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PROVING GENDER: MEDICAL GATEKEEPING, EPISTEMIC POWER, AND THE INSTITUTIONAL PRODUCTION OF TRANSGENDER LEGITIMACY IN DELHI

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ABSTRACT

Transgender healthcare is frequently framed as a question of access, rights, and service delivery. This paper shifts the analytical focus by examining how gender is institutionally produced within medical settings rather than merely recognized. Drawing on a pilot qualitative study conducted in Delhi, the research analyzes in-depth interviews with 30 transgender individuals seeking gender-affirming healthcare and 2 medical professionals involved in providing such care. Anchored in Foucauldian analyses of medical power, Butlerian theories of gender performativity, and the framework of epistemic injustice, the paper demonstrates that medical institutions function as epistemic authorities that determine the legitimacy of gender claims. Psychiatric evaluations, binary diagnostic norms, and professional ethical reasoning operate as mechanisms of medical gatekeeping through which gender identities are evaluated, stabilized, and certified.

Trans respondents describe fear of refusal, pressure to conform to binary expectations, and strategic modification of personal narratives to appear psychologically stable and institutionally legible. In contrast, medical professionals emphasize readiness, risk management, and ethical responsibility, revealing a discursive asymmetry between lived identity and institutional reasoning. The findings suggest that recognition within transgender healthcare is not an automatic outcome of self-identification but a conditional process shaped by disciplinary power, constrained performance, and hierarchical knowledge relations. By conceptualizing legitimacy as an institutional outcome rather than an inherent attribute, the paper contributes to sociological debates on medicalization, gender, and epistemic authority in contemporary governance.

KEYWORDS: *Transgender Healthcare; Medical Gatekeeping; Epistemic Injustice; Gender Performativity; Institutional Legitimacy*

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INTRODUCTION

Transgender healthcare in India has increasingly been framed through the language of rights, access, and inclusion, particularly following recent legal and policy developments. While this scholarship has been instrumental in documenting barriers to care and institutional exclusion, it has largely treated medical recognition of gender as a neutral endpoint. What remains insufficiently examined is the process through which gender itself becomes institutionally legible and authorized within medical settings. This paper argues that gender-affirming healthcare functions not merely as a site of recognition but as a site of institutional production of gender legitimacy. In clinical encounters, gender identity is evaluated and stabilized through psychiatric assessments, binary diagnostic norms, and professional ethical reasoning. Medical institutions thus

operate as epistemic authorities that determine which gender narratives are credible and which remain suspect. By shifting focus from access to authority, this study moves beyond service delivery frameworks toward an analysis of power, knowledge, and legitimacy in the governance of transgender lives.

Drawing on qualitative data from transgender individuals and medical professionals in Delhi, the paper advances the central argument that transgender healthcare operates through a system of medical gatekeeping that transforms gender from an embodied, self-identified reality into an institutionally certified status. Through diagnostic procedures, moral judgments regarding readiness and stability, and discretionary professional practices, doctors authorize some gender claims while delegitimizing others. This process disproportionately marginalizes non-binary individuals, members of Hijra communities, and economically disadvantaged trans persons, revealing how legitimacy is stratified along normative and material lines. Rather than claiming generalizability, the study prioritizes analytical depth to theorize how institutions actively participate in the production of gender. In doing so, it contributes to sociological debates on medicalization, epistemic authority, and the conditional nature of recognition in contemporary governance.

THEORETICAL FRAMEWORK

This study is anchored in three interrelated sociological traditions that together illuminate how transgender legitimacy is produced within medical institutions: Foucauldian analyses of medical power, Butlerian theories of gender performativity, and scholarship on epistemic injustice.

From a Foucauldian perspective, hospitals and clinics function as sites of biopolitical regulation, where bodies are governed through expert knowledge, classificatory practices, and norms of risk management. Medical authority does not merely treat bodies but actively participates in defining what constitutes a legitimate subject of care. Within this framework, gender transition emerges not as an individualized therapeutic journey but as a biopolitical process mediated by institutional procedures, psychiatric scrutiny, and professional accountability. Diagnostic protocols and assessments operate as disciplinary technologies that normalize certain gender trajectories while rendering others unintelligible or risky.

Judith Butler's theory of gender performativity is extended here into the institutional domain. While gender is socially performed through repeated acts, this paper argues that gender is also performed for institutions. Medical settings impose specific expectations of coherence, stability, and binary intelligibility, compelling transgender individuals to align their narratives and self-presentations accordingly. These performances are not expressive but strategic, undertaken within asymmetrical power relations where access to care depends on institutional approval. Institutional contexts thus delimit the conditions under which gender can be intelligibly performed and recognized.

Finally, the framework of epistemic injustice, as articulated by Miranda Fricker, provides critical insight into the hierarchy of knowledge operating within transgender healthcare. Trans individuals' experiential knowledge of their own gender is routinely subordinated to clinical expertise, particularly in psychiatric evaluations and consent processes. This produces testimonial injustice, where self-knowledge is discredited, and hermeneutical injustice, where institutional frameworks fail to adequately interpret non-normative gender experiences. Medical professionals, positioned as objective authorities, exercise epistemic gatekeeping by determining which gender narratives are credible, stable, and actionable.

Together, these frameworks enable an analysis of transgender healthcare as an institutional arena where power, knowledge, and legitimacy converge to produce gender as a certified status rather than a self-evident identity.

METHODOLOGY

This study is based on a pilot qualitative research design intended to explore the institutional dynamics of transgender healthcare rather than to establish representativeness or generalizability. The dataset comprises in-depth interviews with 30 transgender individuals seeking gender-affirming healthcare and 2 medical professionals involved in providing such care in Delhi. Participants were selected to capture variation in gender identity, socio-economic background, and engagement with medical institutions. The transgender respondents include trans men, trans women, non-binary individuals, and members of Hijra communities, enabling comparative analysis of how legitimacy is unevenly produced across different identity positions. The medical professionals, including a psychiatrist and a surgeon, provide insight into institutional reasoning, ethical frameworks, and professional constraints that shape gatekeeping practices.

Data collection focused on participants' experiences of medical evaluation, institutional interaction, and decision-making processes. Interviews were analyzed thematically, with attention to recurring patterns of narrative modification, institutional pressure, and knowledge asymmetry. The study prioritizes analytical depth over breadth, using theory to interpret how everyday clinical practices produce broader structures of legitimacy. Reflexivity was central to the research process. The study acknowledges the positionality of the researcher and the ethical sensitivity of working with marginalized populations. Pseudonyms were used, identifying details were removed, and care was taken to avoid reproducing pathologizing or extractive narratives. The pilot nature of the study is treated not as a limitation but as a methodological choice that allows close engagement with institutional processes often obscured in large-scale research.

FINDINGS

The findings are organized thematically to illustrate how medical gatekeeping operates through everyday institutional practices and how gender legitimacy is unevenly produced across identity positions.

Fear, Risk, and the Moralization of Readiness

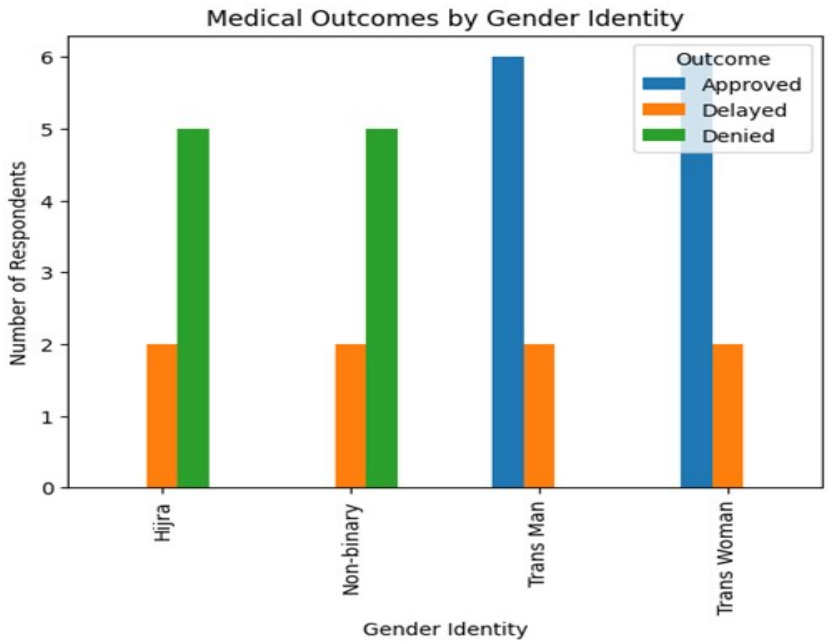

Figure 1: Distribution of Medical Outcomes Across Gender Identities. Binary-Aligned Identities (Trans Men and Trans Women) Show Higher Approval Rates, While Non-Binary and Hijra Participants Experience Disproportionate Denial and Delay.

Fear of refusal structured how respondents approached medical institutions. Clinical encounters were widely described as evaluative rather than collaborative, marked by uncertainty regarding the criteria for approval. This fear was reinforced by doctors' emphasis on readiness, psychological assessment, and risk management, which framed gender-affirming care as a high-stakes ethical responsibility. Medical professionals articulated their decision-making in terms of legal accountability and professional caution. The outcomes of this risk-oriented reasoning are reflected in Figure 1, where delays function as a dominant response alongside denial. Delay, rather than outright refusal, operated as a mechanism of extended surveillance, requiring repeated demonstrations of stability and compliance over time.

Binary Norms and Institutional Erasure

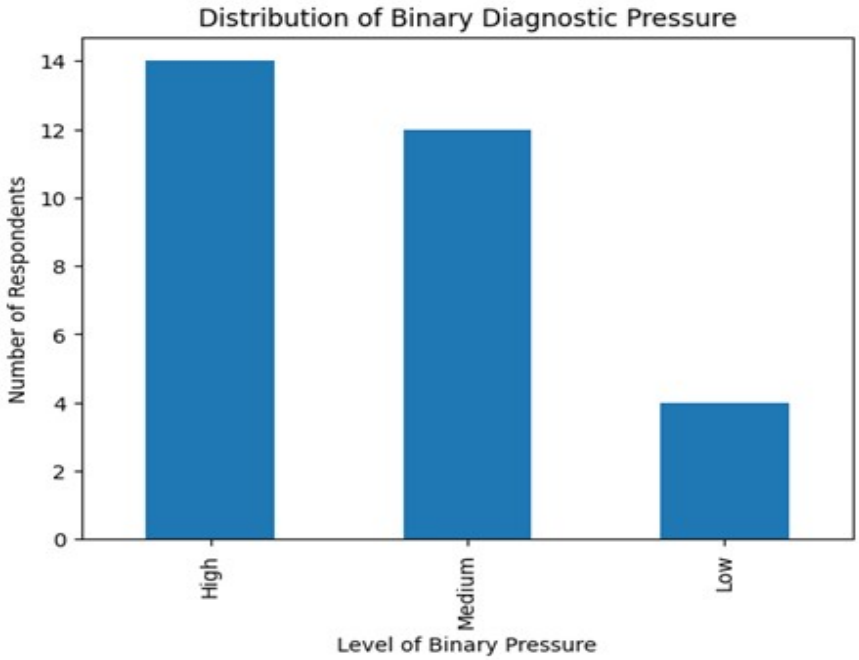

Figure 2: Levels of Binary Diagnostic Pressure Reported by Participants. High Pressure Indicates Repeated Clinical Demands for Binary Gender Coherence.

Binary diagnostic norms emerged as a central organizing principle of medical evaluation. Non-binary respondents and members of Hijra communities consistently reported pressure to adopt binary identifiers or to frame their gender experiences within male–female transition narratives. Several described being misgendered during consultations or advised that non-binary identities were "confusing" or clinically unclear. Figure 2 illustrates the pervasiveness of binary diagnostic pressure across the dataset, with high levels of pressure reported by a majority of respondents. When disaggregated by identity, this pressure translated into unequal outcomes. As shown in Figure 1, trans men and trans women were significantly more likely to receive approvals, while non-binary and Hijra participants clustered around denial and prolonged delay. These patterns suggest that institutional recognition is contingent upon binary legibility rather than self-identified gender alone.

Performing Stability and Certainty

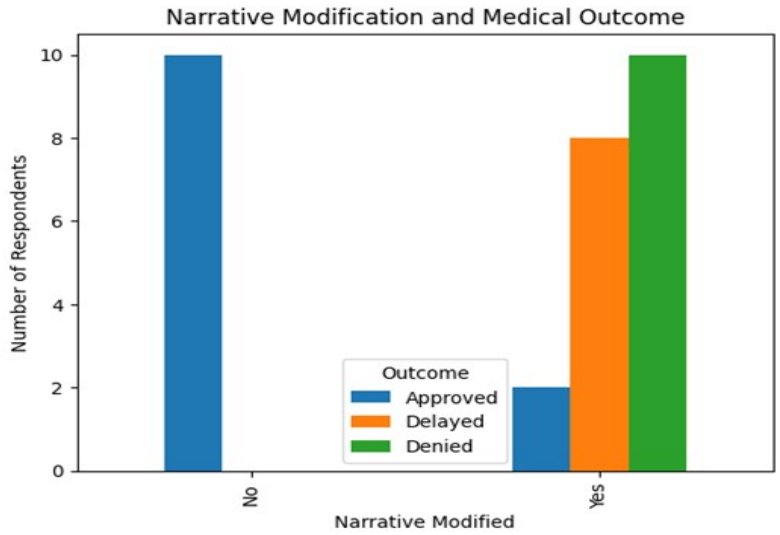

Figure 3: Relationship between Narrative Modification and Medical Outcomes. Participants who Altered their Self-Narratives in Response to Clinical Expectations were more likely to Face Delay or Denial.

Across the dataset, transgender respondents described a persistent expectation to demonstrate psychological stability, narrative coherence, and certainty regarding gender identity. Many participants reported strategically modifying their personal histories, suppressing ambivalence, and emphasizing early-onset or continuous gender awareness to align with clinical expectations. These practices were most pronounced among respondents from lower socio-economic backgrounds, for whom the perceived risk of refusal carried heightened material consequences. The relationship between narrative modification and institutional outcome is visually apparent in Figure 3, which shows that participants who altered their narratives were more likely to experience delay or denial rather than approval. Rather than functioning as a pathway to legitimacy, narrative elaboration often intensified institutional scrutiny. This pattern underscores how legitimacy is conferred not through depth of explanation but through alignment with pre-existing diagnostic scripts.

Epistemic Gatekeeping and Hierarchies of Knowledge

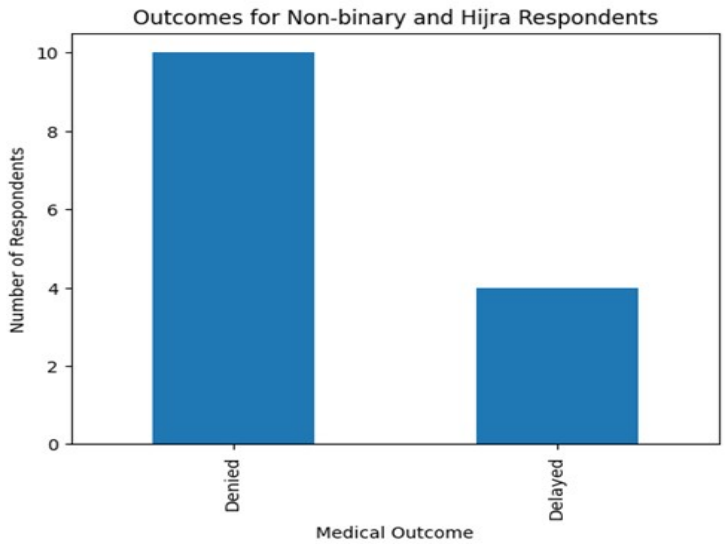

Figure 4: Medical Outcomes for Non-Binary and Hijra Participants. Denial Emerges as the Dominant Institutional Response.

A pronounced asymmetry between lived experience and clinical authority characterized interactions between trans respondents and medical professionals. Participants frequently reported that their self-knowledge was questioned, reinterpreted, or overridden by psychiatric assessments. Clinical judgments were treated as definitive, while experiential accounts were positioned as provisional or unreliable. This epistemic hierarchy is most starkly visible among non-binary and Hijra respondents. Figure 4 isolates these groups and demonstrates that denial constitutes the dominant institutional response, with approval notably absent. Gender authenticity, in these cases, was not recognized as self-evident but remained contingent upon institutional validation. These patterns exemplify epistemic gatekeeping, wherein medical institutions exercise authority not only over treatment but over the credibility of gender knowledge itself.

DISCUSSION

The findings demonstrate that transgender healthcare in Delhi operates as a regime of institutional verification, wherein gender is rendered legitimate only through alignment with medical norms, epistemic authority, and bureaucratic rationality. Rather than functioning as a neutral pathway to care, medical institutions actively participate in producing gender as a governable and certifiable status. From a Foucauldian perspective, the requirement of psychiatric evaluations, assessments of readiness, and prolonged diagnostic timelines reflects the operation of biopower within healthcare settings. Hospitals emerge as disciplinary sites where bodies are regulated through expert knowledge and risk-oriented reasoning. The emphasis on psychological stability and narrative consistency does not merely assess suitability for care; it normalizes particular gender trajectories while marking others as unstable, ambiguous, or risky. Gender transition thus becomes a biopolitical process, shaped by institutional imperatives of control, accountability, and normalization.

Butler's theory of gender performativity further illuminates how legitimacy is achieved through institutionally constrained performances. The data show that transgender individuals do not simply express gender identity; they strategically perform it for institutional audiences. Narratives are curated, affect is managed, and ambiguity is suppressed to conform to binary diagnostic expectations. These performances are neither freely chosen nor purely expressive. Instead, they are shaped by asymmetrical power relations in which access to care depends on institutional approval. Gender performativity, in this context, is not subversive but disciplined, producing compliance rather than destabilization.

The framework of epistemic injustice clarifies the knowledge hierarchies that sustain medical gatekeeping. Trans respondents' experiential knowledge of their own gender is frequently subordinated to clinical interpretations, particularly in psychiatric screening and consent processes. This produces testimonial injustice, where self-knowledge is systematically doubted, and hermeneutical injustice, where institutional frameworks fail to adequately interpret non-binary or culturally specific gender experiences, such as those of Hijra communities. Doctors' knowledge, framed as objective and professional, acquires epistemic primacy, enabling them to function as gatekeepers of legitimacy. Together, these dynamics reveal that medical recognition is not a simple affirmation of identity but an outcome of institutional negotiation. Gender becomes legitimate not through self-identification alone but through successful navigation of disciplinary, performative, and epistemic regimes. This shifts the analytical focus from inclusion to authority, exposing how recognition itself is structured by power.

CONCLUSION

This paper has argued that transgender healthcare in Delhi functions as a site where gender is not merely recognized but institutionally produced. Through psychiatric evaluation, diagnostic norms, and professional discretion, medical institutions transform gender from an embodied and self-identified reality into a certified and conditional status. In this process, doctors emerge as epistemic gatekeepers who authorize certain gender narratives while marginalizing others. By integrating Foucauldian analyses of medical power, Butlerian insights on performativity, and the framework of epistemic injustice, the study demonstrates that legitimacy is shaped by disciplinary authority, constrained performance, and hierarchical knowledge relations. Recognition, far from being neutral or universal, is stratified along binary, classed, and cultural lines, with non-binary individuals, Hijra communities, and economically marginalized trans persons facing heightened institutional scrutiny.

Rather than framing these dynamics as failures of access alone, this paper foregrounds the role of institutions in actively producing the conditions under which gender becomes intelligible and legitimate. In doing so, it challenges celebratory narratives of inclusion and underscores the limits of rights-based frameworks that leave epistemic and disciplinary structures intact. Understanding gender legitimacy as an institutional outcome opens new avenues for sociological inquiry into how authority, knowledge, and embodiment are governed in contemporary medical contexts.

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