THE TRADE-OFF:

READING BODILY AUTONOMY,

CIVIC RIGHTS AND THE MEDICAL SYSTEM

THROUGH TRANS EXPERIENCES

2025

PREAMBLE

Lebanese laws determine personal liberties, rights and duties based on a person's "biological sex", making no mention of gender (Makhlouf & Dghaidi 2021, 25). The relationship between gender and sex – or the degree to which the biological and the social are understood as interrelated or distinct – remains a point of debate. Science is often given the authority to determine "sexual truth" (Mikdashi 2022, 10) because of its dominant framing as an objective, neutral field that is unaffected by socio-political constructions. In our papers, we refer to "gender" and "gender markers" where the Lebanese state would refer to "sex" and "sex markers". We make this choice in order to think and speak from a position that does not privilege science over lived social experience, but rather challenges the sex-gender duality by collapsing it and affirming that even scientific fields are socially and politically situated.

In Lebanon, there is no standard pathway for a person to correct their gender marker on identification documents. Yet, in practice, legal gender recognition remains largely based on assessments of the person's body and medical history. Under such conditions, every person's experience in attempting legal recognition is different, and the impact of class, race, citizenship, geography, and respectability on their experience is all the more heightened. The individuation of the experience of medico-legal recognition highlights the relevance of adopting a research-based approach and speaking to community members about their personal trajectories, in order to better understand how the medico-legal complex functions and how it is navigated by those whose difference it seeks to manage or erase.

This medical research component
is part of the research project

"Between the Clinic and the Courthouse: Trans experiences with bodily autonomy in Lebanon"

PRODUCED BY QORRAS IN 2024-2025

INTRODUCTION

> **I know I need to change my ID eventually, but the thought of surgery right now is overwhelming.**
>
> - *Tarek*

> **For me, my health comes first. I'll deal with the ID when I'm ready, but right now, I need to focus on what matters to me.**
>
> - *Shakib*

> **I haven't even tried to start the process of changing my ID because I haven't decided if I want sexual reassignment surgery.**
>
> - *Mariam*

> **I've done the surgeries, but I won't change my ID because I refuse to comply with such an unreasonable procedure**
>
> - *Dina*

> **I feel forced by the government to do a hysterectomy and that's why I won't do it, I'm not bothered by having a uterus.**
>
> - *Hadi*

Accessing gender-affirming medical care in Lebanon requires navigating a healthcare system that is highly privatized and weakened by ongoing economic crises, medication shortages, staff emigration, and reduced access to essential services. Public hospitals are often underfunded, while private facilities are accessible mainly to those who can afford their rising costs. In this context of generalized difficulty in accessing adequate healthcare, many of the challenges in accessing gender-affirming care are structural. At the same time, because legal gender recognition remains – at least in practice – contingent on bodily and medical assessments, it is important to examine the particularities of how trans people navigate such a system, whether legal recognition is part of their motivations or not.

This paper is based on research conducted under the leadership of Qorras between January and November 2024[1]. Through interviews with community members and medical professionals, the research aimed to bring clarity to four main areas of questioning: trans individuals' lived experiences in accessing gender-affirming medical care; medical institutions, actors, and regulations that they encounter; the overlap between the legal and medical aspects of trans individuals' experiences; and how healthcare providers understand their roles and responsibilities in relation to gender-affirming care. In this paper, we discuss the most significant findings around the medical and bodily conditions for legal recognition, how gender-affirming medical care is accessed, and the role of doctors in constructing or undermining bodily agency.

[1] Details about the research and its methodology can be found in Behind *The Scenes: Research Methodology and Reflections* (Qorras, 2025) – Available on Tajassod's Database

1. Medical/bodily conditions for legal recognition

What the law doesn't say

Legal texts in Lebanon do not mention explicit requirements concerning the medical or bodily conditions that must be met in order for one's gender marker to be corrected in identification documents. In fact, the notion of gender itself is absent from Lebanese law, which refers instead to biological sex as a means to regulate the relations of individuals among each other and their relationship with the state (Makhlouf & Dghaidy 2021, 25). The state expects – and requires – to identify a person's sex due to its legal repercussions on personal liberties, as well as on the rights and duties imposed by the law (Makhlouf & Dghaidy 2021, 25). This reveals the fundamentally gendered nature of the Lebanese legal system, and explains its unease when faced with requests that challenge its fixed binary categorizations. In this context, a great deal of power is concentrated in the figure of the judge: requests for legal gender recognition are decided upon based on legal precedents and judges' individual assessments of the person's case and their gender presentation.[2]

The medico-legal complex

It is often tempting to understand legal ambiguity as something to be resolved, as it could constitute grounds for inequality and discrimination. However, in the case of trans experiences in Lebanon, legal ambiguity warrants a more nuanced approach. Certainly, ambiguity can have undesirable consequences when it becomes a cause for confusion, especially if one's goal is achieving legal gender recognition. However, it can also constitute a space of possibility, for example in the case of people who want to modify their body but have no interest in being recognized by the state or on official documents. In both cases, regardless of the person's motivations and intentions, what is clear is that legal recognition is highly conditioned on bio-medical criteria. This places medical interventions – and more broadly, bodily agency – under a great amount of scrutiny and regulation because they can constitute the basis for legal recognition and subsequently alter one's rights and duties, relationships to others, and to the state. Together, medical and legal institutions define, regulate, and control bodies, identities, and behaviors in what is often referred to as "the medico-legal complex" (Davy 2011, Monro 2018, Friborg 2023). In the case of trans experiences in Lebanon and likely elsewhere, the medico-legal complex determines access to civic rights as well as bodily agency, revealing the extent of this system's power and authority over all bodies and lives that fall under its purview.

Navigating the complex

Navigating the Lebanese medico-legal complex is not an easy task for most, and even more so for those who do not fall neatly into the category of a "cis-abled-healthy body" (Basbous & Nasser 2024). When it comes to medical processes in particular, trans people generally navigate them with little to no guidance or informed support. They tend to rely primarily on peer-to-peer advice that cannot always be generalized, and in some cases, on information obtained from legal professionals who may not be familiar with their specific case. As a result, community members and legal professionals participate in constructing perceived notions of what is medically required in order to achieve legal recognition. For example, there is a common conception among transwomen that changing the gender marker is impossible without Genital

[2] See *Law And Order: Legal Gender Recognition And Its Discontents* (Qorras, 2025) – Available on Tajassod's Database

Reconstruction Surgery (GRS) – a costly and uncommon procedure in Lebanon. While some transwomen want to correct their gender marker, not all are interested in having GRS, or prefer to get it done on their own terms and timings. Therefore, they delay their legal recognition processes until they feel they are ready to go through with GRS. On the other hand, some transwomen have dismissed the idea of legal recognition altogether as a result of their belief that GRS is legally mandated, when it is not explicitly so.

Perceived legal requirements push individuals to make medical decisions based on bureaucratic deadlines and conditions, rather than personal or emotional desires and readiness. In many cases, trans people feel compelled to undergo interventions that they would not have chosen to do otherwise, and whereby they are effectively forced to choose between bodily agency on one hand, and civic rights on the other. This results in a great deal of injustice and feelings of frustration toward a system that, in practice, ends up requiring trans people to alter their bodies in sometimes irreversible ways before they can be recognized as legitimate subjects. In other words, the medico-legal complex in Lebanon conditions civic rights on the loss of bodily agency.

2. Framework for gender-affirming medical care in Lebanon: public, private and informal spheres

There are many ways to embody one's gender, not all of which are medical – wigs, make-up, clothes, binding, and packing, are some examples. Although the boundaries of what is considered medical are often a topic of contention, we focus in this part on medical forms of gender-affirming care in the broadest sense of the term. These include long-term treatments like Hormonal Replacement Therapy (HRT), surgical procedures – such as mastectomies, breast enlargements, rhinoplasties, penectomies, orchiectomies, hysterectomies, genital reconstructions, and others – and cosmetic interventions – such as laser hair removal,hair implants, botox and fillers. To understand how these kinds of interventions are accessed, we begin by laying out how the formal healthcare sector is structured in Lebanon, and we go on to examine how it is navigated in practice.

Structure of the formal Healthcare Sector in Lebanon

The healthcare sector in Lebanon is structured into public and private institutions, with the private sector playing a dominant role. Public facilities tend to serve lower-income populations whereas private institutions cater to those who can afford out-of-pocket expenses or private insurance.

According to reports by the World Health Organization (2024) and Khalife et. al. (2017), the public sector, run by the Ministry of Public Health (MoPH) includes public hospitals[3], primary healthcare centers that provide basic health care services[4], and dispensaries[5]. The private sector includes private hospitals[6], which account for about 82% of all hospitals in Lebanon, faith-based and sectarian organizations providing primary healthcare services, and private clinics and outpatient diagnostic centers (radiology, laboratory, etc.). When it comes to financing healthcare, Khalife et. al. (2017) reported that about 47% of Lebanese citizens have health insurance coverage through various schemes.[7] The remaining 53% of the population lacks formal coverage.

Non-citizens in Lebanon tend to face significant barriers in accessing healthcare due to the country's heavily privatized system and limited public provisions. Syrian refugees rely on a collaboration between the Lebanese MoPH, UNHCR, and NGOs, but dwindling funds make access increasingly difficult. Palestinian refugees have a separate system, relying primarily on UNRWA's network of primary care facilities and the Palestine Red Crescent Society for secondary care, though most lack health insurance and depend on UNRWA subsidies for hospital admissions. Undocumented migrants, with no formal healthcare coverage, can only access services through NGO support. However, NGOs often limit their coverage to the doctor's visit and leave out treatments as well as tests, which are costly and conducted in private laboratories. Overall, non-citizens are largely dependent on private institutions and international aid, facing financial obstacles and limited access to specialized treatments.

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[3] 29 Public Hospitals operate under a semi-autonomous model with administration boards appointed by government decrees

[4] Services provided by 229 PHCCs include reduced-cost consultations, free medicines for chronic diseases, essential medicines, and immunization

[5] Approximately 600

[6] 133 private hospitals constituting 83% of the country's total bed capacity

[7] including the National Social Security Fund (NSSF), military schemes, private insurance, and the Civil Servants Cooperative

The existence of for-profit healthcare institutions in the private sector highlights a fundamental tension between the ethical mandate of medicine to prioritize patient well-being and the financial imperatives of a market-driven system, raising urgent questions about how vital care can be treated as a commodity. When it comes to gender-affirming procedures, availability is often limited due to "low Return on Investment (RoI)", by medical professionals' own admission. This focus on profitability over patient care is particularly problematic in the context of gender-affirming surgeries, which require expertise and training that many institutions are unwilling to invest in due to perceived low demand and financial returns. It is important to mention that within the private sector, some healthcare institutions operate on a non-profit basis, such as Al-Zahraa Hospital University Medical Center (ZHUMC) or the Lebanese Hospital Geitaoui-UMC (LHG-UMC). This type of institution plays a vital role, especially for populations who have limited access to public or for-profit private healthcare services. At the limit of the formal healthcare sector, pharmacists emerge as a key figure for people who are unable to access doctors or specialists: by facilitating informed medical advice and access to treatment, pharmacists provide both general and gender-affirming healthcare to those seeking them. This may be explained by the transactional character of pharmacies, with some pharmacies facilitating payment over installments.

General healthcare is thus difficult to access and afford for most people living in Lebanon, and trans people are no exception. When seeking general healthcare services, trans people who may not have the financial support or insurance coverage to afford private healthcare often resort to the public sector. However, public healthcare facilities tend to be insufficiently equipped to handle the specific needs of trans patients. While private institutions generally offer higher-quality care, including access to specialized services, the cost-prohibitive nature of private healthcare is compounded by the lack of comprehensive insurance coverage for gender-affirming care. Even in private settings, trans individuals must often navigate social networks or personal contacts to identify supportive doctors. Typically, those who seek care from private institutions come from higher socio-economic backgrounds, have access to private insurance, or rely on personal savings or family support to cover the significant costs associated with gender-affirming care. In cases where family members are unsupportive or hostile to the individual's transition, access to private healthcare becomes severely limited. It is with this in mind that we must understand the question of access to gender-affirming medical care.

Transwomen who have spent time in detention report having been denied access to adequate medical care, proper sanitation, and basic necessities. More research is needed to put this in the context of how detainees and prisoners are treated generally when it comes to their healthcare needs, as well as the specificities of trans people in such situations.

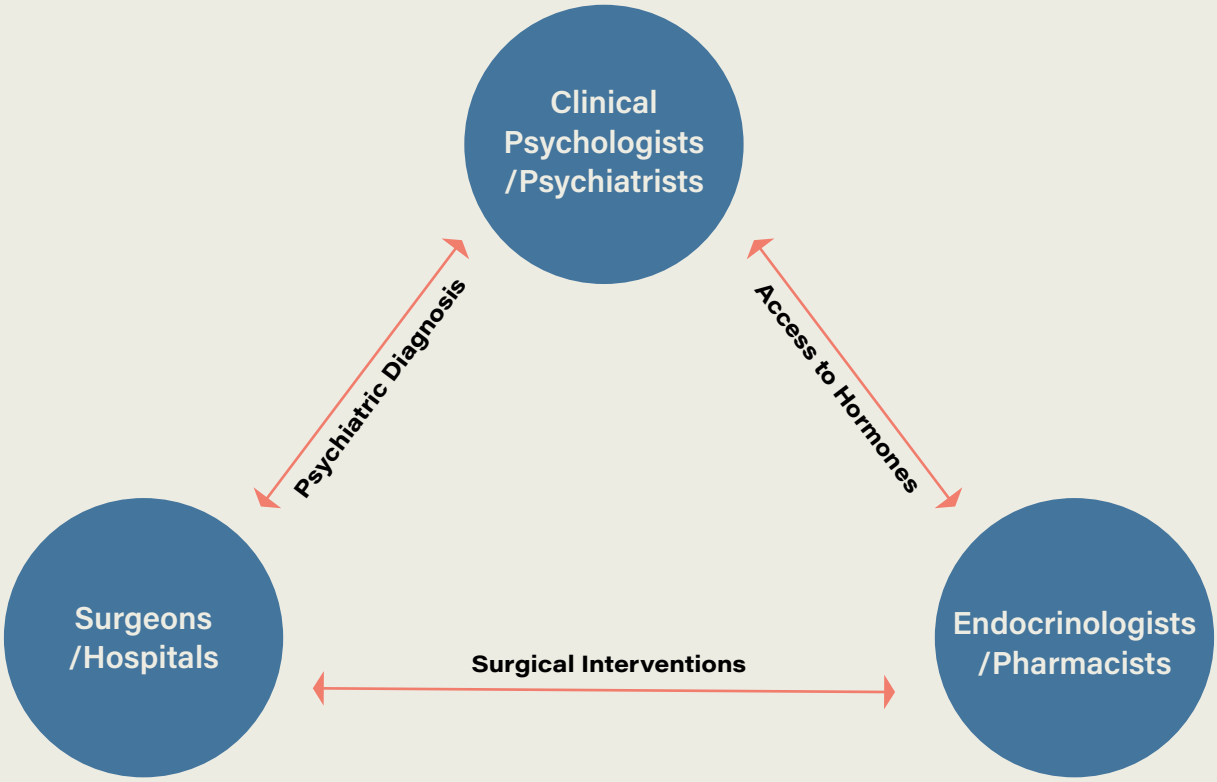
No standard pathway for Gender-Affirming Medical Care

In practice, individuals residing in Lebanon access gender-affirming medical care through one of three possible entry-points which constitute informal prerequisites for legal recognition: psychiatric diagnosis, hormonal replacement therapy, and surgical interventions. The interchangeability of these entry points highlights the fragmented and ad-hoc nature of gender-affirming care pathways in Lebanon, where individuals must navigate multiple actors to access the services they need. For example, some trans individuals bypass psychiatric consultations and directly access hormone therapy via endocrinologists, pharmacists, or peers, while others may prioritize surgical interventions and begin their journey by contacting surgeons or hospitals.

This interchangeability reflects the lack of a standardized, centralized system of care, leading individuals to make decisions based on the resources and information available to them – information that is typically based on experience, and exchanged between trans people. The multiplicity of possible pathways also poses an obstacle to coordination between different fields and specializations to ensure holistic care, which should give equal importance to both general and gender-affirming healthcare: gender affirming interventions do not solve general healthcare issues. This also trickles down to care-seekers' experience, who may struggle to obtain answers to some of their questions For example, Tarek's generally positive experience with surgery was undermined by a lack of coordination among medical staff, which he described as leading to delays and communication failures. Such fragmentation can result in gaps in treatment and added stress, and can have serious consequences for the health and well-being of trans patients, particularly those who require ongoing, multi-disciplinary care. It also restricts access to comprehensive information in cases where patients have questions that touch on multiple specializations. While standardizing some aspects of gender-affirming care can be beneficial, the question remains of how to introduce consistency without imposing measures that limit care-seekers' agency to make choices based on their health and needs – for instance, standardizing the order in which gender-affirming procedures are conducted, as is often the case in other contexts, can cause more harm than good.

The diagram below highlights the interconnected roles of clinical psychologists/psychiatrists, endocrinologists/pharmacists, and surgeons/hospitals in facilitating access to gender-affirming care. Clinical psychologists and psychiatrists are typically responsible for issuing a psychiatric diagnosis. Although not explicitly required by the law, in Lebanon the diagnosis is often a necessary precondition for accessing further medical interventions, including hormone therapy and surgeries. As for endocrinologists and pharmacists, they manage access to hormonal therapy, while surgeons and hospitals provide surgical interventions.

Typical Pathways of Gender Affirming Medical Care in Lebanon



Based on the experiences of community members, factors influencing the quality of care received range from the type of healthcare institution – with private hospitals reported as providing better quality care compared to the public sector – to the level of expertise and training of healthcare professionals, to the availability of post-operative care. In public hospitals, there is a noteworthy absence of specialized training and standard protocols for gender-affirming surgeries that can lead to dangerous outcomes. Jaber's experience in a public hospital serves as a stark example of extreme medical negligence. Following surgery, Jaber experienced severe complications due to the hospital's lack of proper aftercare and oversight. The hospital failed to provide follow-up treatment, leaving Jaber to deal with the consequences of professional negligence on his own. Many trans individuals report a disparity between surgical expertise and general healthcare support, suggesting that even when trans individuals receive competent care for gender-affirming interventions, they may struggle to access the follow-up and post-operative care required for recovery and long-term health. Housam, for example, reported that while his hospital experience during surgery was largely positive, his experience with general medical care afterward was much less satisfactory. This is compounded when community members prioritize aesthetic outcomes over general well-being.

Critical reflections on informality

In some cases, people seeking gender-affirming medical care are pushed to fulfill their needs through informal channels. This can be understood as a consequence of the conditions previously described, but also as a result of the distrust, and resulting avoidance, of medical authority especially in how it views and deals with bodies that fall outside of the cis-abled-healthy norm. Factors such as citizenship status and socio-economic class also play a decisive role in the accessibility and quality of care received, so many of those who resort to informal channels are politically vulnerable or economically precarious. In informal settings, these forms of precarity are compounded by unregulated medical practices that can sometimes have fatal consequences.

Informality in gender-affirming medical care can happen in different ways and to varying degrees. It includes self-medication, reliance on one's community of peers for medical advice, the provision of financial support and access to hormonal therapies through mutual aid funds, and unregulated cosmetic and surgical procedures locally and abroad.

Mutual aid groups, community networks and peer support can offer alternative paths to care when formal options are limited or inaccessible. They help individuals circumvent institutional barriers and restrictive policies, bypass gatekeeping in medical settings, and navigate legal obstacles. Community-driven knowledge also allows for more personalized approaches to gender embodiment and gender-affirming care, incorporating experiences and practices beyond standardized medical protocols. Peers with firsthand experience also offer emotional support, practical advice, and strategies that medical professionals may overlook. Many trans people rely on such networks for access to (self-)medication and guidance to identify willing and affordable healthcare providers and treatments, to anticipate and prepare for exchanges with medical professionals, or to locate and mitigate potential risks.

However, there are limits to the transferability of these types of knowledges, especially when it comes to medication doses, treatment regimens, and their relation to general health. Similarly, the quality integrity of informally acquired medications – hormones for instance – is difficult to verify, and can lead to general health complications, especially if unmonitored. Additionally, community-based knowledge leaves space for myths to develop and circulate. For instance, the widespread use of a contraceptive pill as HRT among transwomen has led to the belief that this

regimen is “stronger” and “more effective” than injectable estrogen. Others are convinced that unless HRT is started before puberty, it will not bear any effects. Generally, transwomen express that available information on HRT and GRS is ambiguous and limited, leading many to worry about potential short and long-term side-effects of these treatments and procedures. This is compounded by the taboo around discussing any negative side-effects related to GRS by those who have done it, such as loss of sensation or mental health effects. On the contrary, there is an exaggeration of the positive outcome that is in some cases later found to be untrue.

Community advice can also include referrals to underground medical networks in Lebanon and abroad, where unregulated practices leave ample space for malpractice and complications to occur. While cosmetic interventions are perceived to pose minimal risk, more invasive surgical interventions can have dangerous consequences. For example, Syria is often chosen as a more affordable alternative for surgeries, however, the unregulated pathway through which this access takes place makes it difficult to hold the medical practitioner to account when post-surgical complications arise. This is the situation Shakib found himself in, having faced serious post-surgical complications after undergoing a procedure in Syria. His doctor later disappeared and his attempts to find care in Lebanon were further complicated by the reluctance of local doctors to take on his case, reflecting the stigmatization of trans patients who have experienced complications abroad. As for prescriptions that are required by pharmacies in order to provide hormonal treatment, these are also sometimes obtained informally due to the prohibitive cost of doctors’ visits and of tests conducted in private laboratories where IDs are often required. Such cases exemplify how the lack of accessible, affordable, and regulated gender-affirming care in Lebanon forces many trans individuals into precarious and dangerous situations. Many know the risks involved, but find themselves with no viable alternative.

3. Experiences accessing gender-affirming medical care in Lebanon

When it comes to gender-affirming care, the general inadequacies of the healthcare system are compounded by widespread societal discrimination and a lack of robust legal protections against medical malpractice, leaving trans individuals vulnerable to substandard care. Medical accountability is generally difficult in Lebanon, and even more so in the case of trans people who experience complications or medical negligence. There are many lessons to be learned from the experience of those who have accessed, or have attempted to access, gender-affirming medical care in the Lebanese setting.

Medical authority and power

Trans people navigate a healthcare system that often views them through a lens of suspicion and prejudice, if not outright pathologization. Medical gaslighting is a commonly reported experience among trans individuals, who describe often facing skepticism or denial of their health issues, particularly in public healthcare settings. Moreover, symptoms and concerns tend to be minimized or dismissed by healthcare providers who instead ask intrusive questions that have no relevance to the symptoms or issues the person is seeking medical attention for. This form of medical discrimination, colloquially known as "trans broken arm syndrome", is also referred to as "gender-related medical misattribution and invasive questioning" (GRMMIQ). While it generally describes the practice of providers incorrectly assuming that a patient's medical condition results from the patient's gender identity or medical transition, it may also take the form of invasive and unnecessary questions regarding the patient's gender identity and sexuality (Wall et. al. 2023). In this context, discrimination doesn't just affect a patient's comfort or dignity—it has direct and harmful impacts on their physical wellbeing. It often results in misdiagnosis, negligence, or inadequate care, and contributes to a general atmosphere of distrust and avoidance among the trans community.

To mitigate the violence they experience in medical settings, a recurring practice among community members consists in finding pharmacists and doctors through community referrals, and working on establishing a long-term relationship of trust and respect with them – even if it means paying out of pocket. Similar tactics are adopted by community members when dealing with other sectors, such as in private businesses or with civil servants.[8]

Gendered differences in medical experiences

Many kinds of comparisons can be made in order to examine how gender expression shapes medical experience. In this section, we focus on the experiences of trans people who are perceived as binary "transwomen" and "transmen" by the medical system, and whose experience is subsequently shaped by this perception and associated preconceptions. Although they share some commonalities, the experiences of transwomen and transmen with the medical field in Lebanon present differences that can be explained through the lens of gender difference. For instance, there is a significant discrepancy between the experiences of transmen and transwomen in accessing hormonal replacement therapies.

[8] See *Law And Order: Legal Gender Recognition And Its Discontents* (Qorras, 2025) – Available on Tajassod's Database

In Lebanon, testosterone tends to be difficult to access without an endocrinologist's prescription, which usually –but not always– requires a psychiatric diagnosis document. Community members explain how accessing testosterone is in fact more costly than the hormonal treatment itself, pointing to a class-based gatekeeping where people need to cover the costs of doctors' visits as well as blood tests. Additionally, as an imported substance, it is not consistently available in pharmacies, especially during pronounced national crises. Community members also believe that testosterone quantities are subject to more stringent governmental regulation compared to estrogen, for instance, possibly as a way to reduce unprescribed use among male gym communities. Interestingly, in times of shortages, these communities become one of the substitute sources for testosterone, along with hormones smuggled/brought in by peers from countries like Syria, Jordan and Turkey. When it is entirely unavailable, some transmen substitute testosterone for steroids sourced through these same circles, which can have devastating effects on health.

As for estrogens, their widespread availability in the form of contraceptive pills and hormonal replacement therapy catering to menopausal women unintentionally results in greater availability and ease of access for transwomen. Similarly, some brands of anti-androgens are sold as diuretic medication and are thus available but expensive; however other brands may need to be sourced outside Lebanon. While some pharmacies may facilitate access to these hormones, others require prescriptions that can be costly to obtain. Mutual aid groups emerge as a primary provider of injectable estrogen which tends to be more effective.

These factors contribute to complicating formal access to hormonal therapy for transmen, and facilitate unmonitored self-medication among transwomen.

The systemic misogyny of the medical system spares no-one. Transwomen and transmen in specific both suffer from its effects, which manifest in different discriminatory practices. While transwomen face the compounded biases of transphobia and sexism, transmen tend to face misgendering and restricted access to specific healthcare needs, such as reproductive care (gynecological care and check-ups, pap-smears, abortion, egg freezing, etc.). Harmful stereotypes and beliefs translate into arbitrary practices: for instance, the unfounded systematic association of transwomen with sex work can lead to unnecessary HIV testing.

Class, citizenship and respectability

Trans people's experiences with the medical system are shaped by intersecting factors like class, citizenship status, and respectability, which interact (with each other and with other factors like ability, age, race, and others) to create varying levels of access and discrimination.

The question of economic class and financial resources is one of the most salient, particularly for its implications on the speed of accessing care, but also on the quality of care provided. When one is unable to afford medical care, this often translates into extended waiting: waiting to save money and be able to afford medical care, waiting to find an affordable provider, waiting for NGO referrals, waiting to identify the right doctor, etc. While the process of waiting can in and of itself be mentally draining, delayed medical attention has physical repercussions: conditions can worsen, complications can arise, etc. Limited financial means can also push those seeking gender-affirming medical care to resort to self-medication or unregulated medical networks in and outside of Lebanon.

Despite presenting as scientifically neutral and egalitarian, the way trans people are treated by doctors, medical staff, and pharmacists to a lesser degree, continues to be largely influenced by respectability politics. In this context, respectability refers to the quality of being considered

socially acceptable, proper, or worthy of esteem based on prevailing moral, cultural, or class-based norms. It often implies adherence to conventional behaviors, appearances, and values that grant legitimacy or status within a given society. “Staying under the radar”, “avoiding attention”, “having the right attitude” and “being discreet” are often cited by community members as ways to obtain respect and quality treatment from medical staff and doctors. Discrimination leading to inappropriate care, denial of care, or denial of medication at pharmacies often occurs when the provider perceives the patient as trans, revealing the role played by appearance and presentation. In some cases, particularly among transwomen, care is refused on the basis of sex work, either because the doctor recognized the person, or because they perceived her as trans and assumed her occupation (Basbous & Nasser, 2024).

Trans people who are not Lebanese citizens and who have limited income tend to be at even greater risk of medical negligence and malpractice. For example, an Arab transwoman reported that her doctor performed her breast augmentation surgery using implants that had been discontinued by the producing company because of their proven harm. Upon realizing this, she confronted the doctor who claimed he didn’t know what she was talking about, yet agreed to redo the procedure. However, the second procedure employed the same brand of dangerous implants. She threatened to report and prosecute the surgeon, who instead offered her hush money that she refused. Ultimately, the patient left the country. This kind of experience understandably increases distrust of the formal medical sphere and dissatisfaction with its performance, and demonstrates how foreigners’ precarious situations are taken advantage of by those whose duty it is to provide them care.

These experiences underscore the inconsistencies in the accessibility and quality of healthcare, which are often the result of intersecting structures of oppression. Finally, they shift the conversation about trans health from being framed as exclusively a matter of gender-affirmation to demand that general health and dental health be considered just as important. This type of medical attention is all the more crucial as people age, as well as for people living with HIV, which also reflects the excessive focus on “healthy” youth and young adults in research, advocacy, and services.

4. Doctors' roles

Community members tend to attribute their variable experiences with medical staff to the attitude and values of individual healthcare providers, which can vary greatly from one person to another, within and across settings. However, the experiences presented in the previous section highlight how discrimination in healthcare settings goes beyond individual biases, even though. It is embedded in the structures and practices of the medical system, and contributes to further marginalizing trans individuals and perpetuating health inequities. However, reality is always the result of an interplay between structures and individual agency. It is thus important here to examine how community members understand doctors' abuse of power but also their supportive attitudes, and to flesh out the ethical constraints that doctors must navigate when providing gender-affirming care in the Lebanese setting.

Abuse of power

Community members explain that even doctors who are willing to provide medical attention can do so in a rude and dismissive way where their needs are not really recognized or met. In other words, it is not because a doctor accepts to see a patient that they will treat them with respect or address the health concerns that they have. When it comes to trans-specific needs, community members often find doctors plainly incompetent. This highlights even more the importance of building long-term relationships with community-vetted doctors. As for doctors referred to via NGOs, community members assume that they are vetted, competent and respectful. When this is not the case, NGO referral systems can provide false legitimacy that exacerbate unhealthy power dynamics.

As previously mentioned, transwomen face a particular kind of discrimination that is related to doctors' assumptions that all transwomen are involved in sex work, but also simplistic understandings about what sex work is and what it entails. This can lead to refusal of medication or treatment on "moral grounds", or lead to cases of sexual extortion, where transwomen's limited financial means are unethically leveraged by a doctor in exchange for providing medical services.

Another point is the authority given to parents over the bodies of their adult children, especially in the case of transmen. It is common for healthcare providers to resort to the patient's family to obtain approval for certain procedures despite the patient being an adult with the capacity to make informed decisions. Medical professionals continue to place familial and parental authority above their patient's desires, needs, or wellbeing, revealing how the agency of trans people is undermined by the medical system. Although they may consider that they have obtained the consent they deem legitimate in order to proceed with certain medical interventions, doctors who administer medication or perform surgeries without the patient's consent are effectively abusing their power. In other cases, no consent whatsoever is sought out by the doctor, who proceeds on the basis of diagnoses that pathologize transness. In one reported incident dating from around 15 years ago, a transwoman was admitted to a hospital after attempting suicide. The attending doctor decided, of his own volition and without her consent, to change her body's existing hormone balance into a more masculine balance (increasing testosterone injections etc) against her will.

Supportive attitudes

Given the financial barriers to accessing healthcare, it is common practice for healthcare providers in Lebanon to circumvent insurance coverage limitations and help individuals access medical procedures that they need but cannot afford. Some surgeries for example are performed under different titles to bypass restrictions, ensuring that patients receive necessary care. In the specific case of trans people, insurance companies do not recognize gender-affirming interventions as essential medical treatment, making such workarounds all the more crucial. When patients have insurance, gender-affirming treatments are often coded under conditions like "hirsutism" or "irregular menstrual cycles" to ensure coverage. In religious hospitals, where gender-affirming surgeries are not recognized, providers bypass institutional barriers by using alternative codes for similar procedures.

While these practices reflect a pragmatic approach to help trans patients access care, they also raise concerns about transparency and accountability, especially if medical complications arise. They also reflect the larger ethical challenge of operating in a healthcare system that fails to fully support the needs of trans individuals. While these creative strategies help patients in the short term, they highlight the need for long-term solutions. Doctors must balance short-term benefits with efforts to advocate for structural changes that would eliminate the need for such measures in the future.

Navigating ethical constraints

Medical professionals must balance their ethical obligations to provide care with societal norms, legal constraints, and institutional policies. These pressures create ethical dilemmas that impact the quality and accessibility of care available to trans individuals.

On the institutional level, hospital boards hold significant power in determining the availability of certain medical procedures, including gender-affirming surgeries. Conservative or religiously influenced hospital policies may thus restrict access to these services. In some religious hospitals, there is a reported "silence regarding these topics", meaning that gender diversity and trans healthcare are rarely addressed.

Healthcare providers also face personal ethical conflicts when it comes to gender-affirming care. Dr. Dalia, a general health doctor we interviewed, shared the internal conflict between her religious beliefs and her duty as a medical professional: "Am I doing something wrong in front of God? I don't know. This is medical care". This highlights the tension some doctors feel when trying to reconcile their professional responsibilities with personal or societal beliefs. While Dr. Dalia ultimately concluded that providing care is a medical obligation, other healthcare providers may deny services based on their religious or cultural beliefs and prevent access to essential care. This ethical dilemma creates an uneven landscape where trans individuals may be denied essential care depending on the provider's beliefs.

In a context like Lebanon, familial and parental authority continues to influence how medical professionals receive the requests of trans people and how they provide medical care. Dr. Samer, a clinical psychologist, shared the challenges of working with families who are resistant to accepting their (adult) child's gender identity. Other healthcare providers mentioned avoiding cases where families were not aware of the procedures requested by the patient, or where parental approval could not be demonstrated, out of fear of legal liability.

CONCLUSION

In conclusion, the medico-legal complex in Lebanon conditions the civic rights of trans individuals on the loss of their bodily agency. It requires trans people to alter their bodies in sometimes irreversible ways before they can be recognized as legitimate subjects.

Throughout their process of gender-affirmation, trans people navigate a medical system that is plagued by systemic issues from unaffordability and inaccessibility to fragmentation, privatization and underfunding of public institutions. This system struggles to meet the needs of residents generally, let alone provide specialized gender-affirming medical care. Trans individuals are thus vulnerable to substandard care due to the general inadequacies of the healthcare system, which are compounded by societal discrimination and a lack of robust legal protections against medical malpractice. As a result, trans people are often pushed to access the medical services they need through informal and unregulated channels that may be fraught with risks.

In the absence of a standard pathway for both legal and medical gender-affirmation, trans people rely primarily on each other in order to navigate the medico-legal complex. However, there are limits to the transferability of these types of knowledges, indicating a need for accessible and consolidated informative material that is community-focused and context-specific, and potentially, supportive medical accompaniment. Perhaps such measures can help to introduce a consistency that, instead of restricting care-seekers' bodily agency, allows them to make medical choices based on their specific case, desires, and needs. The lived experience of trans people with the medical system in Lebanon teaches us the importance of examining power dynamics in doctor-patient interactions and how medical authority manifests in such settings. They also point us to the commonalities and gendered differences between the experiences of transmen and transwomen with the medical field. Finally, they demonstrate how intersecting structures of oppression such as class, citizenship, and respectability, among others, contribute to shaping each individual's experience.

Lastly, doctor's roles and attitudes toward trans patients give us insights as to how medical professionals understand and navigate ethical constraints. In many ways, just as the outcome of the legal process of gender affirmation is at the discretion of individual judges, so the outcome of the medical process is at the discretion of individual healthcare providers. This shows how a lot of power is concentrated with doctors, but also suggests that healthcare providers may be a suitable entry-point for improving the experiences of trans people in the medical realm despite structural shortcomings.

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