenged—creating constraints in possibilities for patients to achieve their transition goals, and even drastic healthcare outcomes, as in Lisa's case.

Anticipating providers' routine adherence to gender-normative document terms in clinics beyond their own, Glendale and Woodfield providers tried to prevent the development of issues caused by this terminology at patients' clinics if they were in a position to do so. For example, Dr. C. helped one patient, Mac, prepare to approach a gynecology clinic he planned to visit after he moved to a different town with his fiancée. Dr. C. was unsure if the new clinic had experience managing or providing transition-related care. "Write a note to the clinic to use the preferred name and pronouns," she suggested. "We only use preferred name here but other places don't and insurance needs both for billing." She also suggested to his fiancée that she call the new clinic to schedule Mac's initial appointment. "Mac's voice might sound confusing to people who are not trained to work with trans people in scheduling” she explained. This example illustrates how gender performance is likewise enfolded into gender-normative bureaucratic practice. As mentioned earlier, Molly might call the insurance company directly to explain why a client was taking testosterone or estrogen under a gender marker that did not seem to “match” the treatment. She also navigated lab ranges linked to clients’ gender markers by drawing on her medical knowledge to make decisions for the client’s care. For example, after she spent a long time looking through a client’s chart, she told them, “The reason why I was tiptoeing through the chart is because we have different lab values for normal—which drives me crazy.” “Your values are the same,” she said, then whispered, “So I’m not gonna worry about it.”

Inscribing Bodily Materiality into the Medical Record

In compliance with federal regulations to change legal gender markers, providers translated patients’ bodily materiality into the medical record in two common ways: by observing transition-related changes directly from the body for approval for legal document changes, and by encouraging patients to frame their transition through their insurances’ understandings of medical necessity to hasten the transition process. As part of the state requirement to receive approval to change the gender marker on widespread legal documents such as the drivers’ license, social security, birth certificates, and insurance, patients must have evidence of “permanent changes” in their bodies (for example, the presence of breast tissue or voice changes) after initiating hormones (Sandler 2019), the timing of which can vary widely as I discuss in Chapter 2. Note that, because gender marker changes in medical records can only occur after changing one’s legal documents, the timing of the appearance of changes considered irreversible is linked to patients’ abilities to change these markers in their medical record. In order to examine whether irreversible changes occurred, providers simply observed the changes during appointments and noted them or performed a short physical exam, such as a breast exam to determine if breast tissue had appeared. Then, providers filled out a template letter stating these changes (at Woodfield) or wrote up a letter (at Glendale), that a notary notarized.

I was able to observe this entire process as Niki came into Woodfield with a family member to have her hormone levels checked and to have a breast exam done so a letter could be created for her that would allow her to initiate transition-related surgery. Dr. C. performed the breast exam then moved to her computer chair and pulled up a letter template with drop-down lists of options the provider could choose to appear in the letter. Dr. C explained to Niki what she was doing as she toggled the dropdown sections of the template. She asked Niki if she felt that her testes had gotten smaller, then turned back and selected the appropriate choice from the dropdown list on that section of the template. Later, I asked Niki what she thought about the process of assessing for permanent changes and she said,

> “Personally I think it’s a great idea. It’s not anything major. You don’t have to have the major surgery and by that I mean SRS or GRS (sexual reassignment surgery or gender reassignment surgery)… And it also means you have to spend at the very least 2-3 months on hormones to know that your body is changing and essentially what I would say is a test run before your breast development gets too big. Because as it stands at this 2-3 month mark I could stop if I wanted to and you couldn’t necessarily tell that I was growing breasts… So I like the 3-month cap—not that it is definitely 3 months but that’s generally when you’ll see your first signs of breast development on hormones and the fact that your doctor just needs to see those changes. I think it’s beneficial in that way. It

> prevents people from being hasty and rushing into things they maybe don't know about while also giving them the chance to test run it and try it out" (Debriefing interview with Niki, Woodfield Clinic).

For Niki, the process of seeking the letter to change legal documents was not disruptive to her transition plans because she considered the few months it typically takes to see permanent bodily changes acceptable for people who are ready at that time to seek legal document changes, while also leaving open the possibility not to continue treatment. This stood in contrast to the one year wait requirement for approval for transition-related surgery such as vaginoplasty, which also requires two letters from two different mental health professionals for approval. Several participants commented on the difficulty of following this feature of bureaucratic gatekeeping. Some discussed the frustration of being forced to "pretend" to approximate therapists' understandings of "living in the preferred gender," as Lisa mentioned above regarding her style of dress. Moe explained how this year-long wait time and its corresponding document requirements could drastically impact someone's life outside the clinic:

> "… And then they'll want you to be on hormones for a year before they'll consider you for surgery, but then you'll need to have been seeing the same mental health professional or specialist for a year consecutively before you can even further be considered for surgery. So they just, they make all of the hoops that you have to jump through that in my opinion just heighten the risk for like unhealthy behaviors to develop. Like, they say that 'you should be presenting physically, dressing as your gender for a year.' But if you're a trans woman for example and you're trying to transition to female, and you still have a

> beard, and you still have your six pack muscles and your big, big body, and they want you to present as a woman and you're trying to go out in a pantsuit and a wig, most people are going to look at you a little funny because you, you don't look the part. Maybe to you inside it shouldn't matter, and you do look the part, but to the people around you, you don't. And that's usually where dysphoria comes from. And so it's like setting you up. Not necessarily for failure, but for the worst to happen. You know, they're sending you out into the world to do this shit, to prove that you *really really* do want this, but like it doesn't really matter if you get murdered for it because you look like a man in a dress. And it doesn't really matter if you've been on hormones for a year waiting for this surgery if they still don't think you look the part" (Debriefing interview with Moe, Glendale clinic).

Federal specifications dictating that patients achieve irreversible bodily changes prior to changing legal sex in legal paperwork and the medical record sometimes created paths of bureaucratic encorpment that did not serve patients' transition plans, with the potential to leave patients waiting to meet these requirements vulnerable to violence and discrimination in daily life.

Aware of the kinds of risks Moe described, providers employed strategies to hasten the process when they saw the opportunity by encouraging patients to frame their transition needs in terms understood by insurance companies to entail medical necessity. For example, a Woodfield provider encouraged a patient not to forget to mention existing symptoms of pelvic discomfort and dysphoria to the gynecologist writing his letter to approve a hysterectomy, telling one patient that his persistent bleeding could actually serve as a "blessing in disguise" (i.e. to have the uterus removed quickly). Or she would tell a patient to document her laser hair removal process with pictures to prove necessity to insurance. She would encourage patients to emphasize these symptoms to letter-writers as soon as patients mentioned them during appointments. This practice was also common at Glendale. Upon hearing Cami mentioning that top surgery was not covered under their insurance and stating bitterly, “So double D’s don’t matter to you?” Molly replied, “You have to come up with a medical reason. Wear a bra with straps biting into the shoulder. You don’t have to call it top surgery.” Through this strategic dialogue, providers helped patients represent their gendered embodiment in the medical record in ways that hastened transition timing.

Relying on accumulated experience with transition care and aware of the risk of social and health consequences of delays for patients seeking transition care, providers attempted to hasten the process of representing bodily materiality in the medical record for patients seeking legal gender marker changes by encouraging patients to frame existing symptoms in language intelligible to patients’ insurance plans to entail medical necessity. These efforts produce trajectories of bureaucratic encorpment that more closely aligned with patients’ timelines for transition.

Conclusion

In this chapter I detailed strategies Woodfield and Glendale healthcare providers utilized in daily bureaucratic practice to represent patients’ non-normative gendered embodiments in a central document of communication in biomedicine: the medical record. Existing language in this record influences possibilities for gendered embodiment at the same time that providers attempt and sometimes succeed to challenge the gender-normative terms undergirding these records, drawing from available clinic resources in their efforts. Providers employed several strategies to represent patients' gendered embodiments in these documents, such as manipulating the existing medical record interface and interpreting polysemic gender-related insurance terminology in ways that served patients' transition needs. I also detailed consequences that arose when providers failed to address gender-normative language presented in this bureaucratic document and engaged instead in routinized bureaucratic practice. Examining providers' engagements with ubiquitous bureaucratic healthcare documents such as medical records reveals the practices enabling providers to manage the co-construction of bureaucratic practice and patients' bodily materiality in ways that create avenues of bureaucratic encorpment serving patients' non-normative gendered embodiments.

Providers' purposeful disruptions of routinized bureaucratic practice—practice that proceeds as providers adhere to existing gender-normative language embedded in healthcare documents—generate possibilities for capturing a plurality of non-normative gendered embodiments in these documents proper and in clinic practice. These efforts to disrupt demand that actors such as the providers of Woodfield and Glendale clinics anticipate and embrace the uncertainty prompted by the multitude non-normative gendered embodiments and corresponding insurance plans providers encounter each day. Only by embracing this uncertainty will bureaucratic technology like EHRs be able to shift alongside our rapidly changing world and "avoid reproducing the status quo" (Pink et al 2018, 100). To accumulate the knowledge necessary to respond to unpredictable diversity in lived gender experience in these ways, providers at both clinics engaged in verbal and non-verbal practices of care with patients that avoided reproducing gender-normative assumptions, as I discuss in the following chapter.

CHAPTER 4: CREATING AFFECT TOWARD GOOD TRANSITION CARE

During an observation day at Woodfield clinic, patient-participant Terrance came in to present a referral letter to receive clearance for transition-related surgery. However, Terrance's appointment coincided with an appeal put forth against a ruling that barred Iowa Medicaid dollars from being allocated for transition-related surgeries. The appeal was in progress at this time and staff and patients would not hear the result—whether patients on Medicaid could have coverage for surgeries—until months later, in Spring 2019. During his appointment, Terrance mentioned to physician assistant Janet several times that the Medicaid delay and the uncertainty it created exacerbated his dysphoria. The following is a portion of the appointment exchange from field notes:

"I need something to make me feel like I am me. I feel like I'm pretending; kinda like this is a show I'm putting on… My clothes are masculine, my haircut's masculine… I'm still presenting as female," Terrance despondently tells Janet, the PA.

Suddenly, a medical assistant walks in and says that Terrance's mom is here. His mom comes in and introduces herself… She looks at Janet and says she's been researching this for a bit, but wonders if Terrance is actually intersex… She hugs Terrance, calls him by incorrect pronouns, tells him she loves him however he is, and leaves the exam room. "Well," Janet says to Terrance, "It's the brain that we treat; it doesn't matter what the secondary sex characteristics are." While watching the exchange, I'm surprised how calm Janet is. She reacted to the mom's impromptu visit by offering biomedical knowledge in response to the mom's statements.

"You're not one to pretend," Janet continues, picking up the conversation where they left off before Terrance's mother came in. "That's not in the top 20 things I would categorize you as… you take care of kids, you're a thinker… that's great, but sometimes you have to think, 'Am I overthinking?'" (Observational field notes, Woodfield Clinic).

Bureaucratic practice in Glendale and Woodfield clinics cannot be understood without considering the affective dimension indispensable to daily clinic life. In this chapter, I outline the relationships between the two gender-affirming health clinics' organizational cultures and the kinds of affective responses they restrict and permit within the political climate surrounding U.S. transgender healthcare. By considering affect as produced through constant encounters occurring within a complex sociopolitical climate that have varied effects for providers and patients, I demonstrate how bureaucratic encorpment occurs as providers incorporate patients' bodily materiality into bureaucratic practice as part of their goal to create positive appointment experiences for patients in the present and future.

From the opening vignette, the reader can recognize several affective responses emerging from the interactions Janet has with Terrance and his mother. Terrance came to the clinic that afternoon distressed with the apprehension brought on as he awaited the Medicaid appeal decision that would allow his surgery to be covered if successful. Within the context of the clinic's biomedical organizational culture, Janet draws from biomedical understandings of non-normative gender experience and works from a guidance role of biomedical provider to comfort Terrance in response to his mother's comments. She uses language distinctly reflective of a hierarchical relationship between provider and patient, a counseling role, to claim authority collectively with other biomedical professionals regarding the origin of non-normative gender experience ("It's the brain we treat"). I will show how this particular way of building rapport with patients and drawing from bodily materiality to do so is in part mediated through Woodfield's organizational culture, and challenges current understandings of professionalism in biomedicine.

Affect is a defining feature of daily clinic life at Glendale and Woodfield. The core purpose of the gender-affirming health clinic is to serve a community that has been historically discriminated against in biomedical clinics unfamiliar with non-normative gender experience and transition care (Meyerowitz 2002). Providers working at both Glendale and Woodfield clinic share this mission, incorporating it into bureaucratic practice in the myriad ways discussed in previous chapters. While analyzing bureaucratic practice, anthropologists have long drawn from Max Weber's conception of routinized bureaucratic practice, which he characterized as rational and devoid of anything related to the emotional (Weber 1947, 1978; Gupta 2012; Bear 2015; Krause 2012).

However, as is clear from the opening vignette and prior chapters, appointment satisfaction hinges on providers' abilities to sympathize with patients' financial, familial, and emotional circumstances beyond providing appropriate transition healthcare. Providers' care practices at the clinics, motivated by the goal to represent gender non-normative experiences in clinical practice, are shaped by clinics' organizational cultures and create particular kinds of affect in patients. In this chapter I argue that, as providers and staff engage in discursive care practices with patients during clinical appointments, they explicitly avoid reproducing the dominant two-sex, two-gender model associated with historically gendered procedures like pap smears, instead privileging patients' own understandings of their bodies over bodily materiality. Staff's discursive practices produce affects that reduce patients' anxiety—aligning their bodily materiality with blood pressure requirements for optimal lab values—and create forms of bureaucratic encorpment that align with patients' transition plans during those appointments.

Throughout this chapter I elucidate traceable affects created as clinic life unfolds in the two gender-affirming health clinics. I demonstrate that here, too, bureaucratic encorpment occurs as bodily materiality equally participates in the interactions providers and patients at the two clinics have with gender-normative healthcare bureaucracy. For example, a feminist philosophy undergirds the mission of Glendale clinic. This feminist foundation structures the affective interactions providers and patients have at Glendale and differ from the kinds of interactions actors at the typical biomedical clinic Woodfield espouse. Affect shared between providers and patients within the healthcare clinics both challenge and maintain broader politico-economic relationships. Given this, it is crucial to consider affect as a central mediator in the maintenance of bureaucratic practice (Berg and Rayas 2015). In a financialized bureaucratic health context where patients must ensure their bodies meet required lab values for insurance coverage, the first hormone injection at a gender-affirming health clinic is a moment of celebration for a patient, making the wait bearable and creating a clinic environment that encourages the patient to return to the clinic for their next appointment. While these celebratory moments are not captured in electronic clinic software and paperwork, they are an essential component of bureaucratic practice and satisfactory transition care in the two clinics, setting the conditions for gender-expansive patients to engage with clinical bureaucracy as they attend future appointments.

I now briefly consider how anthropologists have defined affect and have considered the relationship between affect and power. The definition of affect is not without debate; over the last decades there has been deliberation about how to define affect in relation to emotion and in relation to bodily materiality. I will give brief attention to this conversation to clarify my understanding of discursive care practices and the affects generated from these practices as fostered through continuous encounters generating a multiplicity of social effects. Additionally, I highlight care practice and the affects it produces as a site for political agency. The interpretation of affect as emerging in *practice* is useful for understanding the relationship between the affect providers and patients create vis-a-vis patients' bodily materiality within the broader bureaucratic U.S. healthcare context.

The subsequent sections of this chapter each comprise a central site where affect is generated between staff and patients. In the first section, I detail how schedulers preempted conflicts between patients' bodily materiality and the representation of this materiality in electronic scheduling calendars that otherwise would have produced feelings of anxiety for patients attending the clinics. Schedulers often stepped out of their roles to make transitioning patients comfortable. In addition to physically moving out of their designated workspaces to guide patients as I detail in Chapter 5, schedulers managed affect at the front desk. This included utilizing the scheduling software template at check-in to avoid calling patients a first name they do not use while still following HIPAA protocol for identifying patients. It also included recognizing the anxiety that many patients feel upon scheduling by phone and adjusting their bureaucratic practice to alleviate these feelings of anxiety before patients even stepped foot into the clinic. These affects in turn ensure patients' bodies are in a biomedical state that harmonizes with labwork requirements for hormone prescriptions.

In the subsequent section I discuss how organizational culture shapes affect during appointment interactions at Glendale and Woodfield clinic, two clinics sharing the mission of improving healthcare delivery to gender-expansive patients. I argue that clinics' organizational cultures influence the possibilities for and the character of affects produced as providers invoke patients' bodily materiality through discursive care practices. The care provided in the context of Glendale's organizational culture, founded in a feminist tradition that purposefully denounces healthcare bureaucratization, is characterized by very casual, open dialogue. This organizational culture allows space for Glendale providers to inject humor into their conversations to express empathy with patients' struggles waiting for care or receiving inadequate care. Often, Glendale providers aligned themselves with clients' subjectivities over clients' bodies, especially during historically gendered procedures such as the pap smear. These discursive practices put patients at ease, contributing to satisfactory appointments.

Providers at Woodfield engaged in dialogue considered more typical of provider-patient relationships in biomedicine, where a power hierarchy is assumed and providers take on a counseling role as part of the biomedical value system of professionalism (Craig et al. 2018). This dialogue engendered patients' appreciation for providers' directness and recognition of providers' authoritative knowledge about transition care as providers framed different aspects of patients' shifting bodily materiality in biomedical language. The kinds of affect engendered at Glendale clinic differ from those generated at Woodfield, where the organizational culture of a typical biomedical clinic allows other kinds of affect to manifest by virtue of specialized bureaucratic roles and the hierarchical relationship created between provider and patient as a result of these roles. These examples show that organizational culture is important to examine as affect is created through providers' and patients' engagements with bodily materiality in the bureaucratic healthcare context.

In the final section I discuss how patients viewed the clinical appointment as an opportunity to reflect on their bodily materiality to evaluate their progress toward their transition goals. Patients whose bodies are in transition might not notice the changes occurring in their bodies day-to-day. Many patient-participants noted how their yearly or biyearly encounter at the clinic served as an opportunity to gain insight in the changes happening in their bodies, both upon visual and discursive assessment from providers they considered knowledgeable about transition care and also electronically through the assessment of laboratory values. Learning about the progress patient-participants' bodies made toward their transition goals engendered feelings of pride and accomplishment in patients and appointments served as a benchmark for assessing transition progress. All of the examples in this chapter showcase the care practices providers employ to create paths of bureaucratic encorpment favoring patients' transition plans.

Inquiry Into Affect in Anthropology

Disagreement regarding a clear definition of "affect" has shifted anthropologists' attention toward capturing the nuances of unfolding exchanges between bodies, subjectivities, and political economy in ethnographic analysis, as I will do in this chapter. Considering these exchanges illustrates not only how particular affects are constrained or permitted within specific sociopolitical contexts, but also the ways in which affect maintains these broader contexts (Berg and Ramos-Zayas 2015). As I will demonstrate, affective responses can be agentic, directly challenging the reproduction of harmful bureaucratic practices.

Anthropologists have put forth various definitions of affect, some making distinctions between affect, emotion, and feeling with others using these terms interchangeably (Ahmed 2004; Rutherford 2016). For others, affect comprises an intensity that is pre-subjective (Massumi 1995). Affect, like the other aspects of bureaucratic practice discussed in this dissertation, brings bureaucracy into being. Healthcare staff and patients create affect through the speech they share; these discursive practices comprise social actions that create particular affects in the clinic (Abu-

Lughod and Lutz 1990, 12). In this chapter I use the same terms for affective responses that providers and patients used, and detail how these affects result from specific engagements with gender-normative bureaucracy.

Anthropologists' process of parsing-out the definition of affect alongside existing theories of assemblage led to the understanding that affect cannot be considered in the abstract, but rather emerges in everyday practice through contact with others within constantly shifting sociopolitical contexts. The recognition of affect as existing in this multiplicity allows us to examine the complicated relationships between the individual elements that participate in the generation of particular affect. As Stewart (2017) notes,

> "Affect helped return anthropology to sense and sensation, materialities, and viscera. It proposed a world that is lived, though not simply anchored in the consciousness of the humanist subject or its categories of thought. Rather, a world charged with affect is a prolific, mixed-use contact zone in an ongoing state of transition that leaves people 'improvising with already-felts' (Manning 2009, 30)" (Stewart 2017, 194).

~~I~~ follow Stewart in considering affect as *lived* to capture the multiple contributors to social interaction occurring moment to moment, including political economy, organizational culture, provider and patient subjectivity, and bodily materiality. For instance, at Woodfield and Glendale clinic, the financialization of the healthcare system contributes to the immense bureaucratic gatekeeping patients face as they navigate whatever insurance they have to receive transition care that aligns with their goals for their bodies. As examined in Chapter 2, these bureaucratic requirements create lags in healthcare delivery with sometimes devastating consequences for patients' bodily materiality. Coupled with broader policy changes such as the Medicaid appeal and the still-nascent state of gender-affirming healthcare as a body of knowledge, providers must help patients navigate not only bureaucratic gatekeeping but also the specifics of transition-related medical care. These gaps in care cause frustration and distress for patients. This bureaucratic gatekeeping structures possibilities for particular kinds of affect to emerge during appointments, such as empathy via providers' alignment with patients' politics, as I will detail in this chapter.

Utilizing ethnography to investigate the site of bureaucratic practice as it interfaces with provider and patients' goals and with the agency of bodily materiality in transition captures the theoretical study of affect in practice (Navaro 2017). Ethnography can capture the nuances of affective engagements with particular state forms at specific times and places and the discursive practices that people use to name these affective responses (Laszczkowski and Reeves 2015; Abu-Lughod and Lutz 1990, 12). Ethnographic observation of clinical appointments paired with patient-participant debriefing interviews illuminates the affective responses created between staff and patients responding to specific features of bureaucratic practice. These insights also provide the opportunity to understand the reflections patients and providers had about these experiences following their appointments.

Like Archambault (2016), I consider affect to emerge through encounters with others, regardless whether those others are animate or inanimate. As Archambault (2016) notes,

> "An encounter, a meeting with someone or with something, is affective when it triggers some sort of effect; when it inspires, unsettles, troubles, moves, arouses, motivates, and/or impresses. If some affective encounters remain trivial, others can be life-changing.

> Encounters, in other words, are punctual events that can have enduring effects" (Archambault 2016, 239).

Encounters at the clinics generated various affective responses in patient-participants. For gender-expansive patients who have varied relationships with their bodies and goals for transition, considering affect as encounters that trigger an array of different effects—or no effects at all—is analytically useful to document the nuances of interactions between providers, patients, and the gender-normative aspects of healthcare bureaucracy that produce similar bureaucratic constraints on providers and patients. While the stall in insurance coverage for transition-related surgery under the Medicaid appeal might cause profound feelings of distress for one individual, for another the wait is not at all bothersome as these surgeries do not form part of the patient's transition plan. This analytic perspective permits the anthropologist to attend to these varied interactions through situated observation. Considering the multiplicity of affect alongside the variability of gender-expansive patients' plans for transition allows for a fine-tuned analysis of the ways bureaucratic encorpment unfolds as these subjectivities, affects, and bodily materiality shape each other in the two gender-affirming health clinics.

At Woodfield and Glendale clinic, providers and gender-expansive patients bring the clinic into being through their perpetual engagements with gender-normative bureaucratic technologies (Lipsky 2010; Buchbinder 2016). I demonstrated in the previous chapters how providers challenge gender-normative clinical technologies by representing patients' subjectivities and bodily materiality in the temporal flow of the clinic and in healthcare documents. The discursive care practices providers share with patients toward the goal of providing satisfactory transition care drive the motivation and success of these confrontations. In this chapter I discuss how discursive care practices and identifiable affects they produce lead to forms of bureaucratic encorpment that align with patients' gendered embodiments and plans for transition.

Recent critiques of biomedical practice regard the enculturation of physicians-in-training into the "hidden curriculum" of biomedicine, wherein there is gradual separation of caregiving from biomedical practice as physicians become professionalized within biomedicine (Hafferty 1998; Kleinman and Hanna 2008; Craig et al. 2018). Kleinman and Hanna (2008) argue that this separation occurs as financialization and the shift to technology-driven modes of diagnoses have dominated over the caregiving aspect of clinical practice, relegating caregiving to a place of reduced importance in the clinical appointment. Embedded in the practice of "professionalism" is the enculturation of medical students into medical hierarchy and a code of ethics dictating the use of appropriate dialogue and behaviors that reduce the risk of conflicts of interest with patients (Craig et al. 2018; see also Good and Good 1989). As Robertson (2017) notes, the hidden curriculum in biomedicine engenders in physicians-in-training

> "… the belief that disease and illness are reducible to biophysiological etiologies, enabling inattention to psychosociocultural aspects of disease and illness.
> Thus, physicians-in-training are systematically exposed to the objectification of patient bodies to the extent that physicians can become alienated from patients as persons" (Robertson 2017, 161).

Purposefully oriented against engaging in practices that reproduce gender-normative healthcare bureaucracy, Glendale and Woodfield providers complicate what professionalism means in clinical practice. I argue that the provision of transition care in these clinics unsettle the notions of biomedical professionalism discussed above. Gender-affirming healthcare is a nascent area of study—a currently small but rapidly growing body of knowledge in biomedicine. The position of gender-affirming healthcare as a new area of study, and the consequent existence of medical plurality, challenges providers' medical authority. Instead of relying on an existing body of knowledge, providers must turn outward to gender-expansive patients, engaging in discursive practices of empathy and active listening. Interactions between providers and patients lead to alternative configurations of professionalism in the clinics and these alternatives are further shaped by clinics' organizational cultures, as illustrated by the ethnographic examples in this chapter. Tracing how providers and patients engage in discursive care practices within the rapidly changing sociopolitical landscape of U.S. transgender healthcare highlights care as "an important site for understanding emerging forms of governance" (Buch 2015: 279).

Managing Anxiety from the Front Desk

Feelings of nervousness around attending the clinic for the first time—not knowing what to expect—precipitated even before patients scheduled into the clinics. Schedulers adjusted their bureaucratic practice by specifically challenging gender-normative scheduling software to attempt to prevent these feelings from developing. Encountering a positive check-in process helped to quell patients' anxiety upon their first visit to the clinic. Managing these feelings of nervousness was important for the accurate assessment of lab values as well; providers at both clinics often mentioned the difficulty of accurately assessing the blood pressure of new patients because patients were often so anxious about their first clinic visit that their blood pressure recorded inaccurately high. Through discursive care practices that identified potential areas for distress in gender-normative scheduling software and corrected them, schedulers preempted the development of psychosomatic affects undesirable for patients' transition plans.

While training for her job, front-desk scheduler Stacey was instructed to ask patients for their last name and birth date—a bureaucratic practice that helps schedulers accurately ID the correct patient at check-in. However, Stacey explained that since a recent software update allowed patients' preferred names to be visible in the scheduling template, she now asks patients for their preferred name, which still ensures that patients are identified correctly when there is a match with the software template. "It's just better, you know? They [patients] appreciate when you actually use the preferred name listed," Stacey added.

Scheduler Nathan, who managed a large portion of scheduling workflow at the time of fieldwork, raised an issue with me about existing bureaucratic practice—appointment reminder calls—that he felt conflicted with what he had observed about the emotional state of LGBTQ patients who called into the clinic. He did not feel that reminder calls, which prompted patients to call back to let the office know whether they would be able to attend their appointments, were appropriate for patients who he had personally observed often had phone anxiety. Before patients even entered the clinics, front desk schedulers adjusted their bureaucratic practice to forestall the development of psychosomatic affects in patients that could interfere with patients' plans for transition and by extension their gendered embodiments.

Front-desk receptionists at both clinics strived to create affect with patients that communicated an understanding of issues faced by gender-expansive communities with them. I noticed receptionists' interest in fostering these positive affects throughout my fieldwork, such as when one receptionist made several phone calls to ensure a patient who had carpooled hours to arrive at the clinic with a group of supportive friends could get fit into the clinic's schedule. In another instance, a receptionist asked me if I knew where she could take a refresher training course about scheduling for gender-expansive patients (I told her I didn't know, and suggested she ask her supervisor). Schedulers' efforts to familiarize themselves with the needs of gender-expansive patients translate into discursive practices that can modify patients' bodily states in ways that grant them access to clinic resources. This suggests that the effects of receptionists' emotional labor, understood to shape patients' access to physicians in individual clinics (Strathmann and Hay 2009; Hammond et al. 2013), extends to access to healthcare resources dependent on the measurement of bodily states.

Causal Dialogue as Healing

As I have demonstrated in the previous chapters, the organizational culture of a clinic will influence how providers and patients respond to gender-normative clinic bureaucracy. Organizational culture influences the kinds of affect providers and patients share in the two clinics as providers draw from bodily materiality in discourse to create these affects. In feminist healthcare clinics like Glendale, the organizational work culture is oriented toward valuing women's autonomy and self-care medical practices, activities that are directly meant to challenge the dominant model of biomedical bureaucracy that has historically excluded women's healthcare (Morgen 1995, 1986; Murphy 2012; Nelson 2011). The work culture at Glendale follows a similar model; there is low bureaucratization and staff actively commit to equalizing the relationship between practitioner and client. These practices enabled distinct kinds of rapport building.

At Glendale clinic, efforts to reduce bureaucratic hierarchy seep into the clinical interaction in the form of mutual, egalitarian dialogue shared between providers and patients.

This reduction of the typical bureaucratic hierarchy between provider and client through casual dialogue did not occur at Woodfield clinic, where the hierarchical relationship created between providers and patients as a result of dominant biomedical understandings of professionalism prevent Woodfield providers from participating in this kind of casual dialogue with patients. I present ethnographic examples of the kind of dialogue occurring at Glendale and detail the affective effects this dialogue permits to show how the clinic's feminist organizational culture structures these affects.

Unlike Woodfield physician assistant Janet in the opening vignette, Glendale provider Molly utilized medical terminology in dialogue with clients but she avoided any conversation regarding the ontology of transgender experience, often using medical language that did not include reference to a specific gender experience. The following is one example from observational field notes showcasing the typical way Molly conversed with clients during a procedure that is historically associated with cisgender women's bodies in biomedicine: the pap smear. In this example the reader is introduced to the very casual language Molly routinely uses that I will later show fosters feelings of empathy with clients. On this day, a client had come in for a pap smear and Molly explained the pap smear procedure to him this way:

> "'So, pap smear position sucks eggs,' Molly says. 'The speculum goes in like a tampon or like a penis depending on your experience with any of the above. I need to reach the cervix. We'll feel the vaginal canal and then, [she clicks her tongue and juts out her thumb behind her] we're out of there," (Observational field notes, Glendale clinic).

The frank dialogue at Glendale permits Molly to speak casually with clients using frank language. This kind of discussion was absent at Woodfield clinic, likely due to longstanding notions of professionalism bestowed upon the hierarchical bureaucratic role of healthcare providers precluding a more equalized provider-patient relationship. Molly describes the process of the pap smear with this client while acknowledging the discomfort of the pap smear position, which can cause dysphoria for some patients. Additionally, she avoids making assumptions about the client's sexual experiences and experiences with menstruation, keeping this language vague while still attempting to give him an idea of what to expect during the pap smear. Molly also uses the collective pronoun "we," throughout the exchange. Molly's use of "we" here can also be interpreted as an effort to anticipate the client's possible discomfort around the pap smear and to align herself alongside him against the possibly distressing procedure happening to a body he may not align with. Molly anticipates the potentially negative affective consequences of particular encounters with clients, and adjusts her bureaucratic practice to avoid them.

Molly's causal dialogue engendered empathy with clients in other contexts as well, especially when issues with insurance arose. For example, when client Moe asked Molly whether she could bill under his deadname (the name he does not use) because insurance was denying him under the name he used in daily life, Molly immediately replied, "that's what they [insurance companies] do." When Lisa, who recounted that insurance delayed her request to manage a testicular cyst, mentioned that she had changed her legal gender marker to female and this led to an insurance denial because she was no longer considered to have testicles under the new gender marker, Molly quietly muttered, "insurance companies are evil." As far as issues of insurance were concerned, Molly did not hold back verbally empathizing with clients who had experienced frustration with coverage using blunt language. Insurance denials, of course, were overwhelmingly motivated by a reliance on the dominant two-sex, two-gender model wherein transitioning patients were not legible, as I discussed in Chapter 3.

Patient-participants recounted poor experiences with providers at past clinics to providers at both clinics. At Glendale, the frank dialogue fostered through the clinic's feminist work culture enabled frank discussion of these past experiences. For example, client Moe described a past experience with his provider that left Moe feeling disdain for this past provider. Moe had come in with warts and his doctor told him that he had developed warts because he was taking testosterone. "She's full of shit," Molly immediately replied. While reflecting on Molly's response later during his debriefing interview, Moe told me,

> "Honestly I was glad just to be validated. I have some friends that I see often that know I have a lot of these appointments and stuff and they're never really fun. And trying to come home and explain to them why the appointment was bad or why everything that was to be accomplished wasn't accomplished, why I wasn't happy, it kinda just went over their heads. And so going to talk to Molly about it and have her just go "Yeah, that's horseshit! [laughs] That was a breath of fresh air." (Debriefing interview with Moe, Glendale Clinic).

Moe recognizes Molly's denouncement of his previous provider's comments as validation that something undesirable that his body is experiencing has nothing to do with the changes in his body that he does desire. Moe's warts coincided with his transition on hormones when he encountered his previous provider, and that provider insisted that the undesirable warts were due to testosterone, much to Moe's frustration. Molly's discursive practice of bluntly empathizing with Moe by delinking his warts from his testosterone use, and Moe's subsequent feelings of validation, reconfigure dominant notions of professionalism wherein the existing power hierarchy between provider and patient favors the provider's medical authority over the patient's expertise (Craig et al. 2018). As I will show later on, providers at Woodfield produce similar feelings of validation in patients, but they do not produce these affects through causal dialogue with patients but through other means shaped by the role-focused organizational culture of Woodfield clinic.

Perhaps the most striking example of the affective effects produced as Glendale providers and clients discussed prior providers' interpretations of transition care occurred on the day Lisa was seen in the clinic. On this day, Molly and Lisa were not the only people in the clinic room; nurse practitioner students also joined Molly in the small room. Lisa recalled with annoyance how she had been shopping around on the web for a nearby surgeon to complete her vaginoplasty—a surgeon that her insurance had picked out for her. She had found someone in a large nearby city, but this surgeon's work was unsatisfactory to her as it did not meet the aesthetic expectations she had for her body. The following is the exchange shared between Lisa, Molly, and the nurse practitioner in the room with us, from field notes:

> "Lisa recounts her experience of being sent to a particular surgeon for the surgery that was chosen by her insurance in a city four hours away. Lisa referred to him as a 'quack.' 'I was like, that's not a vagina, that's like a face-hugger from Predator,' she said of the example pictures she'd seen of his work to Molly and the practitioner student. She passes her cell phone around so Molly and the student can see the photos from the doctor's portfolio. Molly leans in to see the photos more closely. Then she says to Lisa, 'You sure

> he's ever seen one?' She and Lisa laugh. Then Molly says that she had a client who had her surgery done in New York and the surgeon had done a 'good job.' 'You can do a better job!' the nurse practitioner student chimes in after looking at the photo. 'Yeah, just give me a garage and tools,' Lisa replies" (Field notes, Glendale Clinic).

A lot of information is packed into this exchange. First, Lisa indicates that the vaginoplasty surgeon her insurance has picked for her fails to perform surgeries in a manner that is aesthetically satisfactory for her transition plan. Recall that Lisa is the same patient-participant who in Chapter 3 described at length her immense struggle trying to become legible to her insurance as a patient with a rapidly worsening testicular cyst and a legal F gender marker. By specifying that her insurance chose the surgeon and describing the poor work the surgeon performed, Lisa implied that her insurance was out of touch with what she classifies as acceptable transition care for her body.

Also important here is Molly's response to Lisa's lament. Molly's comment of "You sure he's ever seen one?" could be alluding to biomedicine's historical lack of attention to the natural variation and accurate depiction of female genitalia in medical textbook depictions of female anatomy (Andrikopoulou et al. 2013; Howarth et al. 2010). In this interpretation, the feminist underpinnings of Molly's medical practice and the goals of this feminist orientation to critique biomedical bureaucratization are clear. In this example as in the example with Moe's appointment above, Glendale's feminist organizational culture enables the informal dialogue Molly shares with clients whose bodies are in transition. Through their discursive care practices, Glendale staff challenge several dominant features of biomedical bureaucratization, including the denial of patient expertise, a hierarchical relationship between provider and patient, and reliance on an existing body of biomedical knowledge that has historically favored a particular kind of gendered embodiment. The open dialogue shared at Glendale culminates in feelings of validation and empathy in the moments that clients share their dissatisfaction with gender-normative clinical bureaucracy.

The mutual dialogue Glendale's feminist organizational culture produces enables feelings of empathy and validation for clients coming in to the clinic in the wake of several kinds of frustrations, especially those related to the time delays for transition discussed at length in Chapter 2 and feelings of invalidation clients received from past providers. In additional to organizational culture, bodily materiality plays a large role in how these modes of affect manifest through discursive care practices, as we saw when Molly discounted Moe's past provider's statement that his warts originated from testosterone use, and Lisa's suggested surgeon's failure to attend to the aesthetics of vaginoplasty.

For many gender-expansive patients, at the moment of the clinical appointment bodily materiality for a diversity of reasons is unsatisfactory for patients; it does not correspond to patients' self-image and subjectivity. However, patients are forced to navigate a variety of medical procedures that assume a particular gender experience is linked to a particular kind of body—like the pap smear. Through her casual conversation with clients Glendale provider Molly invokes aspects of patients' bodily materiality to affirm clients' subjectivities. Woodfield providers similarly fostered feelings of comfort and validation in patients. However, in the following sections I will show how Woodfield's organizational culture—that of a typical, bureaucratized U.S. biomedical clinic, shaped how patients understood Woodfield providers to build rapport with them in different ways than at Glendale.

Demoting the Body

Several patient-participants remarked that they felt comfortable at Woodfield clinic in a way that they had not experienced when seeking care at previous clinics. As in the chapter's opening vignette regarding the appointment between the physician assistant Janet and Terrance, I noted how Janet and Dr. C spoke as if they occupied the role of a counselor, a phenomenon quite different from Glendale where the organizational culture encouraged a relationship between provider and patient that was more equalized. During their interviews, patient-participants framed feelings of comfort they felt about their appointment experience to directness about their care and feeling like Woodfield providers listened to them. As I will show, both of these affects necessitate that providers de-center bodily materiality as a focus during appointments and center the goals patients envision for transitioning, employing care practices of listening and creating empathy with patients, setting the conditions to generate paths of bureaucratic encorpment that incorporate patients' transition plans.

During their interviews, patient-participants frequently linked providers' knowledgeability about transition care and witnessing their providers withhold assumptions about their transition care needs to feeling comfortable, acknowledged, and safe in the clinic. Consider Delia's experience as she discussed it during her debriefing interview. She mentioned that her appointment went "really well," and I asked her if she could provide an example of what she found satisfactory about her appointment. She said,

> "Delia: Everybody at Woodfield is extremely professional. Dr. C is charming and wonderful to work with and you know everything there is set up in a fashion that's extremely professional and makes it a good experience to the

patient.

A-M: What does "professional" mean to you?

Delia: To me in this case it means respecting my pronouns, treating me like any other person. You know… to me it's being treated like any other patient at any other appointment" (Debriefing interview with Delia, Woodfield Clinic).

Delia linked the professionalism of Woodfield's providers to being "treated like any other person." Contrary to whatever history about Delia's body in transition might appear in her medical chart, what matters to Delia and other patients who linked Woodfield providers' professionalism to having their identities respected is that providers overlook the charted bodily history in favor of acknowledging patients' subjectivities. Delia's understanding of Woodfield providers' professionalism entails providers treating her "like any other patient at any other appointment." This kind of professionalism necessitates that providers engage in continuous care practices of listening and showing empathy in order to avoid relying on the gender-normative features currently part of dominant bureaucratic healthcare practice. Patient-participants noted providers' willingness to listen and attend to patients' needs regarding their transition care, which also necessarily involved relegating gender-normative assumptions about transitioning bodily materiality as secondary to patients' understandings of their gender experience.

When I asked him whether the care he received at Woodfield clinic was different from other clinics he had visited in the past, Woodfield patient-participant Tyler replied that it felt much more comfortable because the care directly addressed his gender identity, something the clinic was “out in the open about.” He continued,

> “I didn’t feel small like I usually do, just kinda like I have to explain everything about my existence. Like in a regular doctor’s office it’s just like “Nnn, I’m abnormal!” [strained laugh],” (Debriefing interview with Tyler, Woodfield Clinic).

I asked Tyler what he meant by “out in the open,” and he reiterated,

> “… It was just… I don’t really know I just felt *a lot* more comfortable I didn’t feel like I was being belittled or that I had to explain my identity to anyone” (Debriefing interview with Tyler, Woodfield Clinic).

During Tyler’s appointment, Dr. C commented that Tyler’s voice “sounded good,” to which Tyler replied that he felt comfortable talking a lot more now than in the past. When asking about his sexual orientation to mark down in his chart, Dr. C. simply asked who he was attracted to without specifying any choice of gender. This kind of rapport—acknowledging those bodily changes that meet patients’ expectations for transition—contributed to patients’ feelings of comfort in the clinic. Similar sentiments were expressed by Jaden as well, who said,

> “They actually take the time to get to know you on a personal level and on a patient level as well. Not many places take the time to get to know who you are… they don’t rush you

> to have an appointment, get in and get out," (Debriefing interview with Jaden, Woodfield Clinic).

And Amelia, who said that her experience was "standard" at Woodfield clinic, and then explained what she classified as standard:

> "Dr. C and the nursing staff tend to be very educated on various gender identities, personal pronouns, sexual orientation, etc. so they make it feel very comfortable environment wise and they're also you know genuinely caring about what you're doing, what's going on in your life, your well-being, et cetera," (Debriefing interview with Amelia, Woodfield Clinic).

Patients at both Woodfield and Glendale clinic discussed feelings of comfort and safety as they recalled how Glendale and Woodfield providers avoided framing bodily materiality through the gender-normative gender-sex model. However, the kind of encounter that occurs—shaped by organizational culture—is what differentiates how these similar feelings manifest. While Woodfield providers take the role of a counselor as part of their role when building rapport with patients, adhering to some aspects of biomedical bureaucratization such as medical hierarchy, Glendale practitioner Molly engages in casual dialogue with clients in the near absence of such a hierarchy. Within both kinds of rapport, providers refuse to reproduce the gender-normative two-gender, two-sex model by incorporating features of bodily materiality that align with patients' goals for transition.

“A Person Not Worth Mentioning”

Not only do providers reference bodily materiality while consoling patients through frustration with insurance and negative past clinic experiences, affirming patient subjectivity, but they also utilize the body to indicate their support for patient care in the political arena. This was visible at Woodfield clinic, where one of the providers often indicated her acknowledgement of current politics surrounding gender-affirming care as she assisted patients who were losing hair. Depending on patients’ biological history, anyone taking estrogen or testosterone could become at risk of gradual but permanent balding. To counteract permanent hair loss, providers prescribed finasteride, a medication that preserves existing hair follicles by blocking testosterone production (Moreno-Arrones et al. 2017).

Since the beginning of fieldwork at Woodfield I noticed that this provider repeated a particular phrase to patients. When she described finasteride to her patients, she often included a variation of the following comment in her description of the medication:

> “There’s a certain President who uses finasteride—a person not worth mentioning” (Observational field notes, Woodfield Clinic).

Drawing from her observation of an undesirable process occurring in patients’ bodily materiality (the risk of balding) during their encounter at the clinic, this provider discursively utilized this process as an opportunity to indicate her acknowledgement of the current political situation surrounding transition care to patients. Up to the time of this writing, the current U.S. government administration has been actively targeting the provision of transition-related care to patients. Specifically, the administration has been attempting to strike down language in the

Affordable Care Act that requires federal dollars be allocated to cover transition-related care (National Center for Transgender Equality 2020). This provider invoked the similarities between the bodily processes patients found undesirable (balding) and the President and commented that the President was "a person not worth mentioning" as an attempt to align with patients regarding the current political actions that threaten the coverage of transition-related healthcare. While historically and culturally situated power relations can manifest in the suffering body, the situation occurring here demonstrates that the materiality of the body can also function to disrupt formations of power as clinic providers create feelings of empathy and various forms of alignment with patients through them (Nouvet 2014; see also Povinelli 2006).

Celebrating Progress

Many patients at both clinics considered their encounters during clinic appointments as chances to reflect on the progress they had made toward their transition goals. Patients related lab values and providers' knowledgeable assessments of their transitioning bodies at appointments to these goals. Woodfield patient-participant Tyler explained that his appointment made him feel "joy," as he put it, because he could see how far he had come in his transition. "I could see little bits of how I progressed…" he explained. He continues,

> "Really anything that's changed about me, even the negative things. Dr. C did comment that my hair was getting kinda thin and I noticed that too. So like just knowing that there's changes going on that affirm my gender identity. It's pretty great to recognize things like that [laughs] even the kind of negative things" (Debriefing interview with Tyler, Woodfield Clinic).

Tyler’s arrival at the clinic involved an encounter with a provider who had not seen him in at least 6 months. Like a series of snapshots, appointment encounters with healthcare staff who assess their bodies visually and electronically serve as an opportunity for transitioning patients to gauge changes that are difficult to observe during the incremental encounters of daily life. These clinical encounters often produce feelings of joy, pride, and accomplishment. As Woodfield patient-participant Samantha similarly commented, “It’s very exciting that I’m able to make this a reality for myself.”

For Woodfield patient-participant Mindy, the progesterone prescription she received the day of her appointment solidified what she considered to be the final phase of her transition. During her debriefing appointment I noted how Janet detailed the many changes she would experience after starting progesterone and I asked what she thought about the conversation. She said,

> “No I mean that was something that was exciting and was welcomed so… The fact that I’m in the latter phase of transition, I don’t know. It’s like rewarding. I’m getting towards the end where like… not that I’m not living a normal life, cuz I am, but like I’m getting… I don’t know… I’m getting toward a less complicated part in my life, with bottom surgery, concluding the end of transition. Like once I have bottom surgery, my hormones… I mean I’m in transition all the time but it’ll be more towards a *final* ending versus like a progression, I guess?” (Debriefing interview with Mindy, Woodfield Clinic).

For many patients, interactions with providers knowledgeable about transition care during the clinical appointment and attuned to patients' individual transition goals served as a yardstick for patients who were interested in evaluating their progress toward their goals and how far they had left to go before reaching them. As Woodfield patient-participant Niki noted, "[The appointment] was very informative and helpful for keeping me on track, making sure I'm on track for now and for the future." Providers' accumulated knowledge about transition care, built through the continuous discursive care practices they exchanged with patients, created forms of bureaucratic encorpment that offered the possibility to inform patients about transition progress over time as they continued to return for future appointments.

Conclusion

This chapter showcases affect as central to the emergence of paths of bureaucratic encorpment that serve transition plans during initial appointments and future ones. Healthcare staff and patients at Woodfield and Glendale clinic constantly incorporate bodily materiality into bureaucratic practice, producing a range of affective responses in patient-participants. As I have argued here, as providers and staff engage in discursive care practices with patients and patients' bodily materiality during clinical appointments, they explicitly avoid reproducing the dominant two-sex, two-gender model associated with historically gendered procedures like pap smears by speaking vaguely—leaving room for the range of emotional connections patients might have with their bodies—and by privileging patients' own understandings of their bodies. For patient-participants at Glendale and Woodfield clinic, this was a welcome departure from interactions with past providers that centered gender-normative understandings of bodily materiality in dialogue to the exclusion of patients' subjectivities. Glendale and Woodfield providers and staff listened actively to patients and privileged patient knowledge, departing from dominant ethos in biomedicine related to bureaucratization and professionalization (Craig et al. 2018). Employing these discursive care practices appointment after appointment has allowed providers to build a body of knowledge equipping them to better anticipate sources of negative affect in patients such as anxiety and trivialization and specifically avoid them in discourse about patients' bodies.

It bears noting that the environment created at Glendale and Woodfield that leads to affective responses of comfort and safety speaks to the importance of creating these environments in areas lacking them. Gender-expansive patients experience profound discrimination from healthcare providers, to the point where they would rather avoid seeking healthcare at all (James et al. 2016). Likely due to the kinds negative experiences with past providers many Woodfield patients described, sometimes just the process of mustering enough courage to schedule into the clinic, or scheduling rides to the clinic, engendered feelings of anxiety for patients, as this chapter has demonstrated.

Unfortunately, because of the low number of knowledgeable healthcare staff available to run clinic at Woodfield, patients have a difficult time scheduling into often one of the only clinics they feel comfortable attending. As Woodfield patient-participant Amelia remarked during her interview,

> "…Right now if I would be to call and try to get an appointment it could be two or three months before I could get to see Dr. C. I might be able to be seen quicker if I were to go to her normal everyday clinic but there could also be presentation issues with gender, pronouns, etc. It's kind of a toss-up as far as the patient's comfort level is concerned as far as being seen outside of Woodfield" (Debriefing interview with Amelia, Woodfield Clinic).

As detailed in Chapter 2 patients can experience barriers to care that occur before the patient steps into the clinic, including scheduling into the clinic, arranging rides to the clinic that are often long-distance, and ensuring they are fasting within an appropriate timeframe to complete accurate bloodwork for hormone prescription renewal. The presence of these barriers emphasizes the need to expand the affective environments of gender-affirming health clinics like Glendale and Woodfield over a greater geographical area. Glendale patient-participant Damien summarized this need succinctly when he commented, “I’m super glad that they’re there, because I don’t know what I would do if they weren’t. I wouldn’t be comfortable going anywhere else for the care I get.”

CHAPTER 5: CREATING AFFECT THROUGH BUILT SPACE

I'm watching scheduling today since the first appointment ended right when I walked into Glendale clinic… One of the front desk schedulers, Melinda, is telling me how funny it is when people read the sign on the door to take off their coats and then come in with their coats on anyway. We talk about the clinic's security system. Melinda says that sometimes people come in upset about it—"you don't trust me," someone once said. We talk about a recent incident at the clinic in which someone had broken one of the window panes… Melinda tells me that even if someone were able to get in, the clinic has other structural barriers if the offender tries to move further into the building. The front desk glass is bulletproof and documents are exchanged via a slit in the counter… "So you can't slide explosives under or something, but it makes it hard to slide paper under there too."

"We just have the rule—you can bring in stuff with you [into the clinic] without the bag. We can give you a blanket if you're cold, we can meet your needs, but we have this rule because bad stuff has happened here before," Melinda explains.

I notice not long later that a client comes in with his coat on and immediately the two schedulers look at each other concerned as he walks into the lobby area. One of them tells him to take off his coat. Melinda tells me that she usually reminds clients to take off their coats using a simple gesture [of taking off a coat]. I think about how Melinda used the descriptor of "funny" when describing how clients walked in with coats still on after bypassing the signs; given their concerned expressions, it did not seem like an appropriate descriptor now. (Observational field notes, Glendale Clinic).

Above, Melinda recounts various features of the built environment of Glendale, which provides abortion services, that reflect security measures in place to guard against anti-abortionist violence. In this chapter, I examine how clinic staff and patients integrate their perceptions of clinics' architecture and interior into space-tracking bureaucratic technology to create forms of bureaucratic encorpment that represent patients' transition plans. Thus far, I have discussed how temporality structures bureaucratic practice within and outside of the gender-affirming health clinics and within bodies, and considered the ways providers and patients shape and are shaped by documents—especially the medical record—as they rework these documents to make gender-expansive patients visible. I have also shown how care practices mediate these efforts. These practices of course always occur within material buildings, and staff and patients necessarily interact with clinics' spatial design and with the decorated interiors of the clinics throughout the day. Drawing from recent work in the anthropology of design recognizing material agency, I argue that providers' interactions with Woodfield's space-tracking software and patients' affective responses to clinics' interiors shape patients' future contact with the clinics, enabling forms of bureaucratic encorpment that do or do not incorporate patients' transition plans.

The architecture of Woodfield and Glendale clinics and the kinds of social interactions they permit diverge broadly. The walls of Woodfield were purposefully constructed to ensure providers and patients do not co-exist in space until the time of the patient's appointment. The philosophy built into the clinic's architecture is reinforced through daily bureaucratic practice as staff are restricted in space according to their bureaucratic roles. The same software that displays medical records helps healthcare staff keep track of other staff and patients' positions in the building, even when walls and doors prevent people from seeing each other. Staff's use of this designed software interface as part of their bureaucratic practice structures workflow inside the clinic just as temporality and clinical documents do. From this short description of Woodfield's architecture and interior layout, the importance of giving as much attention to spatial and interior design as to other features of bureaucratic practice becomes apparent. The built environment of the clinic represents an additional site through which staff and patients experience bureaucratic practice. For gender-expansive patients, the built environment of the clinics generated affective expressions that patients linked to their lived experiences of gender. Staff and patients' daily management of clinic space—how these actors move through buildings and acknowledge buildings' interiors—impacts how bureaucratic encorpment unfolds as patients incorporate positive and negative perceptions of clinics' age, security fixtures, cleanliness and the like into their appointment experiences.

In contrast to Woodfield's large and divided space, the built environment of smaller community Glendale clinic houses staff of various roles close together and visibly reflects its offering of abortion services within a turbulent political landscape. In the opening vignette, Melinda hints at precautions the clinic takes to ensure the safety of clients and staff, such as coat racks and multiple locked hallways. Features of the built environment, while designed for a particular purpose, influence providers' and patients' bureaucratic practices in unanticipated ways (Roberts 2012, 2514). Through these interactions, forms of bureaucratic encorpment are created as staff and patients interact with clinic interiors and architecture and incorporate these experiences into bureaucratic practice. For example, a patient might interpret the presence of paper medical records at Glendale clinic to convey a lack of clinic funding and this might lead them to think the clinic has limited transition care resources to offer the patient. As with affective responses created between people, affective responses to spatial design and interior are multiple

(Archambault 2016); while one patient might link paper records to a lack of resources, another may interpret the effort of organizing these records on a tight clinic budget within a hostile political climate as admirable.

Anthropological Approaches to Design and Affect

Anthropological approaches to design have only recently been taken as an object of inquiry in the discipline (Murphy 2016). In an effort to investigate why anthropology has recently turned to design at the present moment, Murphy proposes that,

> “Many of anthropology’s prevailing analytics are typically applied to a world of given forms and proceed through a critical reading of those forms and their effects. A design framework, by comparison, remains compatible with this inclination, but also highlights, rather than presumes, *form-giving as an active and vital phase of social reproduction*. Meanwhile, a theoretical emphasis on so-called nonhuman actors attempts to account for the truism that humans are affected by spaces, interfaces, material things, etc. by simply redesigning the analytic so that agency is redistributed outside of human bodies. But within a design framework such as the one presented here, people, practices, objects, materiality, forms, ideologies, consumption, politics, etc. are all afforded attention without having to promote or demote any one of them” (Murphy 2016, 443, emphasis added).

Echoing Murphy and drawing from Deleuze, Roberts (2012) notes that “assembled as it is from the background hum of molecular trajectories, a ‘thing’ (or body) has no unchanging essence, and as such can only be defined according to its capacity to enter into relations with its environment (Roberts 2012, 2516, drawing from Deleuze 1988, 125). I draw from this understanding that the materiality of built environments is constantly entering in relations with subjectivity and with bodily materiality to show how providers and patients actively incorporate specific features of the built interiors of the clinics—and in the case of Woodfield, the design of space-tracking software—into their bureaucratic practice, with consequences for patients' access to transition care.

At Glendale and Woodfield, staff and patients inevitably interact with electronic bureaucratic technology that tracks people's movements through clinic space—the electronic health record (EHR)—and features of the built clinic environment such as doors, hallways, and interior decorations. These material and technological features were designed with specific anticipated outcomes in mind, but as I will demonstrate, the ways that staff and patients interact with(in) them sometimes produced unforeseen affective effects and impacted bureaucratic workflow as actors predicted—and failed to predict—the movement of bodies in the clinic space. In the first section of this chapter I illustrate how Woodfield's built space and space-tracking electronic technology together become embodied as staff and patients moved through and interacted with them.

The space-tracking function of the EHR interface can become another example in which adhering to routinized bureaucratic practice—in this case via the use of digital bureaucratic technology—serves to exclude the very population staff aims to serve. As staff incorporated this clinic-wide technology into habitual use through their mouse clicks (Miller and Horst 2012, 29; Bourdieu 1977) to reflect the reality of staff's and patients' positions in space, digital representations of space use did not mirror staff's actual spatiality, leading to scheduling errors.

Staff's interactions with this digital technology—clicking through screens and icons as part of routine bureaucratic practice— "produced subjects and places in and through the process of depicting them" (Poggiali 2016, 390). These practices consequently and unintentionally barred patients from scheduling into the clinic. These patients' absences from the clinic in the present enables forms of bureaucratic encorpment that do not embody their transition plans in the future because these patients' future engagements with gender-normative healthcare bureaucracy are foreclosed.

In the second section of this chapter, I show how patients' affective responses to specific features of clinics' interiors shaped the interactions they shared with healthcare staff. Pink and colleagues (2017) outline a definition of the notion of atmosphere in the home that I draw from to analyze people's affective relationships with interiors in the clinic. These scholars' definition of "atmosphere" brings to light our "embodied relationships with the material and intangible environments of home" (Pink et al. 2017, 55). Material environments and sensory things like light, music, and scents generate mundane, complex, and intense feelings. To be able to capture these relationships ethnographically, Pink et al. advocate for an understanding of atmosphere as emerging from processes of making (Pink et al. 2017; see also Ingold 2010). From this line of scholarship, these authors argue that to capture atmosphere and the affects it generates ethnographically we need to

> "...Identify empirically the contingencies that constitute particular atmospheres; understand their qualities and affordances; and, use this knowledge to generate insights into mundane everyday lifeworlds where atmospheres, people, things, and processes together constitute everyday environments" (Pink et al. 2015, cited in Pink et al. 2017,

56).

At Woodfield and Glendale, atmospheres are constantly created—and affects continuously arise—as staff and patients move through the clinics and interact with the affordances of bureaucratic features like electronic software, and with sounds, lighting, and architecture. In this chapter I realize Pink and colleagues call in practice as I identify and trace how concrete factors produce specific affects in patients that constitute overall appointment impressions or atmospheres, creating particular paths of bureaucratic encorpment.

A small body of anthropological literature explores how built environments generate affect in individuals (Adey 2008; Navaro-Yashin 2009; Street 2012; Zhang and Spicer 2014). I briefly reference this work here to model how I will analyze ways that digital technologies such as the EHR influence the relationship between built environments and affect and how patients relate these environments to themselves and to the staff in the clinics. Adey (2008) examines how power and surveillance shape the emotions travelers feel as they move through the built environment of the airport. For example, the presence of security guards as well as narrow barriers and ropes keep people in a single-file line and intentionally create the feeling in travelers that they are controlled; in this way airport design "embodies an affective understanding of the transition of feelings and emotions to affect the body's power to act and move" (Adey 2008, 445). We can look back to Pink and colleagues' work and argue that the airport's interior design created an atmosphere of control over the positions and movements of travelers.

In a similar vein, Navaro-Yashin (2009) investigates how dispossessed refugees adopted the living spaces and belongings of the community of people considered the "enemy." Navaro-Yashin examines how refugees' interactions with these items and spaces generated an affect of melancholy as refugees recognized this materiality as the losses of their original owners (Navaro-Yashin 2009). Street's (2012) ethnography in a Papua New Guinea hospital details how the conditions of hospital infrastructure built in different historical times influenced hospital staff's emotional attachments to the state, and in one Chinese hierarchical bureaucracy, employees made sense of their own place in bureaucratic hierarchy by drawing similarities between their employment positions and the architecture and layout of the building. For example, low-rank clerks related the ability of cubicle plants to grow and the low ceiling in their workspace to personal feelings of insignificance as employees (Zhang and Spicer 2014, 10).

As these ethnographies demonstrate, architecture and interior design are an important site for investigating the constantly unfolding correspondence between bodies' positions in space, affect, and the built environment. I extend this discussion to consider the ways that the built environment influences the relationship between material and electronically-mediated bureaucratic practice and gendered embodiment. I show how these relationships in the present create conditions that produce forms of bureaucratic encorpment that either incorporate patients' transition plans (because these forms encourage gender-expansive patients to interact with clinics' bureaucracy in the future) or do not incorporate them (because patients' future absence leaves gender-normative healthcare bureaucracy consequently unchallenged).

To give the reader a sense of what the clinics look like, I briefly sketch the layouts of Woodfield and Glendale clinics, which differ in size, structure, and age, and restrict the movement of people through them in different ways (Figure 1). I demonstrate how staff and patients draw from their movements (and limitations of movement) through these spaces and relate them to themselves and their interactions with gender-normative clinical bureaucracy.

In the first section in the chapter, I focus on staff's interactions with Woodfield's electronic health record (EHR) software, which not only stores medical records and manages billing as discussed in Chapter 3, but also tracks staff's and patients' movements through the clinic in real time through its interface. I emphasize how providers' reliance on this interface in lieu of physically perceiving patients and other staff sometimes led staff to misjudge where individuals stood in space with consequences for patients' clinic access. For example, there was a day when a nurse recorded Dr. C as ill on the digital schedule, blocking schedulers from being able to schedule patients for appointments, and yet Dr. C was standing in the staff room ready to enter a clinic room with a patient. When staff block the schedule, the blocked time slots turn red, alerting staff not to schedule into them. Such instances prevented schedulers from being able to schedule patients into the appointment slots of the difficult to schedule into clinic and caused providers frustration within the clinic. Here, electronic and material bureaucracies intertwine to create forms of bureaucratic encorpment that have the potential to leave gender-normative clinical bureaucracy intact because gender-expansive patients are barred from interacting with clinic bureaucracy when they cannot schedule into the clinic.

The scheduling software was also sometimes insufficient to obtain certain information schedulers needed about the precise location of health staff during clinic. For example, staff occasionally rotated which pod they held clinic in. Information about this kind of mobility could not be determined from the interface. Interactions with the software interface were further limited by staff's bureaucratic roles as they related to HIPAA requirements, which delimited the amount and kind of information particular staff roles were able to share about patients over the interface with other staff. Given the obstacles Woodfield's architecture placed on healthcare staff, the design of the software interface was a key mediator of Woodfield's bureaucratic workflow in its goal to track individuals' bodies in space. This interface both facilitated and precluded ideal clinical practice with consequences for patients' access to care. Through these ethnographic examples I emphasize that the digital software mediating people's spatiality through clinic architecture structures the creation of forms of bureaucratic encorpment that do or do not incorporate patients' transition plans.

In the second part of this chapter, I move from discussing the ability of Woodfield's unique electronic software to mediate people's movement in space to discussing how the materiality of clinic spatial and interior design structured how people could move in the clinics, which produced particular expressions of affect. As I discussed in Chapter 4, positive affects affirm patients' subjectivities and encourage patients to return to the clinics. While Woodfield clinic is large and newly built and staff roles are spread out throughout the building (with providers physically separated from patients as previously noted), Glendale clinic is small enough that staff can see each other at all times and the clinic is housed in an older building. These differences in proximity facilitated scheduling at Glendale, but at times also enabled clients to overhear staff refer to them with incorrect pronouns in the hallway outside clinic rooms. At Woodfield, patients who had been waiting a long time for their appointments during very busy clinic days and who had not been checked on by MAs took it upon themselves to open the sound-proof door to the staff area to check on the status of their appointments. In these examples, staff and patients utilized the clinics' architecture in ways that created affective responses in patients and influenced clinic workflow (eg. hurrying it along). I show how clinics' built environment contributes to the creation of avenues of bureaucratic encorpment that either encourage or discourage patients from returning to the clinic.

Features of the interior design of Woodfield and Glendale clinics generated different kinds of affect in patients. At Woodfield, the presence of gender-neutral bathrooms and the clean, sterilized atmosphere of this biomedical clinic engendered in patients' feelings of affirmation and provider competence in transition-related care. Glendale's operation in an old building sometimes generated concerns that the clinic was underfunded, but patients simultaneously expressed feelings of solidarity with staff under the security precautions the clinic took to protect the clinic from anti-abortion violence. These examples highlight how, in addition to wall and door partitions in the architecture of the clinics, patients' acknowledgement of features of clinics' interior design such as aged fixtures and narrow hallways influenced gendered subjectivity and perceptions of good transition care, culminating in forms of bureaucratic encorpment that favor or do not incorporate patients' gendered embodiments.

The Layout of Woodfield Clinic

As I mentioned in the previous chapters, the brick-and-mortar layouts of Glendale and Woodfield clinics vary considerably in size and structure, which shapes how people can occupy them. It is important to more clearly detail the layouts of the two clinics here to give the reader a sense of the built environments through which staff and patients move. I have included simple diagrams of these layouts below in (Figure 1).

The layout of Woodfield clinic both resembles and departs from that of a typical large biomedical clinic. The building has large windows looking out from the waiting rooms and boasts a high LEED (Leadership in Energy and Environmental Design) rating. Like a typical biomedical clinic, several staff roles are present and occupy specific bureaucratic roles throughout the space. That is, there are designated spaces for each staff role in the clinic. For example, as part of their job role schedulers occupy the front desk throughout the workday, while healthcare staff remain in the pod in the back of the clinic. Additionally, in contrast to Glendale clinic, where all staff are in view of each other, staff positions were physically separated at Woodfield by walls and doors. For instance, schedulers are separated from healthcare staff, who are not seen by patients until their appointment times. Greeters meet patients as they walk through the building's revolving door, and patients take an elevator to the clinic. When the elevator door opens, the check-in desk is the first structure patients see as they exit, as it sits in the center of waiting areas that span each side of it. Following check-in, a medical assistant calls the patient through a door separating the clinic rooms from the waiting area, asks the patient to step on a scale in the hallway to record the patient's weight, and guides the patient into their assigned clinic room.

There is another door on the other side of the clinic appointment room, one that opens out to the clinic staff area—what staff called the "pod." The patient never walks through this door (besides the rare instance patients opened this door when clinic workflow ran behind schedule). This is because staff and patients are purposefully separated from each other by an organizational philosophy that is reinforced through the clinic's spatial design. As discussed extensively in Chapter 2, rows of computer desks line the pod and face away from the line of doors to clinic rooms. A plaque listing the room number appears by each door, and small magnets affix the next patients' appointment information on each door, which staff pick up on their way in. The very large monitor (what I refer to as the "patient board") is suspended above the row of computer desks, and staff refer to this board several times throughout clinic to track the flow of patient appointments in between dictating and note-writing on their own computer monitors.

As previously mentioned, Woodfield's EHR tracks patient appointments through its software, but it also constantly tracks the movement of staff and patients in space through an arrangement of icon and color signifiers. This occurs not only on staff's computer monitors and the patient board, but also on schedulers' computer displays, albeit via different interface views. As I will discuss, Woodfield's EHR software alerts healthcare staff to the movement of patients in space from check-in to check-out and staff come to rely on this technology to staff's locations and locate patients in the building when staff are not in view. Such reliance on the EHR's visual tracking interface can complicate bureaucratic workflow rather than facilitate it, impacting patients' abilities to schedule appointments, as I will discuss.

At Woodfield, a peculiar organizational philosophy guides healthcare staff through space. I learned this during one of the early days I sat with schedulers to observe scheduling practices. I noticed a patient walking around seemingly aimlessly through the waiting area, looking lost. I was sitting at one of the empty scheduling desks, and the scheduler next to me stood up and walked over to him to ask where he needed to go. He was looking for the pharmacy, and the scheduler walked into the elevator with him to take him down to the pharmacy. She came back up alone and walked back to her spot behind the check-in counter. "Technically I'm not supposed to do that," she tells me. I asked her why and she replied, "It's part of this on-stage off-stage thing," she said. Noticing my puzzled look, she clarified that all staff have to stay within their specified roles—as in, they need to remain behind their desks when not tidying the waiting area for patients, and they cannot take the same elevators that patients take. She explained that people who trained employees at Disney came in to her employee training session to teach her and other staff about this "on-stage, off-stage" philosophy they should follow each day. "You know," she continued, "if you're dressed like Cinderella out there you're supposed to BE Cinderella."

According to this scheduler, this is also the reason that physicians are rarely seen in the same spaces patients occupy. Indeed, whereas at a hospital ancillary to the clinic staff and patients frequently cross paths and eat in the same cafeteria, staff eat at a separate cafeteria in this building, which they take a separate elevator from patients to get to (as I learned when I once joined staff for lunch). This separation of staff and patients, reinforced by the spatial design of the building, dictated where staff and patients put their bodies in space as part of their specialized roles, with various consequences for bureaucratic workflow.

The Layout of Glendale Clinic

The layout of Glendale diverges from that of Woodfield as shown below (Figure 1). Even prior to walking through Glendale's door, it is immediately apparent that the clinic places great importance on security and surveillance, reflecting the relationship between Glendale's offering of abortion services and a broader contentious political climate surrounding abortion in U.S. politics. Sometimes, a line of protestors stood outside the clinic with signs. Even if clients do not encounter protestors on their way in, they come face-to-face with several security cameras before they walk through the clinic's door. The clinic is held in an old building, with wooden accordion doors and trim ("I swear the cabinets look like they're from the 1920s," Molly once said). There is a small hallway with a coat rack past the front door, with signs stating that weapons of any kind are not allowed in the clinic and asking clients to leave belongings and coats on the rack before entering the clinic. Beyond this liminal space, clients approach the check-in staff, who sit behind bulletproof glass. They exchange documents through a slit in the wooden counter to prevent individuals from sliding explosives to the schedulers but to allow documents to pass through, as Melinda explained in the opening vignette of this chapter.

At the time of their appointment, someone from the front desk leads the client through a locked door to their clinic room. The hallway between the schedulers, the administration office where Sarah sits, the office where Molly sits in between appointments, and the clinic rooms is very short, so much so that I had little room to sit on a stool in the hallway to observe interactions between staff. At Glendale clinic, there is no EHR that tracks staff and clients' movements through the clinic day, but brightly colored mobiles hang above the examination tables, soft music flows through the waiting and clinic rooms, and colorful brochures about fertility and sexual health and boxes of condoms are available in several areas of the waiting room. Through these materials and sensorial experiences, staff aimed to create a calming and reassuring atmosphere for clients coming in for cervical exams and abortions.

As I outlined in Chapter 2, the lack of strict EHR oversight at Glendale contributes to the relaxed and unhurried workflow in the clinic. Additionally, it is unnecessary for staff to track staff movement, as all staff sit within feet of each other and can simply call down the hallway to consult each other. As I will discuss, this proximity occasionally led clients to overhear staff misgendering them as they discussed their appointment plans, something precluded by the thick walls and doors at Woodfield, although misgendering occurred there at a similar (rare) frequency. The clinic's space limitations, building materials, and interior decorations, as well as the aesthetic experiences staff strove to cultivate, shaped how providers' and patients' bodies moved through space and how these movements generated particular expressions of affect.

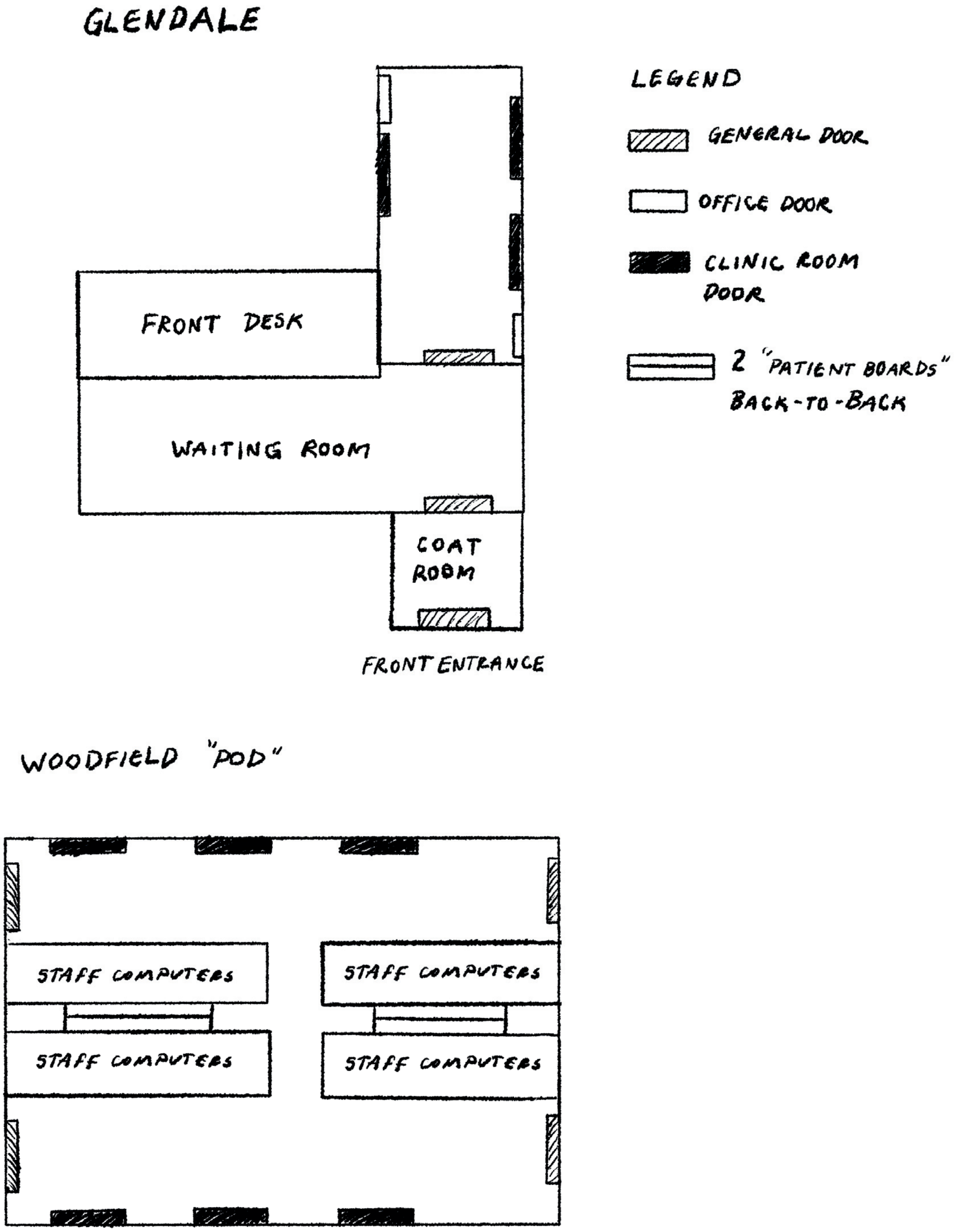

Figure 1. Author’s reconstruction of key features of Glendale clinic’s interior and the interior of a Woodfield staff “pod.” Each general door in the “pod” leads out to a hallway of adjacent pods and to the floor’s front desk and waiting room.

Using Software to See Through Walls

The aforementioned Disney-inspired organizational philosophy dictating Woodfield staff's and patients' movements through clinic space and separating staff from patients would present issues for staff-patient communication if a mechanism were not in place to ensure their interfacing. At Woodfield, the electronic health record (EHR) does the work of tracking staff's and patients' movements in space when these actors cannot be seen through walls and doors and when staff must remain in one place as part of their job role. Additionally, different staff positions see different views of the EHR interface on their computer monitors. HIPAA regulations staff must follow as part of their job role further shapes what different staff roles are able to see on their monitors. There are note sections in the interface available for staff to type in details about patients' appointments and this section is visible to all staff. However, HIPAA requirements shape how much information each staff position can write in this section. Sometimes, information entered on the scheduling side was too vague for providers.

In addition to providing the minimum required appointment information, the interface continuously tracks patients' movement in space using a variety of icons and color signifiers and these icons change for other staff as staff complete actions on the interface, such as checking a patient in. Through this arrangement of abstract icons, the interface tracks patients at the moment they check in, while they wait in the waiting room, when the MA checks them into the appointment room, as they wait in the clinic room, when the physician enters the clinic room, and when the patient checks out of the clinic. As discussed in Chapter 3, part of the function of these icons is to audit bureaucratic workflow. But these icons also served as visual signifiers for staff to track the movements of other staff and patients through the day. I will discuss HIPAA requirements vis-à-vis EHR software and the software interface design in turn. The software interface structured the kind of communication that occurred between staff and patients scattered spatially throughout the clinic and beyond. In some cases, staff's reliance on software to track other staff and patients in space precluded patients from scheduling into the clinic and led to forms of bureaucratic encorpment that did not incorporate patients' gendered embodiments.

Appropriately adhering to HIPAA regulations involves ensuring that each staff only manages the amount of patient information necessary to fulfill their job role. I first became aware of the role of HIPAA in shaping what staff could write about patients in the EHR interface during the day I had the opportunity to sit with schedulers who managed patient scheduling for multiple specialties, including Woodfield clinic. These "centralized schedulers" were situated in a location away from Woodfield and they served as the first contact for new patients who needed to be scheduled into a specific clinic.

On the morning that I was scheduled to visit the centralized schedulers, administrator Raina gave me a tour of the space. All of the schedulers here have their own cubicles, and the schedulers are partitioned by specialty. For example, centralized schedulers might be specialized in scheduling for cardiology, internal medicine, or family medicine. After the short tour, Raina introduced me to centralized scheduler Cynthia, who usually schedules patients into Woodfield clinic. Cynthia is wearing a headset that looks high-tech—it's wireless. She picks another one up, activates it on a pad, and hands it to me so I can listen in on her scheduling conversations. I tell Cynthia what the aim of my research is—that I want to follow the bureaucratic chain and that I am interested in transition-related care specifically. Cynthia tells me that whenever she schedules through centralized scheduling she asks about the specific aims of the appointment and asks for patients' preferred names and pronouns. I ask what different people can see on the screen. From field notes,

> “*Cynthia says that providers can’t see whether patients reschedule, or if a spot is “truly” open or not. Cynthia mentions that people don’t need to see things that they shouldn’t know. So, schedulers are encouraged to write just the bare minimum. People shouldn’t see information that isn’t necessary for them to see or isn’t part of their jobs. I ask Cynthia if this is related to HIPAA and she says, ‘yes, it is’*” (Observational field notes, Woodfield clinic).

Cynthia continues, telling me that sometimes, physicians grow upset because they are unable to see on their monitors (or in the case of Woodfield clinic, on the large patient monitor) what patients are coming in for, due to the HIPAA obligation to protect patient privacy on the schedulers’ side. Cynthia steps out for a meeting and I move to sit with Penny, another centralized scheduler close by who schedules patients at Woodfield. I ask Penny what Cynthia may have meant when she said that providers can’t see when a scheduling spot is actually open or not, and she clarified that spots that are “on hold” tell schedulers that those appointment spots are reserved and that they shouldn’t schedule patients into them. “It tells schedulers, ‘don’t touch it.’” Holds expire after 48 hours. I made the connection later that the “on hold” placements schedulers placed on appointment spots produced quite a few consequences as Woodfield providers then interpreted these interface displays at Woodfield clinic.

Even during the first days of observation at Woodfield, it was clear that the scheduling calendar posed frustration for providers. On one particular day, Dr. C. had not yet come into the clinic and word was spreading to the staff that she had a cold. “Is she coming in?” One nurse asked. “Oh yes,” another answered. She came in later wearing a surgical mask and mentioned to staff that she had a very mild cold. As I sat next to Dr. C's computer station when she logged in, I heard her *tsk* under her breath and mumble something at her computer monitor. She turned to me and told me that schedulers had put her patients on hold because the schedulers assumed she was sick. She motioned for me to come look at her monitor, where she showed me a red box with the word "sick(?)" in it. Next to the red box, the names of patients scheduled in those slots and set to be rescheduled were displayed.

It seems that the schedulers thought Dr. C was sick with a cold and would stay home, yet there she was with a surgical mask on, talking to me. "It's like a broken wire," she says, because no one ultimately followed back up with her as to whether she was in the clinic. If the patients are on hold or don't show, the schedulers do not put other patients in their place. This is a problem because at this clinic, patients can be scheduled out for months. Thus even when Dr. C was clearly present in the space and ready to begin clinic, the broadly visible scheduling interface represented her assumed absence as a large red block on the schedule, which took precedence over the reality of her presence in the clinic. Woodfield staff sometimes preemptively remedied these situations directly by taking advantage of the schedule display. For example, I once observed Dr. C calling someone on the phone to tell them to shift a color on an appointment block from red to yellow, so that "nurses will be more comfortable putting people in there" and didn't think she had a lecture or other obligation preventing her from overseeing clinic. Failing to address schedulers' assumptions prevented patients from scheduling into scheduling spots. This creates forms of bureaucratic encorpment that would leave features of gender-normative bureaucracy intact, because it would not allow for the opportunity for providers and patients to address gender-normative healthcare bureaucracy during the patient appointments that did not occur.

In the majority of cases of course, auditing cues emerging from the software interface greatly assisted Woodfield staff. For Woodfield's front-desk schedulers who, as described above, had limited mobility while performing their jobs, the schedule interface was crucial. Especially on busy clinic days, front-desk schedulers had to be present at the front end of the clinic to check in a myriad of patients while they adhered to the clinic's organizational philosophy that prevented them from walking away from the front desk. Thus, they needed some way to track the process of patients entering and exiting the clinic while staying in one place. Schedulers heavily relied on the scheduling software interface to do this, attending to various markers corresponding to patients in space to plan their workdays. Sandra, one of the MAs, introduced me to Nathan, who was a lead scheduler, on a day when the clinic had rotating medical students and I could not observe patient appointments. Nathan talked to me about the orders that physicians send for procedures and diagnoses completed. He told me that when they input these orders on the EHR "it's a signifier for schedulers sometimes" (that patients are ready to check out). This is the first time I became aware of the cues that schedulers wait to see in the interface to structure their bureaucratic activities. Nathan detailed how the check-in process worked as schedulers interact with the EHR interface:

> "*Check-ins manually check "ARR" for "arrived" and this sends a signal to the pod (and of course, patient billboards) that patients have arrived. He showed me that when health staff puts in a number corresponding to the clinic room number this means that the patient is being "pulled into the room." This lets the check-in schedulers know that patients are taken care of. Then, when MA's come in to the clinic room to meet the patient and take vitals, the "full check-in occurs" and the scheduling slot turns green—*

> *blue is for completed appointments. White signals that the patient is not fully checked in yet*" (Observational field notes, Woodfield Clinic).

Schedulers, while not able to directly view staff and patients' movements through the clinic, are still able to track this information visually through their view of the EHR interface alongside the time auditing that the interface performs. Nathan outlines the check-in process when things go well—when MAs designate a room number for the patient and when the colors cycle through indicating to schedulers that the appointment is proceeding normally. However, there are times when patients remain in parts of the clinic they should not be in at the appointed time, and schedulers do not have to physically see the patient to know when this happens. For example, there is no room number listed by the patient's name, or a color does not change in a timely manner. In these cases, schedulers act. A scheduler will briefly step out of their usual role and call the pod from the front desk to make sure the patient is accounted for so they do not have to wait. In these ways, the constantly shifting visual icons in the software interface assist schedulers who cannot otherwise physically see patients and other staff by tracking them in space, ensuring appointments proceed smoothly. Prompted by the interface, schedulers correct any spatial discrepancies they observe, sometimes stepping out of their roles to do so. These bureaucratic practices ensured patients spent the appropriate amount of time in each space of the clinical appointment and ensured patients did not wait. Such practices contribute to the creation of forms of bureaucratic encorpment that incorporate patients' gendered embodiments because patients are likely to experience timely (and therefore satisfactory) appointments and are more likely to return for future ones.

Schedulers’ reliance on the EHR interface allows them several ways to track the movement of staff and patients. However, the pod healthcare staff occupied on any particular day might change, and this information was not available through the EHR interface. Instead, schedulers relied on a Woodfield nurse, Angela, to come out to the front of the clinic and let schedulers know which pod healthcare staff would reside in that day. She would also give the check-in staff a list of patients that needed to be scheduled ahead of time, which prevented schedulers from having to guess which patients needed to schedule additional appointments upon approaching the check-out desk, facilitating workflow efficiency. Completing this task was extraneous to Angela’s role as a nurse and greatly helpful to schedulers. Angela relayed important information because different pods corresponded to different clinic room numbers. Midway through fieldwork, however, Angela left the clinic. Schedulers relied on staff like Angela to serve as their “eyes” to facilitate appointments when they couldn’t receive important spatial information from the software interface.

Creating Affect Through Clinics’ Built Environment

In this section I move from discussing the unique software Woodfield staff used to manage the movement of staff and patients in space to discussing how the built environment engendered particular affects in patient-participants and how they related these emotive states to their understanding of good transition-related care. Patient-participants linked their perceptions of clinic cleanliness and building age, the amount of patients moving through the clinic, and features of interior design to personal understandings of gendered lived experience. Examining patient-participants’ understandings of the built environment at Glendale and at Woodfield makes clear the different impact that these varied environments had for patients. Positive affects correspond to a positive appointment experience and create forms of bureaucratic encorpment that represent patients' transition plans because in these cases, clinic bureaucracy embodies patients' gendered embodiments as patients interact with staff and with gender-normative bureaucratic practice. In cases where patients' transition plans are not incorporated—such as when affects are created that make patients less likely to attend future appointments—gender-normative bureaucracy remains intact during those future appointments these patients will not attend.

As mentioned above, Glendale clinic offers abortion services within a political climate that explicitly targets these services for elimination, and upon walking into the clinic the myriad of ways the built environment reflects this are strikingly apparent. As Melinda states in the opening vignette, multiple sealed doors act as barriers to potential intruders, security cameras surround the clinic, clients are asked to leave bags and coats in a specified coatrack outside of the clinic proper, and bulletproof glass protects front-desk workers. When Melinda mentioned that "bad stuff has happened here before," she was hinting that the clinic has been a target of anti-abortion violence. These visual features of the clinic environment elicited several affective responses from clients that clients incorporated into their understandings of satisfactory transition care.

Brett, for example, linked the way front desk schedulers' inquired about the presence of protesters to his perception of the helpfulness of staff and their ability to be patient with him as he nervously navigated clinical paperwork, aiming to fill everything out correctly for insurance. "She [the front desk worker] asked if there had been any protesters outside which last time I went nobody asked me, and there had been protesters the previous time. So it was nice of them to ask," Brett added. I asked him if he would be willing to clarify what he meant when he said "front desk staff were patient with him," and he said,

> "I asked *a lot* of questions because I was nervous, plus I wanted to make sure I was filling everything out correctly. And they were willing to answer all of my questions without making me feel like rushed or like I was being annoying. Like, they understood *why* I would be nervous. Because if you fill out anything in the wrong way then you're going to be denied by Medicaid. And it's a weird situation going into [the] clinic because there's the locks on the front door and the cameras and like the bulletproof glass in front of the reception area, so it could very easily feel unsafe or like there was a disconnect and I felt like that the personality and the interactions with the receptionist make up for it. And even kind of passively acknowledge that like this is weird, that the setup is strange and that it's unfortunate and a lot of the way, it's often, 'God, I can't believe we're both in this situation.' You know? As opposed to 'Oh, you're here.' [laughs] So that's nice, it kind of builds a sense of camaraderie I think'" (Debriefing interview with Brett, Glendale Clinic).

Filling out paperwork correctly for Medicaid—navigating gender-normative insurance language in a way that represented Brett's care needs as well as government requirements ("… I didn't know, was I filling it out based on my identity or what was assigned at birth? Like what do they want?") made Brett nervous, an emotion he states could have easily been exacerbated by feelings of unsafety the "locks on the front door and the cameras and like the bulletproof glass" of the clinic could have instilled. But it wasn't. Brett considered front desk staff to be sympathetic to his initial nervousness around navigating paperwork, and he positioned himself alongside staff against the features of the built environment that could have caused a "disconnect," stating that this ultimately created a "sense of camaraderie" with staff. Brett's description highlights the ongoing dialogue between built environment, affect, bureaucratic practice, and gendered embodiment. Here, Brett describes how he felt a sense of camaraderie with staff regarding the clinic's severe security measures, when he could have easily felt unsafe and isolated. A similar sentiment was shared by Emma, who said,

> "I understand why they have everything set up the way they do in terms of the coat check in. Of course, for people who are normal and decent human individuals, we don't have a problem not having our personal items or our coat… You know, we live in a shitty world where most modern terrorism in America is done by Christian evangelicals, which are also primarily against abortion clinics. So I understand what they're doing and why they're doing it" (Debriefing interview with Emma, Glendale Clinic).

For Emma, too, aligning with "people who are normal and decent human individuals" who are not bothered by leaving coats and bags outside of the clinic and against people who intended to harm the clinic was one way she positively incorporated Glendale's built environment into her visit experience. From these examples it is clear that attending to features in the built environment is critical to analyses of bureaucratic practice. The positive affects created here between Glendale clinic staff and clients create forms of bureaucratic encorpment that represent gender-expansive embodiments insofar as the affects created encourage patients to return for future appointments.

Affects shared in the clinics are, reasonably, not all positive; in some cases the clinics' built environment evoked negative affects between staff and clients. In addition to the precautionary features of Glendale's interior, perceptions of its size also made their way into clients' understandings of funding and ability to provide transition-related care. When I spoke with Lindsey during her interview after she came in for a follow-up exam, she told me that her experience was "good overall," but she noticed that she got misgendered by the staff at least once, "whether it's overhearing conversations or at the front desk or any of the nurse practitioners…" I asked if they remembered a specific time this had happened during the appointment I observed, and Lindsey responded that she overheard people in the hallways misgendering her as "he." In this case the proximity of staff in the small building allowed Lindsey to easily hear instances of misgendering through the clinic room door. This differed from Woodfield clinic, where clinic doors were sound-proof, but where I had observed cases of misgendering by staff to occur with similar frequency during fieldwork. Overhearing instances of misgendering—in these cases facilitated by narrow hallways—creates affects that range from annoyance to anguish and carry the potential to turn clients away from the clinics in the future, creating forms of bureaucratic encorpment where bureaucracy does not embody patients' non-normative gendered embodiments.

Clients interpreted the same features of the clinics' interiors in vastly different ways. While explaining to me why she preferred to do her own research online when she had questions about bodily changes under hormone medications, Lindsey mentioned that the clinic seemed to be overworked and underfunded. I asked Lindsey if she could provide an example of how it was "overworked," and she said that she noticed that staff "tend to have quite a few people in and out of there" and she would rather look up this information online herself rather than ask Molly to avoid taking up the clinics' time. For Lindsey, seeing clients move through the small space generated a feeling that for staff, the large number of clients moving through the clinic "must be stressful" and she responded by deciding to do online research on her own time rather than consult Molly with questions about her transition care.

Perceptions of the clinic as underfunded were not always viewed in a negative light, however. As Emma stated,

> "You know, I have a deep respect for everyone who works there, they know that every day. It's like Planned Parenthood, they go in there every day and they know they might not walk out because they work in an industry, a place that isn't being provided protection. I'm very empathetic for them and I think that Glendale as a clinic deserves far better because their providers are so passionate about what they're doing, serving the areas that they serve. The fact that they're so into… like have you ever had to call their number, their general number, and be put on hold at all? Like if you are transmasculine or a trans man or a trans woman they are including non-binary identities that are also often underserved and so they're being incredibly inclusive for such a small clinic" (Debriefing interview with Emma, Glendale Clinic).

Like Brett's expression of empathy for staff against the necessary security precautions the clinic has to take against anti-abortionists, Emma considered the small size of the clinic and its dangers to magnify the staff's passion for serving an underserved gender minority.

At Woodfield, characteristics of the building and interior generated expressions of affect relating to perceptions of the clinic as supportive, safe, and as a place that provided competent transition-related care. One patient-participant, Marie, discussed the difficulty she had finding a clinic that was "forward and openly supportive" of transition-related care. I asked her how her experience at Woodfield differed from her past experiences at other clinics and she said,

> "Part of it's like the questions that they ask. They ask about preferred pronouns and things like that and then part of it is that it's got [visibly gender-affirming clinic name] as the name of it and that immediately implies that it's going to be accepting. But I've never felt pressured to do anything there, aside from medical advice, which isn't like a bad sort of thing. And then another thing that I noticed early on when I was there is that they have gender-neutral bathrooms, which is nice to see" (Debriefing interview with Marie, Woodfield clinic).

For Marie, the name of the clinic and the presence of bathrooms clearly labeled as gender neutral (and positioned directly next to the front desk) constituted what she understood as a "forward and openly supportive" space. Visible interior markers of support such as gender-neutral restrooms contribute to patients' likelihood of returning to the clinic because they communicate clinic staff's understandings of patients' gender non-normative embodiments, creating feelings of safety and acceptance. Patients' return to the clinics creates forms of bureaucratic encorpment that incorporate patients' gender-expansive embodiments into clinical bureaucracy by virtue of patients' presence at appointments.

Art, who in the past had seen an endocrinologist he trusted to receive hormones, but mentioned that this endocrinologist's practice was "outdated" ("he used a blood pressure cuff to get the veins to get your blood drawn"), said that Woodfield's environment stood in contrast to this,

> "The care is different in the fact that it's straight forward and more professional. Cut-clean environment, which I can appreciate. It is a very much so in and out and it's much easier to schedule appointments. I find that to be an advantage. It was more holistic… It's a hospital environment. Everything is very clean, versus an office in an office building that has this doctor and then the shoe repair guy down the hallway. In that sense of environment" (Art, Glendale Clinic).

Here, Art equates the straight-forwardness and cleanliness of his movement "in and out" of Woodfield clinic with professionalism. As I have discussed above, by relying on the software interface schedulers are in part responsible for maintaining the smooth "in-and-out" appointment pace Art describes that contributes to patient satisfaction. For Art, the environment at Woodfield was "holistic," visually seamless, without an introduced disconnect of additional staff unrelated to medical care in the space (e.g. like a "shoe-repair guy down the hallway").

Conclusion

In this chapter, I have shown the myriad ways clinics' built environments and interior design continuously shape bureaucratic practice and gendered embodiment, emphasizing the built environment as a key participant in the ways that bureaucratic encorpment occurs. As part of large biomedical clinic Woodfield's organizational culture, staff have designated spaces within the clinic that they are required to occupy throughout the day. By utilizing electronic software—the electronic health record (EHR's) capability to track staff and patients in space—staff could track the movement of patients through Woodfield clinic's built environment without physically moving from the space they were required to remain in as part of their job role, with varied success. The successes and failures of staff's use of the software interface to monitor staff's and patients' movements in space determined whether patients were able to schedule into the clinics. The appearance of gender-expansive patients at the clinics brings these patients into contact with gender-normative bureaucracy, creating forms of bureaucratic encorpment that incorporate patients' gendered embodiments into clinical bureaucracy. As I have argued in this chapter, Woodfield's electronic software is key in this process. Examining the use of space-tracking digital technology in the built environment opens up a new mode of inquiry into bureaucratic practice that departs from an examination of space that relies solely on a brick-and-mortar approach (Miller et al. 2016).

Moving through built environments generates expressions of affect that influence how staff and patients interact with gender-normative clinical bureaucracy. For example, clients at Glendale incorporated the size and break-in security measures of the clinic to clinic staff's competency and passion for providing transition-related care. At Woodfield, patient-participants' feelings that clinic staff was professional and openly supportive of transition-related care emerged from physical features of the clinic such as its cleanliness and the presence of clearly marked gender-neutral bathrooms. Engagements with clinic architecture generated a myriad of affective responses—both positive and negative perceptions of clinics' transition care—that have a hand in shaping whether patients will return for future appointments (and thus future engagements with gender-normative clinical bureaucracy). From these ethnographic examples it is clear that the built environment is a key participant in the co-constitutive relationship between bureaucratic practice and embodiment. If the goal of design is to modify conditions in the present toward realizing anticipated futures (Pink et al. 2018; Halse 2013), attending to the ways that bodily materiality intersects with actors' subjectivities and interactions with built environments helps us reproduce those positive conditions that optimize patient comfort in the future.

CHAPTER 6: CONCLUSION AND APPLICATIONS

"A-M: Thanks so much for sharing your experience… Do you have any other questions or anything like that?

Lucas: Um a big thing, I don't know if this will help you but with a lot of transitioning people, I know another person that is just starting, just like me, and um and he said his, just like, me and him we— our depression, it gets better, but at the same time like we fight against it. It's a struggle with T (testosterone) because of who we are and what we have to go through.

A-M: What do you mean by fighting against it?

Lucas: Before I started T it was the whole, I wasn't in the right body, I need to get started and everything and once I started taking T it started getting better. But some days you don't want to do anything. You look in the mirror, you don't see who you are and it goes on from there. Every day you try to get out more and do things, and the T helps. But our journey is long, you know? I mean no one really likes to talk about, you know, the dark part, the depression. Heh" (Debriefing interview with Lucas, Woodfield clinic).

In this dissertation I demonstrated how bureaucracy and bodily materiality are engaged in conversation within multiple facets of gender-affirming clinics and come to embody each other, a process I named bureaucratic encorpment. The discussions I put forth in this dissertation emphasize the importance of attending to the provision of transition healthcare beyond initial access to transition care as I identified concrete processes by which healthcare bureaucracy embody or do not embody gender non-normative embodiments. Reproducing avenues that favor non-normative gendered embodiments will minimize features of clinical bureaucracy that cause distress for patients, ensuring a smoother transition journey. In this closing chapter, I discuss the interventions that the findings of this dissertation make in the anthropological literatures of bureaucracy and the body and in the future of U.S. transgender healthcare. Then, I provide specific recommendations that providers can use to create forms of bureaucratic encorpment that represent non gender-normative bodily materiality in their own healthcare practices (condensed in Appendix B).

In the opening section of this chapter I provide a brief summary of the conclusions drawn in the first five chapters of this dissertation surrounding the main realms of gender-affirming health clinics I have examined: time, bureaucratic health documents, affect created between providers and patients, and affect created via movement through built clinic environments. I outline the contributions that these insights bring to current conversations in the anthropology of bureaucracy, the body, and the anthropology of design. In each subsequent section of this chapter, I discuss how the insights built in these previous chapters can be applied to the improvement of gender-affirming healthcare practice in the United States.

Both of the clinics where I conducted fieldwork represent places where patient-participants reported satisfaction with transition care as I have discussed in this dissertation, and where providers actively generate new research and follow current standards of transition care. Bureaucratic practice in these clinics is purposefully arranged to challenge gender-normative cultural assumptions in bureaucratic systems. Throughout this chapter I reference bureaucratic activities of both clinics as models of competent transition healthcare and outline additional activities that will continue to improve the healthcare of gender-expansive people nationally.

Contributions to Anthropological Literature

This dissertation advances ongoing conversations in the anthropology of bureaucracy and the anthropology of the body. In each chapter of this project I have shown how engagements between providers and patients can be understood through a practice approach as we consider how these actors manage daily bureaucratic practice as "street bureaucrats" responsible for bringing bureaucracy into being (Lipsky 2010; Ferguson and Gupta 2002). Every patient entering the clinic brings with them a bodily materiality shaped by a unique biological history, a materiality that is agentic, dynamic, and non-linear and that is constantly open to interactions with people, places, and things (Braidotti 2018; Bennett 2004; Davis 2014). Bodily materiality interacts with bureaucratic practice and bodies, like bureaucracy, are "materialized through practices" (Yates-Doerr 2017, 145). Observing staff's and patients' bureaucratic practices allows us to capture competing bureaucratic and bodily rhythms occurring during the clinic day, the specific features of healthcare documents providers represent individual gender-expansive patients in, and the concrete bureaucratic practices that create the conditions for particular affects to emerge between providers and patients.

In Chapter 2 I discussed how rhythms of the body—shaped by patients' unique biological and immunological histories—constantly come into contact with patients' rhythms inside the clinic like auditing constraints and outside the clinic, like the distance from appointments. Utilizing Laura Bear's concept of "timemaps," I argued that bureaucratic encorpment occurs as providers work to bring these competing rhythms into harmony with clinic time auditing requirements while working to meet patients' transition plans (Bear 2014). Harmonizing these rhythms necessitates that providers are open to the diversity of experiences patients can have in terms of their body materiality and their plans for transition. Attuning to the unpredictable variability of bodily responses to specific features of bureaucratic practice makes visible the creative possibilities of embracing rather than fearing uncertain futures central to current theoretical discussion in the fields of anthropology and of design (Pink et al. 2018). Instead of viewing uncertainty as threatening and something to avoid, anticipating emergent and unpredictable effects of constantly interacting bodily and bureaucratic temporal representations helps us track how representations shift and change in relationship to others, refining over time to produce positive health outcomes for patients.

Bodily materiality contributes to the maintenance of ideal bureaucratic time and impacts how providers manage broader political policy changes inside gender-affirming clinics. Factors such as distance from the clinic and federal laboratory requirements such as fasting prior to blood draw shape patients' appointment experiences even before patients enter the clinics. For patients taking testosterone who must attend follow-up appointments every six months under current FDA requirements for testosterone for example, factors such as labwork and distance traveled create barriers for patients that providers managed through bureaucratic practice. How bodily materiality responds to the substances hormones are suspended in can also create delays in receiving transition care. Later in this chapter I offer concrete recommendations for ways future policy decision-makers and insurers can address these delays to help patients meet transition goals.

In medical records—whether paper or electronic—patients' complex lives are abstracted into discrete data points to be tracked as part of a broader federal mandate to standardize records across practices (Steinbrook 2009; Merry 2011). The cultural assumption that two experiences of gender are definitively linked to two distinct sexes is also part of this standardization (Fausto-Sterling 2000). In Chapter 3 I showed how providers at both Glendale and Woodfield directly addressed the limitations of the gender-normative markers F and M in the records by providing additional context about patients' non-normative bodily materiality in spaces reserved for other purposes, like clinic notes. These practices were further mediated through these documents' material forms (Hull 2008; see also van Eijk 2019). Representing patients' non-normative bodily materiality in medical records directly challenged the two-sex, two-gender model embedded in them, broadening bureaucratic health practice to better serve non-normative gendered embodiments as these documents travelled to other healthcare practices.

Observing how providers challenged terminology in EHRs complicates prominent concepts in the anthropology of bureaucracy such as Foucault's concept of "technologies of self," which relies on the idea that the possibility of surveillance rather than surveillance itself engages subjects in self-discipline, leading them to police their own behavior in light of broader modes of governance (Foucault 1988). I argue that in gender-affirming health clinics—established specifically to deliver healthcare to patients with non-normative gendered embodiments—providers specifically refuse to internalize those practices of self-governance in the EHR that uphold gender-normative assumptions about patients' health and bodies. In fact, engaging in routinized engagements with the EHR served to negatively impact this patient population, as is clear from patients' testaments about negative prior appointment experiences at clinics unfamiliar with gender-affirming care.

Healthcare staff's manipulation of the existing structure of electronic health records (EHRs), which were created without the understanding that patients' gender and sex can change, carries implications for how medical records could be modified to better capture the experiences of gender-expansive patients. The medical record is a key mediator of the interactions providers and patients share with each other and with gender-normative healthcare bureaucracy. In the recommendations section of this chapter, I reiterate the various creative bureaucratic practices providers at the clinics employed to represent patients in the medical record, including such strategies as taking advantage of the electronic record's portability to fashion it into an educational tool and informing patients of terminology intelligible to patients' insurance. I sketch a model of how these bureaucratic practices could be applied in healthcare settings beyond these clinics.

In Chapter 4 I discussed how staff invoked bodily materiality in discursive care practices to create positive affect with patients, encouraging them to return to the clinics in the future. From taking care to avoid framing pap smear procedures in gender-normative language when examining patients to taking cues from scheduling software to use patients' preferred names, healthcare staff strived to create affects of empathy, comfort, and safety with patients. Providers recognized that patients have different understandings of and relationships to their bodies (Archambault 2016). These care practices challenge recent fears that caregiving has steadily been eclipsed from the practice of biomedicine by increasing commercialization and bureaucratization (Kleinman and Hanna 2008; Craig et al. 2018). At Glendale and Woodfield, discursive care practices are essential to maintaining a clinic space that patients want to return to, in contrast to common framings of routinized bureaucratic practice in anthropology, which figures like Max Weber characterized as rational and devoid of aspects related to the emotional (Weber 1947, 1978; Gupta 2012; Bear 2015; Krause 2012). Discursive care practices that encourage patients to return to the clinics create conditions in the present that bring gender-expansive patients into future contact with gender-normative healthcare bureaucracy and therefore future opportunities to create forms of bureaucratic encorpment that incorporate non-normative gendered embodiment.

Although the process of accessing competent transition care frequently causes feelings of uncertainty and distress (James et al. 2016), gender-affirming health clinics are also sites of celebration and understanding. Features of clinics' existing organizational cultures led to emerging affects as patients and staff interacted. For example, the feminist work culture of Glendale community clinic is purposefully oriented toward preventing the development of hierarchy in the provider-patient relationship (Morgen 1995, 1986; Murphy 2012; Nelson 2011). Woodfield clinic is in contrast is highly bureaucratized. Patients' bodily materiality is fully engaged in the interactions that are mediated by these different organizational cultures. For example, for patients receiving pap smears or completing the federal requirement to take a pregnancy test prior to receiving testosterone, providers might specifically avoid using historically gendered language to describe the procedure process to patients, creating empathy with patients as together they challenge gender-normative medical bureaucracy. Of course, the kinds of affective responses created differ according to patients' various relationships with their bodies and their goals for transition. I identify the factors that generate these positive affects and outline ways that they can be reproduced in healthcare practice.

This dissertation opens a novel focus of inquiry in the anthropology of bureaucracy by recognizing that engagements between electronic, bodily, and built bureaucratic environments shape bureaucratic healthcare practice (Miller et al. 2016; Miller and Horst 2012, 29). In Chapter 5 I argued that the architecture and interior layout and design of clinics shapes bureaucratic practice as interiors impact the kinds of affects generated between providers and patients in space. When clinic buildings are large and staff and patients cannot see each other easily, as at Woodfield, providers use electronic space-tracking software as "eyes" to monitor people' movements through the clinic. However, this software did not always accurately represent people's actual positions in space, leading to various consequences for patient care when staff relied on it.

In this chapter I also discussed how, beyond communication between providers and patients during the clinical appointment, space and the built environment created particular affects in providers and patients that were likewise mediated through clinics' organizational cultures. The spaces that built clinic environments create and permit healthcare staff and patients to physically occupy actively shape affect vis-a-vis bureaucratic practice (Murphy 2016; Roberts 2012). For instance, the widespread presence of bulletproof glass and overhanging security cameras at Glendale clinic created not feelings of fear but of political solidarity in clients and an appreciation for providers' efforts to provide transition care within a tumultuous political climate. I restate these features of affective architecture and space here, highlighting how specific features of the built environment can be considered in ways that produce positive affect in providers and patients to improve healthcare practice. Patients incorporated their perceptions of the age and size of Glendale clinic into their understandings of clinic staff as admirable, or alternatively as lacking resources to address patients' questions. Tracking these spatial and affective relationships ethnographically shows us how specific features of the built environment produce particular atmospheres that influence the kinds of affect created between provider and patient, shaping patients' perceptions of bureaucratic practice and influencing whether they will return to the clinics for future appointments (Pink et al. 2017).

Bodily materiality is in constant engagement with bureaucratic practice. The applied interventions I outline in this chapter correspondingly involve attending to the ways that bodies are incorporated into bureaucratic practice, creating forms of bureaucratic encorpment that serve patients' transition plans. As discussed above, bureaucratic encorpment occurs throughout each domain of the clinic at any given time. Different patients have different timelines for transition and these ideal timings can come into harmony or be disrupted by patients' unique biological histories and the flow of bureaucratic time. As the rhythms of bodily materiality and bureaucracy interact, possibilities for gendered embodiment close off and open up. The transitioning body's representation in or absence from patient-participants' electronic medical record (EHR)—a bureaucratic document created with the understanding that gender cannot change over time—likewise shapes how patient-participants receive transition care. Providers utilized bodily materiality as a springboard to create empathy and understanding with patients, sometimes by aligning with patients' subjectivities against specific features of bodily materiality that did not reflect patients' self-image. Throughout all of these cases, it is clear that the body plays a key role in the ways that providers and patients enact bureaucratic practice in the clinics. Throughout the rest of this chapter I discuss how providers can attend to bodily materiality in clinical practice, referencing ethnographic data from the two gender-affirming healthcare clinics as examples.

During debriefing interviews with patient-participants, some participants mentioned ways that their experiences seeking transition healthcare at the two gender-affirming clinics could have been improved. Often, patients had done their own research beforehand regarding transition care, usually online, and shared this knowledge with providers at both clinics. Yet sometimes, online research fell short and patients requested more information from providers, discussing these experiences later during their interviews with me. During debriefing interviews, patient-participants mentioned a need for more information regarding the long-term bodily effects of specific transition-related medications in initial bureaucratic paperwork such as healthcare pamphlets. Some patient-participants also cited a need for guidance about how to initially approach healthcare bureaucracy—often a source of frustration and anxiety. I discuss feasible solutions to these issues in the closing section of this chapter.

Reconciling Clinic Rhythms for Transition Healthcare Delivery

In transgender health clinics, providers are constantly audited by the rhythms of healthcare bureaucracy, including the timelines insurances require, available scheduling slots for patients, and broader federal requirements that dictate when labwork must be acquired. Thus, often in order to receive transition healthcare at all, providers and patients must align the transition timelines and the rhythms of bodily materiality with this dominant bureaucratic rhythm (Bear 2014). If policymakers wish to improve patients' access to the various facets of transition care individuals need, they will first need to recognize and anticipate that the agency of patients' bodily materiality—how patients' bodies react to labwork fasting, hormone compounds, et. cetera—is often unpredictable (Davis 2014). An applied approach to improving the timeliness of transition care provision should therefore target temporal barriers produced by bureaucratic time-maps and other rhythms interacting with them such as distance from the clinic. These, again, relate to features of bureaucratic practice such as scheduling and time-related clinic auditing constraints. Below I discuss how possible time-related barriers could be addressed both in highly bureaucratized clinics with several specialized roles such as Woodfield, and in clinics with low bureaucratization like Glendale.

Promoting Timely Letter-Writing

Woodfield clinic is staffed by physicians, a physician's assistant, medical assistants, and nurses, all of whom are specifically trained to provide transition care. Certain bureaucratic roles, but not others, are endowed with the capability to perform tasks like letter-writing for patients, which can create barriers to receiving transition care in a timely manner. Recall that Janet, the physician's assistant at Woodfield, and Molly, the practitioner at Glendale clinic, are both unable to sign off on patients' letters to initiate legal gender marker changes because they do not hold MDs. Recall also that it is very difficult to schedule patients with physicians at Woodfield, often leading patients to schedule appointments months out.

At Glendale, Molly performs the relevant physical exams to ensure "permanent changes" have occurred in patients' bodies, complying with federal requirements (Sandler 2019). Then she carefully documents these changes in a letter. A physician residing in the clinic then reviews the letters and signs them. A similar approach could be adopted at Woodfield and similar bureaucratized clinics, wherein a staff role that includes the capability to perform and document physical examinations could assess for "permanent" bodily changes and document these in a letter template, and then the letter could then be reviewed and signed by the physician. Such a practice would not change the administrative load for the physician—since the number of letters to be reviewed and signed would remain the same—but would require other appropriate staff roles to allocate time to perform exams during appointments.

Expanding Scheduling Availability

Due to the low number of specialized staff in Woodfield clinic, patients seeking transition care are many but scheduling spots are few, often forcing patients to schedule out months in advance. When I asked patient-participants what could have been improved about their appointment experience, several patients noted the wait time of scheduling into Woodfield clinic was the only thing they would improve. As Woodfield patient-participant Amelia explained,

> "…These doctors are amazing but there's only so much you can do with two individuals. I think expanding more physicians and more availability in hours or days would do wonders in terms of being able to be seen in that specific clinic. 'Cuz right now if I would be to call and try to get an appointment it could be two or three months before I could get to see Dr. C. I might be able to be seen quicker if I were to go to her normal everyday clinic but there could also be presentation issues with gender, pronouns, etc. It's kind of a toss-up as far as the patient's comfort level is concerned as far as being seen outside of [Woodfield]" (Debriefing interview with Amelia, Woodfield clinic).

Amelia states that she might be able to schedule more quickly in Dr. C.'s regular outpatient clinic, but she does not want to risk feeling uncomfortable. This excerpt highlights the importance for patients to see particular staff who are not only specialized to provide transition healthcare proper, like Dr. C, but also be certain to interact with bureaucratic staff up to the time of the appointment that will address patients by their correct pronouns and have their subjectivities affirmed. The insight that familiarity with gender-affirming care should be cohesive throughout the bureaucratic chain is key to increasing patients' comfort with approaching clinics for routine and preventative care (Harb et al. 2019). The scheduling issue at Woodfield is by no means an isolated problem; as nationally, transgender healthcare is an emerging specialization and healthcare centers trained to offer transition care are few and scattered across the country (MyTransHealth 2020). Woodfield staff are likewise aware of this issue and work to address it in several ways that could be helpful for other healthcare centers.

In response to the popularity of Woodfield clinic and its corresponding scheduling congestion, Woodfield providers already leverage their expertise by constantly engaging in education efforts with the surrounding healthcare professional community during clinics. Janet, the physician assistant, purposefully dedicated her time to the clinic to open up additional scheduling spots for the estimated 10-12 patients (according to schedulers) who schedule into it a day. Healthcare professionals from other specializations and rotating medical students frequently visit Woodfield to shadow the staff and learn how to incorporate the clinic's bureaucratic practice into their own clinics. During my fieldwork I had the opportunity to meet a visiting gynecologist, a nurse practitioner, a plastic surgeon, and several medical students completing their rotations as part of their education requirements. Woodfield schedulers and staff also informed me that staff from a nearby healthcare center shadowed both Woodfield clinic and scheduling and later incorporated what they had learned as they launched their own LGBTQ-centered clinic. Shadowing opportunities such as these may be feasible for providers experiencing difficulties organizing individual outreach activities due to existing clinical administrative load. By inviting external staff and students to shadow the clinic, the clinic day can go on as usual, but visitors will take away relevant concepts to integrate into their own practices.

Hastening Hormone Renewals

As I have discussed in Chapter 2, patients travel on average an hour to reach the clinics. The distance patients had to travel often conflicted with broader policy (and insurance) requirements to fast bodies prior to required bloodwork. Federal requirements dictate that patients must schedule appointments every six months or sooner to have testosterone levels assessed before providers can renew testosterone prescriptions. This can cause problems for patients who may not be able to schedule rides to the clinics or who need to go without food the entire drive to and from the clinic, which can take an hour or more. In order to manage these time-related difficulties, Woodfield and Glendale providers employed several strategies.

Providers held injection demonstration sessions with patients taking testosterone, and this first injection dose helped patients practice injecting themselves safely and additionally allowed patients up to two weeks for insurance to "kick in," as one MA put it—to accept coverage for the medication. At Woodfield, healthcare staff intentionally worked with the pharmacy in the same building to ensure injection needles were free, allowing many patients the option to receive their hormone medication on-site a short walk away from their appointments instead of driving to a faraway pharmacy. These strategies may be useful for staff in other bureaucratized clinics who need to synchronize patients' time-maps with those of medical bureaucracies. Injection demonstrations in particular are further benefited by the fact that patients might have preferences as to where on the body they feel most comfortable injecting hormones; staff can assist them in administering hormones correctly in these areas. Successfully closing gaps in bureaucratic time maps may simply involve creatively reorienting existing bureaucratic practices such as injection demonstrations toward meeting insurance and transition goals.

Making Gender-Expansive Patients Visible in Medical Documents

One of the consistent ways providers work to ensure that patients receive the transition care they desire is to represent patients' bodily materiality in bureaucratic medical documents like the medical record. As discussed in Chapter 3, these records do not stay inside the clinic—they communicate with entities beyond the clinic like pharmacists and insurance companies and, in the case of electronic health records (EHRs), they travel with patients as they visit other clinics. This portability is facilitated by federal policy to ensure seamless communication between U.S. medical institutions (Steinbrook 2009). However, these records embed the cultural assumption that a patient's gender does not change and this assumption carried through federal attempts to standardize these records. Using resources available to them and leveraging the electronic or paper form of medical records, Glendale and Woodfield providers worked to incorporate patients' shifting material bodies in these records in creative ways. Such strategies can serve as a model for providers seeking to represent gender-expansive patients in their own practices.

Modifying EHR Templates to Include Gender-Expansive Patients

At Woodfield, the gender markers in EHRs F or M, corresponding to "male" or "female," embed the cultural assumption that two discrete experiences of gender—woman and man—are definitively linked to two distinct sexes, female and male (Fausto-Sterling 2000). This dominant gender-normative model in biomedicine does not allow for the possibility that patients' bodies and genders might change over time and this assumption is reflected in multiple medical record fields. It is providers who work within the record to challenge this notion directly. Woodfield providers do this by including pronouns in existing fields in the EHR. For example, they may list a patient's pronouns within a brightly-colored "FYI" button whose default function is to alert providers to a patients' special care needs. Woodfield providers also created their own templates listing the patients' entire transition history, including sex assigned at birth, pronouns of use, gender identity, and current legal gender, as I discussed in Chapter 3. They paste this template at the top of a patient's clinic note where other providers can see it immediately when they open the patient's record. This bureaucratic practice doubles as an educational tool—providers take advantage of the fact that electronic medical records travel easily from institution to institution as part of the federal mandate of record standardization. When discussing patients' care in clinic notes, Woodfield physicians purposefully included statements worded for audiences unfamiliar with the provision of transition care, citing names of major medical associations supporting its medical necessity right inside the clinic note and including and the typical timeline for transition (hormones, hair removal, psychological evaluations, and possible future surgeries if patients desire them).

Meeting Insurance Terminology Requirements

Matching individual insurers' terminology requirements for transition care coverage facilitated care delivery at both clinics. At Glendale, where electronic health records feature less prominently in daily clinic practice, practitioner Molly communicated with insurance companies directly to represent patient-participants' shifting gender embodiments in paper medical documents. Several times during fieldwork, Molly recounted what I refer to as the "sexual transition story" to clients. She described how an insurance company continued to deny coverage for hormones for a client, despite the fact that Molly used a term she knew from experience was appropriate to receive coverage. Finally, she coded for "sexual transition" and insurance covered the hormones. This incident was the first time she realized that, although many insurance companies might state that they cover hormones and surgeries related to transition, different insurance companies understand terminology related to transition differently.

Molly seemed to have assumed that "sexual transition" was an appropriate term to use to cover transition-related surgery but not hormone medication, yet this insurance company seemed to have grouped both under the same term. Molly was able to have the client's hormones covered while simultaneously meeting this insurer's understandings of transition care and without directly challenging the language this insurer used. In fact, directly challenging insurer language was often not necessary for Glendale staff. "It doesn't matter how 'hip' their language is," Glendale administrator Sarah once noted. "We do what is needed for the client." Woodfield providers adopted a similar practice when they coded transition-related care as "endocrine disorder," a practice that avoids revealing a patients' identity to others but that harmonizes with insurance terminology requirements. Woodfield and Glendale providers' constant communication with insurance companies emphasizes the need to allocate time to communicate with individual insurance companies to ensure coverage denials are not due to an easily correctable disconnect in understandings of transition care terminology.

Encouraging Patients to Communicate with Insurers

Providers at both clinics shared knowledge they had accumulated about terminology needed to meet insurance requirements directly with patients to empower them to advocate for their own healthcare. As mentioned above, in order for patients to receive the go-ahead to change legal gender markers on fundamental documents such as the driver's license and birth certificate, providers must perform physical exams to assess for "permanent" (irreversible) changes in the body such as breast growth and voice change, and write up a letter listing these changes (Sandler 2019). During their first appointment providers encouraged patients to be on the lookout for these changes about a year into transition in preparation for legal gender marker change.

Additionally, when patients spontaneously relayed symptoms such as back pain and cramping during appointments, providers encouraged patients to underscore these symptoms in letters requesting hysterectomies and mastectomies (uterus and breast removal). For example, a provider might tell a patient to emphasize existing symptoms of unusual bleeding and pelvic discomfort to a gynecologist writing a letter for the patient's hysterectomy. Or, upon noticing a client experiencing pain from a bra strap, Molly might encourage the client to mention this symptom as a way to hasten the mastectomy process. Future providers could similarly share existing knowledge about individual insurance requirements within such discursive practices to represent patients' embodiments in medical documents and facilitate the transition process in a timely manner.

Creating a Space of Safety and Empathy

Affective responses created between healthcare staff and patients are mediated through clinics' organizational cultures, as I have discussed in Chapter 4. As with providers' management of clinic time and representation of patients in documents, bodily materiality participates in the kinds of affects created as providers and patients interact. At Woodfield the hierarchical relationship created between provider and patient is typical to that of a bureaucratized and role-diverse clinic, and at Glendale the clinic's feminist organizational culture is purposefully organized to challenge the development of a hierarchical relationship between practitioner and client (Morgen 1995, 1986; Murphy 2012; Nelson 2011) These differences in organizational culture shape how affect is produced.

In order to ground affect in practice instead of merely describing the characteristics of particular affect, it is useful to consider affect as a series of encounters, both with animate and inanimate objects, that produce a range of affective responses (Archambault 2016), and track the contingencies that produce these specific responses. In transition care it is important to anticipate variance in patients' transition goals. The transition goals of gender-expansive patients are diverse; whereas one patient might consider a feature of healthcare bureaucracy a barrier to their care, another may not. In their interactions with patients, gender-affirming providers were aware of this reality and intentionally employed discursive practices like using ambiguous language to refer to the body to acknowledge this diversity. This attention to patients' varied relationships with their bodies is important for providers to keep in mind when communicating with future gender-expansive patients.

Privileging Patients' Understandings of Their Bodies

The egalitarian dialogue fostered between practitioner and client at Glendale clinic showcases how staff at this clinic translated the patients' diverse relationships with their bodies into bureaucratic practice. During procedures that are historically gendered like pap smears and breast exams, provider Molly specifically avoided framing the procedure as a women's health procedure because she anticipated the range of relationships clients could have with their bodies.

In Woodfield clinic, providers similarly centered patients' subjectivities—their understandings of their transitioning bodies—above gender-normative understandings of bodily materiality. Here as in other typical biomedical outpatient clinics where notions of professionalism in which the provider and patient are positioned in a hierarchical counseling relationship exist (Craig et al. 2018; Good and Good 1989), it is essential that providers working in the nascent field of transgender healthcare disrupt this relationship in order to serve this patient population. For example, Dr. C. constantly engages in active listening with patients, routinely asking open-ended questions about sexual orientation and commenting positively on transition-related changes in bodily materiality that align with patients' transition plans.

Providers' conscious privileging of patients' diverse understandings of their gendered embodiments produced feelings of empathy and safety in patient-participants, increasing the likelihood patients attend the clinics in the future.

Incorporating Affect into Architecture

Like affect created between healthcare staff and patients, space and the built environment likewise structure bureaucratic practice and create affect, contributing to the kinds of avenues of bureaucratic encorpment created. The interior design of clinics, including the walls that separate the space, influence how healthcare staff are able to occupy space as they interact with patients through bureaucratic practice. This spatial positioning is further mediated through clinics' organizational cultures. For example, the architecture of Woodfield clinic was purposely built to separate healthcare staff from patients until the time of the appointment and this separation is reinforced through an organizational philosophy that dictates how healthcare staff can occupy clinic space in accordance with their job role. When staff cannot physically move to keep track of patients, the same software that contains patients' medical records also tracks providers' and patients' movements in space in real time. This software helps Woodfield staff anticipate the positions of other staff and patients in space even when they cannot see them.

Enhancing Space-Tracking Clinic Software

Relying on the software interface to track people in space sometimes caused Woodfield staff to misjudge the locations of patients with consequences for patients' access to the clinic. In clinics with a high level of bureaucratic role specialization that rely on software to audit bureaucratic workflow, especially large clinics, communication between staff is key to keep appointments moving at a pace satisfactory for patients and clinic auditing purposes. Such clinics could benefit from utilizing desktop messaging applications during clinic practice. In the ethnographic case of Woodfield clinic, wherein schedulers mistook Dr. C as absent from the clinic with a cold and blocked out all her patients from being scheduled on the software interface, a convenient method of quickly reaching schedulers to let them know that Dr. C. was present would have immediately mended what she remarked represented a “broken wire” between the clinic and the schedulers.

Space-tracking capabilities of electronic software—initiated through staff’s actions such as mouse clicks—obviously benefits healthcare staff in several ways as they serve as “eyes” for staff who are largely restricted from moving freely about the clinic due to the requirements of their bureaucratic roles. At Woodfield, schedulers closely followed the shifting icons and colors in the electronic space-tracking interface corresponding to patients’ progression through appointments. Schedulers stepped away from their desks when icons and colors took too long to change, quickly ensuring that patients were in the right place at the right time.

Additionally, the software greatly assisted healthcare staff in hurrying appointments along within the clinic, as staff looked to shifting icons and colors to track how long patients had been waiting in clinic rooms and mobilizing physicians to tend to those patients. From these ethnographic observations it appears that in clinics where such auditing software exists, healthcare staff across roles should strive to consider indicators in the software alongside the reality of people’s positions in space and resolve any discrepancies quickly, perhaps through the aid of instant messaging software installed by default on all staff computers.

At Glendale clinic, no auditing software exists that tracks people’s movement in space, because there is no need for it. The clinic is small and staff are close enough to call out to one another. As I discussed in the last chapter, staff benefit from being in such close contact, but this proximity also generated negative affective responses as patients occasionally overheard staff misgender them. Although these instances occurred with a similar rare frequency at Woodfield, Woodfield's soundproof clinic room doors prevented staff from being overheard. At both clinics, misgendering typically occurred when staff was in training. Instances of misgendering could be reduced simply by emphasizing to new and rotating staff the importance of using the correct pronouns for patients early on, and indicating patients' names and pronouns of use to staff clearly before each appointment.

Interiors Shape Patients' Perceptions of Care

As illustrated in the Glendale clinic example above, clinics' built environments structure the kinds of affects that occur between staff and patients. As we know, different patients develop different perceptions of clinic features, incorporating these perceptions into their appointment experiences. Positive affect generated from these perceptions—such as noticing a clinic's gender-neutral bathrooms in the lobby—contribute to patients' willingness to return to the clinics for future appointments because they produce feelings of safety and trustworthiness in providers' knowledge about transition care. At Glendale, the small size of the clinic and the use of paper medical records generated perceptions of the clinic as underfunded; one patient-participant linked this perception to a lack of information about transition care. For other patients, it is precisely these interior features of the clinic that generated feelings in patients of admiration for staff who managed to maintain abortion services within a harsh political climate set to eliminate them. Obviously, it is unfeasible to anticipate every possible response to clinic architecture a patient may have. Rather, I argue that staff (and scholars) should be aware that the maintenance of interior clinic space is a silent, yet intricate part of bureaucratic practice that shapes patient care.

Helping Patients Approach the Clinic

When I asked patient-participants what they would improve about their appointments, most said their appointments proceeded perfectly, but some participants cited the need for more information about changes to their bodies on hormones and about assistance with scheduling into the clinics and preparing for their initial appointment. I detail these concerns here to offer some solutions to help navigate these issues in the future. Note that feelings of anxiety can correspond with bodily materiality in negative ways that must be addressed, such as instigating high blood pressure that can skew labwork and preclude patients from accessing care, as I discussed in Chapter 4.

During their debriefing interviews, some Glendale patient-participants wanted more information about the effects that individual hormone medications would have for them over time. As one Glendale patient-participant noted:

> "… I think I would like more information on different hormone options in terms of injections versus oral pills, what exactly each medication does, spironolactone and the estrogen like what changes each one of them has like independently of each other. And more information on how changing doses would affect things. We're given this information packet but it's pretty sparse and isn't too detailed to the medication or means of taking it… I think there's an assumption that we do a lot of research online" (Debriefing interview with patient-participant, Glendale clinic).

Resolving this issue could involve including a chart finely detailing the effects different individual hormone medications are expected to bring—based on available contemporary research—in introductory packets. Additionally, initial injection demonstrations could be given as part of appointments in clinics where appointment times are not audited as strictly and during which information about the effects of different medications could be addressed. For example, patients may find they do not feel comfortable injecting and express a preference for patches or pills during that appointment. Injection demonstrations would have the added benefit of allowing the patient time to have insurance cover additional doses while the first dose is active in their bodies, as I discuss in Chapter 2.

Healthcare staff and patients at both clinics mentioned that patients have a difficult time approaching the clinic for their first appointment. Some patient-participants mentioned that they did not know which number to call to schedule into the clinic, a sentiment echoed by schedulers and by clinic staff who were aware that many patients had high blood pressure during their first appointment (recall that having blood pressure within a normal range is required to receive approval for hormones). To address this issue, healthcare staff should make the steps of scheduling appointments—including a listed phone number—and expectations of the first appointment clear on their respective websites. Ideally, they should directly specify that staff patients will encounter when scheduling into the clinics are familiar with gender-affirming care. Doing so is a simple and accessible way to inform patients about what to expect and to reduce possible feelings of anxiety prior to initial appointments.

Conclusion

Improving U.S. transgender healthcare practice necessarily involves striving to create forms of bureaucratic encorpment that incorporate patients' transition plans. Drawing from the bureaucratic practices providers and patients engaged in at Glendale and Woodfield clinics and patient-participants' evaluations of them, in this final chapter I have outlined ways that these practices can be improved and modeled for healthcare clinics in the United States. Central to the success and satisfaction of Glendale and Woodfield's clinic practice is providers' acceptance that there is no single way to be transgender or gender-expansive. Providers bring this anticipation of complexity and unpredictability into daily bureaucratic practice. Adopting this approach will go a long way to assist providers and patients in building the rapport necessary to address features of clinical bureaucracy that do not yet represent gender-expansive experiences (Grasso et al. 2019; Dunne et al. 2017). I reiterate the recommendations I made in this chapter in Appendix 2 for easily reference. While patients' journeys are long, clinic spaces that are oriented toward exemplary transition care can make these journeys easier.

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APPENDIX A

Have you chosen to receive some form of gender-affirming surgery and/or are you currently receiving hormone replacement therapy (HRT)?

Are you currently a patient at [Woodfield/Glendale] Clinic?

If you answered “yes” to these questions, then you may be eligible to participate in a research study exploring how transgender, non-binary, and gender non-conforming individuals and their healthcare providers rework a medical system designed for cisgender individuals.

A UIowa anthropologist will observe your appointment, take notes of the clinical interactions between you and your provider, and meet with you right after the appointment or call you within the week to ask about your appointment experience, depending on your preference. You will not be personally identified from the notes collected.

If you are interested in participating in this study, ask your provider for more information.

Your voice is important!

APPENDIX B

Time-Related Bureaucratic Barriers

Issue: MDs are the only staff role permitted to sign letters for legal gender-marker changes, causing possible delays in transition plans.

Recommendation: Designate another staff role to assess for permanent bodily changes and write letters; MD then reviews and signs letters in bulk.

Issue: There are too few staff to manage patient scheduling needs at clinics specialized to provide transition care.

Recommendation: Staff from specialized clinics set up informal workshops and training sessions with non-specialized health staff; specialized staff can then refer people they trust from these sessions to patients.

Recommendation: Invite staff from other clinics to shadow in the specialized clinics and use clinic practice as a model for their own practice.

Recommendation: Advocate for LGBTQ curricula in medical training.

Issue: Federal requirements dictate that patients must have testosterone prescriptions renewed every 6 or 3 months, causing potential interruptions in patients' hormone use.

Recommendation: Utilize initial "demonstration injections" with patients. This both educates the patient about proper injection and extends the time between the initial and subsequent injections, allowing time for insurance to accept the prescription renewal.

Making Gender-Expansive Patients Visible in Medical Documents

Issue: This patient is trans/gender expansive and I want my staff to call them by their correct name and pronouns.

Recommendation: List patient's name of use and pronouns in a visible section in the EHR, such as an alert section if one exists. Arrange patient information in schedules so that preferred name is listed first when reading from left to right.

Recommendation: Construct a template to paste at the top of clinic notes containing information such as the patient's assigned sex, current gender identity, name of use, pronouns. An example from Woodfield clinic can be found in Chapter 3.

Issue: Insurance is denying my patient's care because the gender listed in the EHR conflicts with the diagnostic or procedure code I selected.

Recommendation: Make sure codes selected match insurer's understandings of transition care by reading individual plans or calling the insurance company directly.

Recommendation: Contextualize patient's identity in clinic notes, explaining directly how the listed gender marker relates to patient's actual gendered embodiment.

Recommendation: Empower patients to navigate insurance by highlighting existing symptoms patients could communicate with insurance and letter writers to hasten the transition process.

Creating a Space of Safety and Empathy

Issue: I want to communicate with patients in a way that is affirming and empathetic.

Recommendation: Engage in dialogue that is direct in conveying information while also engaging in active listening with the patient to understand how they experience their bodies and unique transition plans.

Recommendation: Frame historically gendered procedures (eg. breast exams, pap smears) in gender-neutral language.

Recommendation: Privilege patients' understandings of their bodies over normative understandings of gender and sex in medical training.

Recommendation: Be aware of the messages that clinic interiors communicate to patients, and the potential of these features to make patients feel safe or unsafe (eg. gender-neutral bathrooms).