

Bureaucratizing Medicine: Creating a Gender Identity Clinic in the Welfare State

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Abstract: This essay considers the creation of a gender identity clinic at Rikshospitalet, the National Hospital of Norway, in the early 2000s and its implications for the production of medical knowledge during that era. In the preceding decades, medical transition was overseen by an informal, self-organized, multidisciplinary team of medical experts, but this situation changed when a centralized gender identity clinic was established under psychiatric control. The essay argues that shifting institutional, societal, economic, legal, and bureaucratic circumstances redistributed expertise and authority on trans medicine. Economic framing, institutional frictions, patient activism, and media attention restricted the doctors' room for maneuver and created a scientific crisis of legitimacy in trans medicine. These processes changed medical knowledge regarding medical transition; eventually, "sex change" and, therefore, all that is denoted by "sex" became intertwined with and inseparable from the politico-bureaucratic processes of reforming a modern public health-care system and welfare state. By anchoring the analysis in the history of science and expertise, this inquiry offers a new focus on the role of bureaucratic practices in the production, structuring, and circulation of medical knowledge in the welfare state.

When Bjorn looks back on his first encounter with Rikshospitalet, the National Hospital of Norway, in early 2000, he does not have good memories. That was the first time he met with the psychiatric team that assessed all patients requesting hormonal and surgical gender

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confirmation therapy.¹ Bjorn knew from a very early age that he did not feel like a girl. As a child, he told his family that he did not want to have a high-pitched female voice when he grew up and asked if there were other pronouns he might use apart from “she” and “he.” He recalled the cold winter day when he first entered the gates of the hospital in the city center of Oslo, the capital of Norway. There Bjorn encountered a psychiatric diagnostic regime that he experienced as aloof, distanced, and evaluating. “I felt desperate. I felt completely rejected, as if I was being looked at like a creature under a microscope. There was no empathy. I was devastated.”² Before the consultation, he had already completed nearly eighty pages of questionnaires, diagnostic instruments, and psychiatric interviews detailing his past and his current situation. These forms, which were not discussed during the interview at the hospital, were kept in his medical record for use by the psychiatric team in diagnostic assessment and therapeutic decision making. Although Bjorn eventually succeeded in obtaining hormonal and surgical treatment, the process was to prove lengthy and complicated—largely because, at that very time, the diagnostic and therapeutic health service for trans patients was being reorganized and a specialized and centralized gender identity clinic under psychiatric control was being established. If Bjorn had applied for medical transition a few years earlier, he would have encountered a completely different diagnostic system and approach to trans medicine.

This essay takes the shifting expertise and authority on trans medicine in Norway at the turn of the twenty-first century as its starting point to ask what this particular example says about the production, structuring, and circulation of medical knowledge in the late twentieth-century Nordic welfare state. In the wake of the scandal the media made of the celebrity patient Christine Jorgensen’s medical transition in Copenhagen in the early 1950s, knowledge about this type of therapy circulated among the public, and people began to turn to the Norwegian health authorities for similar treatment. After receiving the report of an expert committee of four psychiatrists to elucidate the question of “feminizing” and “masculinizing” treatment of transvestism—formed as a direct result of the increasing number of requests for such treatment—Director General of Health Karl Evang concluded in 1956 that no public body should be empowered to authorize these types of medical procedures.³ Thus the main responsibility for such therapy, including deciding which patients should receive treatment, stayed with clinicians.

Trans health care remained an unformalized, unsanctioned field of medicine under expert control without interference from the authorities. From the 1950s, trans patients were offered hormone replacement therapy to a limited extent, and in 1963 a trans woman underwent the first vaginoplasty at Rikshospitalet. Trans patients were treated by various specialists and hospitals, although all genital reconstructive surgery was performed at Rikshospitalet. In the late 1970s a group of physicians, psychologists, and social workers, who assessed patients for medical transition

¹ In this essay, I sometimes use the contemporary terms “gender confirmation therapy,” “trans medicine,” and “medical transition” interchangeably, in place of the historical terms “*kjønnsskifte*” (“sex change”/“sex reassignment”) and “*kjønnskorriger*” (“sex correction”). I sometimes use the term “trans” when writing about people in the past instead of historical terms such as “transvestite” or “transsexual.” This intervention can be criticized as anachronistic, but a historical analysis that simply reproduces medicalized and pathologizing concepts also risks giving primacy to the hegemonic actors’ perspectives and a binary understanding of gender based on assigned sex. When I sometimes speak of “sex change,” a term that has mostly been dismissed in trans health and trans communities, I do so to underscore the discursive nature of medical terms. Since contemporary terms will also change, the wording of this essay will eventually become anachronistic, an inevitable historical process that I welcome. For a nuanced discussion of the historian’s approach to these concepts when writing trans history see Leah DeVun and Zeb Tortorici, “Trans, Time, and History,” *Transgender Studies Quarterly*, 2018, 5:518–539, <https://doi.org/10.1215/23289252-7090003>; and J. Gill-Peterson, *Histories of the Transgender Child* (Minneapolis: Univ. Minnesota Press, 2018), pp. 8–9.

² Bjorn, interview with Ketil Slagstad, 9 Mar. 2020.

³ Karl Evang. Note to H4, Behandling av transvestisme, 26 Nov. 1956, RA/S-4736/D/L0057/0002, S-4736 Det sakkyndige råd i saker om seksualinngrep, D, Box 57, Kjønnsskifte folder, National Archives of Norway (hereafter NAN), Oslo.

in the Oslo Health Council, sought to establish a public, centralized clinic for trans health.⁴ The Directorate of Health rejected this proposal, however: the moment a clinic was formalized several legal issues would have to be clarified, and it would lead to more people seeking treatment. The authorities therefore preferred that assessment remain with individual clinicians. From the early 1980s, then, an *ad hoc*, self-organized team of multidisciplinary experts under neither market nor governmental control continued to assess patients for medical transition. The team, referred to as the Working Group for Transsexuals/Transsexualism, consisted of endocrinologists, plastic surgeons, and psychiatrists under the direction of Berthold Grünfeld, a sexologist, psychiatrist, specialist in social medicine, and, later, professor of social medicine. It was not until the early 2000s that a separate, specialized clinic for trans medicine was established under psychiatric control at Rikshospitalet.

Much of postwar trans historiography has focused on the situation in the United States.⁵ While access to medical transition was liberalized in the United States in the 1970s and 1980s as it was taken over by the medical market, giving access to such therapy to people who would not have met the strict criteria at university-based clinics, in Norway health services were monopolized in the state-owned Rikshospitalet, and many patients did not pass the strict regime to access care.⁶ The Norwegian story shows that trans medicine was by no means globally unified, coherent, or streamlined but, rather, local, specific, and personal and that this history needs to be studied in a local context. A distinctive feature of the Norwegian context is the role of the welfare state, a public health-care system, and centralized health services, which set this history of trans medicine apart from that in the United States, where one can hardly speak of *one* model of trans medicine, and from that of postwar Germany, where psychiatrists took center stage on both sides of the Iron Curtain.⁷ Although there are many similarities among the Nordic countries and their health-care systems, to date there have been no comprehensive accounts of late twentieth-century trans medicine in the Nordic context.⁸

⁴ Ketil Slagstad, "Society as Cause and Cure: The Norms of Transgender Social Medicine," *Culture, Medicine, and Psychiatry*, 2021, 45:456–478, <https://doi.org/10.1007/s11013-021-09727-4>.

⁵ Gill-Peterson, *Histories of the Transgender Child* (cit. n. 1); Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Cambridge, Mass.: Harvard Univ. Press, 2002); and Susan Stryker, *Transgender History: The Roots of Today's Revolution*, 2nd ed. (Berkeley, Calif.: Seal, 2017). See also Bernice L. Hausman, *Changing Sex: Transsexualism, Technology, and the Idea of Gender* (Durham, N.C.: Duke Univ. Press, 1995).

⁶ Meyerowitz, *How Sex Changed*, pp. 268–277. For a discussion of recent practice in Norway see Elian Eve Jentoft, "Through the Needle's Eye: A Qualitative Study of the Experiences of Adolescents with Gender Incongruence and Their Families Seeking Gender Affirming Healthcare in Norway" (M.A. thesis, Univ. Oslo, 2019).

⁷ Psychiatrists played important roles in both East Germany and West Germany. See Sabine Meyer, ed., *Auf nach Casablanca? Lebensrealitäten transgeschlechtlicher Menschen zwischen 1945 und 1980* (Berlin: Senatsverwaltung für Justiz, Verbraucherschutz und Antidiskriminierung und Landesstelle für Gleichbehandlung—gegen Diskriminierung [LADS], 2018); and Ulrike Klöppel, *XXOXY ungelöst: Hermaphroditismus, Sex und Gender in der deutschen Medizin: Eine historische Studie zu Intersexualität* (Bielefeld: Transcript, 2010), pp. 547–584.

⁸ Sigrid Sandal has mapped out the discussions between clinicians and the Norwegian health and legal bureaucracy in the first three decades after World War II. See Sigrid Sandal, "En særlig trang til å ville forandre sitt kjønn" (M.A. thesis, Univ. Bergen, 2017). For an analysis of autobiographical accounts of trans and intersex people requesting medical interventions in early and mid-twentieth-century Denmark see M. Holm (now Sølve M. Holm), "Fleshing Out the Self: Reimagining Intersexed and Trans Embodied Lives through (Auto)biographical Accounts of the Past" (Ph.D. diss., Linköping Univ., 2017). Katariina Parhi examined the medical records of eleven patients diagnosed with transvestism who were admitted to the Psychiatric Clinic of the Helsinki University Central Hospital in the period 1954–1968. See Katariina Parhi, "Boyish Mannerisms and Womanly Coquetry: Patients with the Diagnosis of Transvestitism in the Helsinki Psychiatric Clinic in Finland, 1954–68," *Medical History*, 2018, 62:50–66, <https://doi.org/10.1017/mdh.2017.73>. In Sweden, Erika Alm has analyzed white papers and public documents regulating the lives of trans and gender-diverse people, in particular the Gender Recognition Act of 1972. See Erika Alm, "Ett emballage för inälvor och emotioner: Föreställningar om kroppen i statliga utredningar från 1960- & 1970-talen" (Ph.D. diss., Univ. Gothenburg, 2006); and Alm, "A State Affair? Notions of the State in Discourses on Trans Rights in Sweden," in *Pluralistic Struggles in Gender, Sexuality,*

The major argument of this essay is that issues of expertise on trans medicine — issues that enabled the creation of a specialized gender identity clinic — did not arise because of developments within medicine, such as the emergence of new knowledge or the development of new technologies. Historians have shown how the endocrine technologies of trans medicine, originally developed in the 1910s and 1920s, were implemented more systematically by doctors in the second half of the twentieth century.⁹ On the contrary, the creation of a specialized gender identity clinic in the welfare state was the result of changing institutional, societal, and bureaucratic circumstances. In the 1980s and 1990s, several European welfare states, including the Nordic countries, were pressured to liberalize, and in Norway the health-care system was liberalized under tight governmental control: some services were decentralized, some were privatized, and the financing of public hospitals was reorganized to stimulate productivity.¹⁰ It was within this shifting landscape that medical services for trans people were negotiated and recreated, and in an increasingly liberalized but regulated public health-care system guidelines, standards, economic planning, and reimbursement based on diagnosis-related groups took center stage. This process narrowed the medical experts' room to maneuver. Economic deliberations, political and public debates, emerging activism, and the professional positioning of medical experts gave rise to questions such as how patients should be diagnosed and treated, who had the core expertise to make these decisions, and how this type of medicine should be organized. In the end, medical knowledge production became inextricably linked to bureaucratic practices.

This nontransparent model of care, emerging from bureaucratic factors and the anxieties of doctors who maintained absolute authority, created a particularly restrictive system of trans health care in the welfare state, with a small team of physicians asserting a monopoly over all diagnostic and therapeutic decisions: many patients were turned away, waiting times were long, the rigid sequence of procedures left little room for individual adjustments, and transition-related care could be denied at the last minute. Several patients committed suicide while waiting for an operation. In this situation, mobilizing a patient identity rather than a trans identity became the main activist strategy for accessing care. Importantly, activists' strategy of positioning themselves as patients denied medical care, circumventing identity politics, was exceedingly successful and secured support for transition-related care across party lines, even from Christian conservatives.

and *Coloniality: Challenging Swedish Exceptionalism*, ed. Alm *et al.* (Cham: Springer International, 2021), pp. 209–237. See also Sara Edenheim, *Begärets lagar—Moderna statliga utredningar och heteronormativitetens genealogi* (Stockholm: Brutus Östlings Bokförlag Symposion, 2005), esp. pp. 121–125. According to Julian Honkasalo, the policy of forced sterilization or castration to access gender-confirmation treatment, introduced in Scandinavian countries in the second half of the twentieth century, continued the biopolitical regulation of trans lives rooted in interwar eugenics. See Julian Honkasalo, “In the Shadow of Eugenics: Transgender Sterilisation Legislation and the Struggle for Self-Determination,” in *The Emergence of Trans: Culture, Politics, and Everyday Lives*, ed. Ruth Pearce *et al.* (Oxon: Routledge, 2020), pp. 17–33. See also Honkasalo, “The Intimate Labour of Non-Normative Bodies: Transgender Patients in Early Swedish Medical Research,” in *Bodily Interventions and Intimate Labour: Understanding Bioprecarity*, ed. Gabriele Griffin and Doris Leibetseder (Manchester: Manchester Univ. Press, 2020), pp. 232–256.

⁹ Gill-Peterson, *Histories of the Transgender Child* (cit. n. 1); Rainer Herm, *Schnittmuster des Geschlechts: Transvestismus und Transsexualität in der frühen Sexualwissenschaft* (Gießen: Psychosozial-Verlag, 2005); Herm, “Geschlecht als Option: Selbstversuche und medizinische Experimente zur Geschlechtsumwandlung im frühen 20. Jahrhundert,” in *Sexualität als Experiment: Identität, Lust und Reproduktion zwischen Science und Fiction*, ed. Nicolas Pethes and Silke Schicktanz (Frankfurt: Campus, 2008), pp. 45–69; Holm, “Fleshing Out the Self”; Nelly Oudshoorn, *Beyond the Natural Body: An Archeology of Sex Hormones* (London: Routledge, 1994); and Chandak Sengoopta, *The Most Secret Quintessence of Life: Sex, Glands, and Hormones, 1850–1950* (Chicago: Univ. Chicago Press, 2006).

¹⁰ Anne Lise Ellingsæter *et al.*, *Den nye velferdsstatens historie: Ekspansjon og omdanning etter 1966* (Oslo: Gyldendal Akademisk, 2020), esp. Ch. 15: Per Haave, “Sterkere politisk styring og begynnende markedsorientering i sykehelsektoren,” pp. 186–196; and Maren Skaset, “Reformtid og markedsgløtt: Det offentlige helsevesen etter 1985,” in *Folkets helse—landets styrke, 1850–2003*, ed. Aina Schiøtz (Oslo: Universitetsforlaget, 2003), pp. 499–548. For a comparison of this period in Norway and Sweden see Francis Sejersted, *The Age of Social Democracy: Norway and Sweden in the Twentieth Century* (Princeton, N.J.: Princeton Univ. Press, 2011), pp. 388–430.

I base this story on a range of source materials: unpublished sources (from private and public archives), medical records, newspaper articles (found through keyword searches in a digitalized newspaper database, *nb.no*) and oral history interviews with former patients, activists, and medical professionals (I recorded and transcribed the interviews and translated them into English). Important to this history is the way documents other than scientific articles or medical textbooks—such as annual reports from hospitals, white papers, official letters, guidelines, and organization maps—have modified and changed medical concepts and practices. These “little tools of knowledge” demonstrate how bureaucratic and institutional frameworks have been integral parts of pathologization and normalization processes and biomedical knowledge production more generally.¹¹

The philosopher of medicine Georges Canguilhem wrote, “To set a norm (*normer*), to normalize, is to impose a requirement on an existence, a given whose variety, disparity, with regard to the requirement, present themselves as a hostile, even more than an unknown, indeterminant.”¹² Following Canguilhem, I approach the bureaucratization of health services and knowledge production in trans medicine as a process of normalization and a way to streamline, institutionalize, and rationalize a recalcitrant and unruly field of medicine. The normalization of trans medicine had numerous consequences. The practice of “sex change” and the process of reforming the welfare state shaped each other in co-productive ways: “sex change” was enacted as a *whole*; a patient’s sex could only be changed completely, into either female or male. This left the sex binary intact (Section I). The expertise and discretionary power of physicians faced multiple challenges: legally, through expanded patient rights (Section II), but also through activism and the liberalization of the health-care system, including the introduction of diagnosis-based funding (Section III). All these processes partially produced and partially coincided with a broader medical and scientific crisis of legitimacy and demand for objectivity that led to the takeover of trans medicine by psychiatrists (Section IV).

I. NATIONAL SPECIALIST SERVICES AND THE CASE OF TRANSSEXUALISM

As the twentieth century came to a close, *kjønnsskifte* (sex change)—and therefore all that is denoted by “*kjønn*” (“sex”)—ultimately became intertwined with and inseparable from the politico-bureaucratic processes of reforming the public health-care system.¹³ In this period, the government decentralized some health services and centralized others, and the purpose and practice of sex change was shaped by these bureaucratic processes. To understand the discussions about the formalization, institutionalization, and governmentalization of a national service for trans people in the 1990s, however, we must look to the context of the more general reorganization of the health system that took place in the 1970s and 1980s.

While the organization and planning of the hospital structure in Norway had been on the agenda of medical authorities since the 1930s, it was not until the Storting—the Norwegian parliament—passed the first hospital act in 1969 that county municipalities were given formal responsibility for the future organization and development of hospitals. The exception was the single state-owned hospital, Rikshospitalet. In the decades following World War II, public health officers, politicians, and experts began to distinguish between local and central hospitals. Politicians and bureaucrats were inspired by developments in other European countries, such as

¹¹ Peter Becker and William Clark, “Introduction,” in *Little Tools of Knowledge: Historical Essays on Academic and Bureaucratic Practice*, ed. Becker and Clark (Ann Arbor: Univ. Michigan Press, 2001), pp. 1–34.

¹² Georges Canguilhem, *On the Normal and the Pathological*, trans. Carolyn R. Fawcett, ed. Robert S. Cohen (Dordrecht: Reidel, 1978), p. 146.

¹³ In Norwegian, there is only one term for “sex” and “gender”: “*kjønn*.”

England and Sweden, and the hospital act was part of a more general policy change in health administration that sought to centralize and regionalize the country's hospital structure.¹⁴ At this time, a third regional hospital level was introduced, as indicated in a report to the Storting.¹⁵ According to the official strategic document, which for the first time laid out a plan for the future organization of hospitals, certain specialized tasks should be carried out in only one location. Following convention, the organization of these functions had been decided by "the special interests of particular departments and doctors," but in the future this had to be better coordinated and was to include the centralization of certain health services to control costs and better meet the needs and demands of the population.¹⁶

The question of centralizing specialized medical services was increasingly debated among Norwegian politicians from the late 1980s, partly as a response to the World Health Organization (WHO) initiative to put the infrastructure of health-care services in member countries on the political agenda. In a report to the Storting about future health policy, the government underscored that even if medical and technological progress demanded that the organization of regional and national functions remain relatively dynamic, it was still important to control the distribution of highly specialized services, mainly because such services were extremely expensive and labor intensive. These discussions were crucial to the adoption of the concept of a *landsfunksjon*, a "national, countrywide function," which the report defined as a "highly specialized medical activity that from a total appraisal of the magnitude of health-care need, degree of difficulty and treatment costs should only be built at one, possibly a few locations in the country."¹⁷ Three prerequisites had to be fulfilled: the disease had to be rare; the service had to require expensive equipment, technology, or labor-intensive care; and, finally, the clinical expertise had to be concentrated in a single location to guarantee that knowledge and services remained up-to-date and of high quality.¹⁸ These stipulations would become crucial to the future organization of health services for trans people.

This was not an uncontroversial shift in policy in a country with a long, narrow landmass and a scattered population but with strong traditions of local democracy.¹⁹ Although the health administration was centralized, Norway had a long tradition of decentralizing political power. Where hospitals should be built was a recurring and controversial topic, with the closure of hospitals mobilizing much resistance. Local communities wanted to keep the small hospitals in the districts, while politicians were looking to cut costs by limiting numbers and centralizing services. Politicians therefore sought to balance the demands of local communities while creating space for more government regulation of regional hospitals, and the Storting ultimately gave the Ministry of Social Affairs authority to allocate specialized services to different hospitals. Moreover, as a part of this rearrangement of Norway's health-care services, health authorities appointed a committee to provide an overview of psychiatric services and assess the need for centralized national functions.

¹⁴ Schiøtz, ed., *Folkets helse* (cit. n. 10), pp. 374–379.

¹⁵ St. meld. nr. 9 (1974–1975), *Sykehusutbygging m.v. i et regionalisert helsevesen* (Oslo: Sosialdepartementet) ("St. meld." is the abbreviation for "Stortingsmelding," the Norwegian term for white papers).

¹⁶ St. meld. nr. 9, p. 95 (here and throughout this essay, translations into English are mine). On the institutionalization and centralization of infertility treatment, one such "specialized task," see Eira Bjørnvik, "Conceiving Infertility: Infertility Treatment and Assisted Reproductive Technologies in Twentieth-Century Norway" (Ph.D. diss., Univ. Oslo, 2018).

¹⁷ St. meld. nr. 41 (1987–1988), *Helsepolitikken mot år 2000, Nasjonal Helseplan* (Oslo: Sosialdepartementet), p. 192. A report on the centralization of highly specialized somatic health care was published in 1992: Helsedirektoratet, *Styring av høyspesialiserte somatiske funksjoner i helsetjenesten* (Oslo: Helsedirektoratet, 1992).

¹⁸ At that time, Rikshospitalet was still a state-owned hospital, whereas the other hospitals were under the authority of the counties. In 2001 the Storting decided that, beginning in 2002, the ownership of specialized health-care services, including the hospitals, would be transferred to the state. In addition, five regional health authorities were established under state ownership.

¹⁹ Schiøtz, ed., *Folkets helse* (cit. n. 10), pp. 376–386.

The committee consisted of health professionals, mostly psychiatrists, one of whom was part of the informal team of doctors that at the time decided on requests for medical transition.

In 1995, when the committee delivered its report, it recommended only three such national psychiatric services: a department for the assessment and treatment of “transsexual patients,” a psychiatric epidemiological register, and a department for deaf people with psychiatric illnesses. Transsexualism was so rare, the committee reasoned, and the patients in need of such highly specialized competence, that the service should remain centralized: “At Rikshospitalet there has been established a national service with assessment and treatment of psychiatric and somatic aspects of transsexuality with the Working Group for Transsexuals.”²⁰ This was true only to an extent: although all genital surgery was conducted at Rikshospitalet, the Working Group for Transsexuals/Transsexualism assessed and diagnosed patients on a volunteer basis (Rikshospitalet did not have a separate psychiatric department). Moreover, while the assessment of patients was in effect centralized, as all the doctors in the working group were based in Oslo, the report enacted the institutionalization and governmentalization of this service, with the state formally taking over responsibility for this patient group and this particular type of medicine. The all-male working group functioned as a “team as a whole,” contributing their expertise as an avocation in addition to their regular jobs.²¹ The patients were personally assessed by all the specialists, whereupon each case was discussed in irregular meetings—often in the doctors’ private homes after working hours—attended by all the team members. “It was a mix of socializing and professional matters,” one plastic surgeon recalled. “In every case,” another plastic surgeon stated, “the team together decided the indication before treatment towards a final sex change was started.”²²

The complete procedure of assessing, diagnosing, and treating the patients was extensive and immensely expensive, and, as a public hospital, Rikshospitalet had to cover the costs from its regular budget. First, the patients were assessed by a psychiatrist and the expert in social medicine, a process that included “extensive psychosocial observation, selection and treatment” and often lasted more than a year.²³ This waiting period was particularly painful for the patients, since it added to the time that they had already spent hiding a fundamental side of themselves before coming out and daring to seek medical help. When they finally managed to find the few experts in the capital who dealt with this type of medicine, they had to convince the team of their gender identity and determination to see the process through. In the early 1980s, referring to one trans masculine patient and ignoring his preferred pronouns, Grünfeld wrote:

We explained to her that we need to take time, talk through the situation with her before making a concrete decision on what to do. We also emphasized that we cannot be guided by her current decision to inform the outside world about her plans and goals. The patient is in complete agreement with our expectant and observant attitude towards the situation. She also expects that there will be tensions and conflicts between her wish of a rapid conversion and our more watchful and careful approach, but this is something we have to live with, the patient says.²⁴

²⁰ Statens helsetilsyn, *Styring av høyspesialiserte funksjoner innen psykisk helsevern for voksne* (Oslo: Statens helsetilsyn, 1995), p. 32.

²¹ Knut Chr. Skolleborg, “Transsexualisme,” annual report, 1996, Plastisk kirurgisk avdeling, Rikshospitalet, no. 1997/4045, Norwegian Board of Health Supervision Archive (hereafter NBHSA), Oslo.

²² Knut Skolleborg, interview with Ketil Slagstad, 14 Jan. 2021; and Henrik Borchgrevink, “Transsexualisme som landsfunksjon,” 10 Aug. 1990, Rikshospitalet, no. 1991/1410, NBHSA.

²³ Borchgrevink, “Transsexualisme som landsfunksjon.” Several former patients also confirmed this in interviews with me.

²⁴ Berthold Grünfeld, case 1005, medical record, Oslo University Hospital Archive, Oslo.

This waiting period was followed by another eighteen months to two years of endocrinological and psychosocial treatment and examination, including a “broad laboratory screening, personal consultation with each specialist and evaluation in regular meetings where the whole team discusses the cases.” Patients were frustrated not only by time dragging on but also by the opacity of the diagnostic process and therapeutic reasoning over which they had no influence. “I went for several years and started to get impatient because nothing was happening,” Frida recalled in an interview. She continued:

Then I say to the doctor: “What happens, one year goes by after another, everyone else around me is having an operation.” In my circle of acquaintances, there were several who underwent surgery after a year. And why? Then the fool says, even if you have received this cure, it does not mean that you will have surgery. And, at that time, I had gone so many years that I had developed breasts and everything.²⁵

She remembered being so angry and frustrated that she threw one of the doctor’s typewriters against the wall. After this incident, she did get a referral to the plastic surgeon.

What followed for Frida and other trans patients was a series of extensive and highly specialized surgeries: “Every patient went through a mean of 4–5 surgical procedures: one main surgery and a variable number of successive operations.”²⁶ For trans women, this involved castration, removal of the penis, and vaginoplasty. From 1995, gynecologists from the women’s clinic at Rikshospitalet regularly performed endoscopic oophorectomies as part of the procedure on trans men. Trans men would undergo masculinizing chest surgery, and they had the option of phalloplasty, the construction of a penis. From the 1990s so-called metoidioplasty became an alternative—that is, using the clitoris, which had become enlarged through testosterone therapy, to construct a functional penis. Each patient spent a mean of forty-three days in the hospital; in addition, the costs for breast and penis prostheses added 30,000 kroner per patient (approximately U.S. \$3,400).

It was of fundamental importance to patients to have their national identity number changed, since that signified the person’s sex and was printed on all identity documents. Not until the plastic surgeon confirmed to the National Population Register that “surgical conversion,” including castration or removal of the ovaries, had been carried out was a patient’s legal gender changed in the register and on official documents. In contrast, in neighboring Sweden, beginning in 1972, one’s legal gender status could be changed without preceding sex reassignment surgery, though sterility had to be documented; and in the 1980s several European countries followed suit, although only with the stipulation that “sex change surgery” would ensue.²⁷ Not until 2016 was a new law allowing the self-declaration of legal gender passed in Norway.

The prerequisite of sterilization or castration to change *kjønnsstatus* (legal gender status) protected and reinforced the sex binary. This criterion lacked any legal basis but was rooted in the postwar medical and bureaucratic apparatus of sex change. “In my opinion, a prerequisite for the change and determination of sex in transsexuals of both sexes must be a previous completed sterilization,” wrote Per Anchersen, a psychiatrist who had been assessing trans patients since the 1950s, in 1979. He nonetheless always recommended castration; he also recommended oophorectomy in trans

²⁵ Borchgrevink, “Transsexualisme som landsfunksjon” (cit. n. 22); and Frida, interview with Ketil Slagstad, Oslo, Dec. 2019.

²⁶ Borchgrevink, “Transsexualisme som landsfunksjon.”

²⁷ Alm, “Ett emballage för inälvor och emotioner” (cit. n. 8), pp. 18–24; Honkasalo, “In the Shadow of Eugenics” (cit. n. 8); and Amy Rappole, “Trans People and Legal Recognition: What the U.S. Federal Government Can Learn from Foreign Nations,” *Maryland Journal of International Law*, 2015, 30:191–216. It should be noted that the change of legal gender status in Sweden was not based on self-declaration but depended, among other things, on a long psychiatric assessment, a “real life test,” and proof that the person was incapable of procreation, because of either natural infertility or sterilization.

masculine patients to avoid the potential scenario of a “menstruating man” or, “at worst, a man who can become a mother”: “Such an (almost imaginary) calamity would lead to unsolvable legal complications and bring the entire treatment procedure for transsexualism into disrepute.” This reasoning was in line with the position of Director General of Health Torbjørn Mork: “A name change to a non-gender-neutral name can only take place if sterility is definitely guaranteed and then in connection with the change of the national identity number.”²⁸ More than expressing a eugenic aim of preventing trans people from reproducing, the castration criterion reflected the objective of social medicine of making patients adapt to, adjust to, and integrate into society: a pregnant man would threaten the judicial system and the philosophy underpinning the treatment regime, both of which were based on the binarity of sex.²⁹ Hence, it was the plastic surgeon at Rikshospitalet who had the final authority and ultimate power to decide when “sex change” had occurred. In other words, the definition of the patient’s sex was based on the appearance of the new genitalia and the removal of the sex glands, a practice that not only was a product of a binary understanding of sex but one that also cemented it by means of surgical procedures. “Partial sex change,” such as offering hormone therapy without surgical interventions, was not an option. Both the medical and the bureaucratic regime of sex change ensured that only two options were made available: female or male.

Reifying the sex binary went hand-in-hand with codifying all trans medicine—not just vaginoplasty and phalloplasty—as highly specialized. At the beginning of the 1990s, the Directorate of Health had begun to collect reports on the regional and national services, and hospitals were asked to list the number of patients treated yearly, their demographic data and treatment results, how the services were financed, and whether they could be regionalized. Rikshospitalet specifically reported the following three specialized practices for which it had national responsibility: treatment of transsexualism, treatment of people with intersex conditions, and embolization of cerebral and spinal arteriovenous malformations.³⁰ The Rikshospitalet department of plastic surgery concurred that the surgical treatment of “transsexual patients” was indeed “very special.” Among the two to three patients treated annually, there were equal numbers of men and women, and each patient underwent four to five surgical procedures, for a total of ten to fifteen operations per year. A count conducted at the hospital indicated that eighty patients had received such treatment since the first genital reconstructive surgery in Norway in 1963. Furthermore, the treatment demanded a “particular routine,” not only surgically and technically but also among the nursing staff; and owing to the nature of the condition and the procedures, the caregivers had to demonstrate certain “human abilities.” Henrik Borchgrevink, the plastic surgeon who wrote the report and who was responsible for sex reassignment surgery, underscored that he carried out such extensive operations partly on the recommendations of colleagues, and it was therefore reassuring to know the other team members through continuous, direct cooperation.³¹ Thus it was determined that medical transition should be offered in only one location in Norway—specifically, at Rikshospitalet.³² It is worth noting, however, that a decade earlier, as the

²⁸ Per Anchersen to Ministry of Education and Church Affairs, 7 Aug. 1979, S-1286 Sosialdepartementet, Helsedirektoratet, Kontoret for psykiatri, H4, Dc, Box 611, Transseksualitet folder (hereafter **Transseksualitet folder**), NAN; and Director General of Health Torbjørn Mork to Leif T. Eldring, Secretary General in the Ministry of Justice, 9 Nov. 1979, Transseksualitet folder, NAN.

²⁹ See Honkasalo, “In the Shadow of Eugenics” (cit. n. 8); Honkasalo, “Intimate Labour of Non-Normative Bodies” (cit. n. 8); and Slagstad, “Society as Cause and Cure” (cit. n. 4). See also Sigrid Sandal, “Kirurgi og byråkrati,” in *Frihet, likhet og mangfold*, ed. Anne Hellum and Anniken Sørlic (Oslo: Gyldendal, 2021), pp. 42–62.

³⁰ Director Odd Arild Haugen and Medical Director Dagfinn Albrechtsen, Rikshospitalet, to Directorate of Health, 15 July 1992, no. 1991/1410, NBHSA.

³¹ Borchgrevink, “Transsexualisme som landsfunksjon” (cit. n. 22).

³² Rapportskjema for lands- og flerregionale helsetjenester, 15 July 1992, no. 1991/1410, NBHSA.

working group was being established, an endocrinologist and professor of medicine who was involved primarily in the treatment of trans masculine patients had defended the opposite position: most surgical procedures, at least chest surgery in trans men, were “so simple” that they could be performed at “a number of hospitals.” The same was true for the endocrinological treatment: “This is very easy and requires no expertise. Any internist should be able to perform such treatment.”³³ In other words, bureaucratization processes rather than medical or technological developments propelled the specialization and monopolization of trans medicine in the welfare state.

What do bureaucratic practices and the question of centralizing or decentralizing trans medicine have to do with a scientific and medical understanding of sex? “Knowledge and its material embodiments are at once products of social work and constitutive of forms of social life,” Sheila Jasanoff has emphasized.³⁴ She proposed the concept of “co-production” to describe the facts that knowledge about the world cannot be separated from how we choose to live in it and that knowledge about the natural and the societal world is mutually constitutive. In the Norwegian story, practices of sex change and politico-bureaucratic discussions about the future organization of the public health-care system worked in co-productive ways—they constituted each other. While the rarity of the procedures and the highly specialized form of surgery was an argument for formalizing a national service, the debate about centralizing hospital services posited medical transition as a highly specialized form of medicine. However, not all doctors agreed. The conception of such medicine as highly specialized was enabled both by discussions in the Storting and by the practices of trans medicine, as the definition of sex change depended on removal of the gonads and genital reconstructive surgery, a highly demanding procedure requiring particularly specialized skills and competence. In fact, only genital surgery—such as vaginoplasty and phalloplasty—was technically complicated. Hormonal therapy and the other surgical procedures rested on principles, practices, and technologies that were well known to many doctors. However, when sex change was enacted as a *whole*, as a medical practice demanding highly specialized skills, including experience and expertise in diagnostic evaluation, it secured the working group’s regulation of medical transition and stabilized the sex binary.

II. FORMALIZING A HEALTH SERVICE: BUREAUCRATIC INERTIA AS GATEKEEPING

The official handling of trans medicine throughout the second half of the twentieth century can best be characterized as a politics of doing nothing: bureaucratic inertia became an efficient strategy for restricting access to care. Sex reassignment raised legal and political conundrums that haunted the topic of health service formalization from the time such treatment was first offered in the 1950s until the establishment of a clinic in the early 2000s. Repeatedly, the health authorities preferred to look away and leave the matter to doctors instead of creating a legal and institutional framework around the practice.

In 1977, for instance, Oslo’s Chief Medical Officer argued that more formalized procedures for medical transition were needed, including a government-supported clinic.³⁵ But the Director General of Health, Torbjørn Mork, rejected the idea of a national service under government control. Formalization would lead more people to seek treatment, he reasoned—people who until then had been taken care of by individual clinicians. His reasoning reflected a general tradition

³³ Harald Frey, Aker Hospital, to Otto W. Steinfeldt-Foss, Directorate of Health, 23 Nov. 1979, Transseksualitet folder, NAN.

³⁴ Sheila Jasanoff, “The Idiom of Co-Production,” in *States of Knowledge: The Co-Production of Science and Social Order*, ed. Jasanoff (London: Routledge, 2004), pp. 1–12, on p. 2.

³⁵ Stadsfysikus in Oslo Fredrik Mellbye to Director General of Health, 5 Feb. 1979, Oslo helseråd, Box 122, Homofile-transseksualitet folder (hereafter **Homofile-transseksualitet folder**), Oslo City Archives (hereafter **OCA**), Oslo.

and philosophy of social medicine that promoted social solutions to health issues and limited “biomedical,” pharmaceutical, and technical alternatives.³⁶ Mork feared that the moment such a service was formalized, several legal questions would have to be settled, regarding issues such as sterilization, castration, and name changes; to that point, this collection of problems had been satisfactorily addressed on an *ad hoc* basis. Finally, he held that in such a peculiar and marginal field of medicine, efficient care depended on highly committed clinicians with “personal engagement, interests, and attitudes”; and to secure the medical autonomy of experts, he preferred doctors to continue handling these issues independently of the Directorate of Health in “an informal professional forum.” “Until now,” he observed, “this has been carried out and worked well on an informal basis.”³⁷ In other words, the health authorities preserved the status quo, and the question of formalizing and institutionalizing a specialized service was put to rest. These discussions, however, gave impetus to the establishment of the informal working group, which remained in place until the creation of a gender identity clinic at Rikshospitalet in the early 2000s.

When the question of formalizing the health service was put on the agenda at the highest political level in the 1990s, legal matters were once again at the forefront. In December 1994 two members of the working group, Berthold Grünfeld and the psychiatrist Alv A. Dahl, wrote a letter to the Norwegian Board of Health Supervision in which they raised concerns regarding the lack of capacity to follow up with patients after treatment. Routinely, after surgery patients were left to themselves and their primary care providers. To follow up with patients, they argued, a nurse or a social worker should be hired, and this also presented a good opportunity to formalize and institutionalize diagnostic and therapeutic procedures. For the first time, the working group had received a formal complaint from a person who was denied treatment; given the constant stream of patients seeking medical transition, the psychiatrists argued, future complaints could be expected. Judicial aspects, which had previously been handled on an *ad hoc* basis, now had to be addressed.³⁸ The members of the working group felt confident that they alone should decide who should receive medical help to transition, and that in essence meant that patients who were denied treatment had nowhere to direct their complaints and no avenues for obtaining a second opinion. In a further letter to the Chief County Medical Officer in Oslo, Grünfeld explained that the question of a second opinion for people whose applications had been rejected “might be worth discussing”; but, he added, “we have never encountered this as a problem up until now, even though we have assessed approximately 100 cases since the mid-1970s.”³⁹

In the 1970s and 1980s, a range of grassroots, patient, and activist movements emerged that challenged hierarchical power structures in medicine and contested medical knowledge “detached” from lived experience. Activists demanded rights and control over their bodies and a seat at the table in scientific and clinical decision making.⁴⁰ In medicine and society at large, patients’ rights were increasingly discussed and acknowledged. As one professor of law put it, “‘patients’ rights’ became a term with strong positive connotations with major argumentative power in

³⁶ Slagstad, “Society as Cause and Cure” (cit. n. 4). For the regulation of pharmaceuticals see Bård Hobæk and Anne Kveim Lie, “Less Is More: Norwegian Drug Regulation, Antibiotic Policy, and the ‘Need Clause,’” *Milbank Quarterly*, 2019, 97:762–795, <https://doi.org/10.1111/1468-0009.12405>.

³⁷ Director General of Health Mork to Stadsfysikus in Oslo Mellbye, 16 Feb. 1979, Homofile-transseksualitet folder, OCA.

³⁸ Alv A. Dahl and Berthold Grünfeld to Norwegian Board of Health Supervision, 30 Dec. 1994, no. 1995/94, NBHSA.

³⁹ Grünfeld to Chief County Medical Officer in Oslo, “Innhenting av uttalelse vedr. klage på avslag for kjønnskifteoperasjon ved Rikshospitalet for NN,” no. 1995/6160, NBHSA.

⁴⁰ See Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley: Univ. California Press, 1996); Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women’s Health in the Second Wave* (Chicago: Univ. Chicago Press, 2010); Alex Mold, *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain* (Manchester: Manchester Univ. Press, 2015); and Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers* (Chapel Hill: Univ. North Carolina Press, 2015), esp. Ch. 8.

health politics.”⁴¹ In Norway, several laws aiming to increase individual rights were implemented: an act on organ transplantation (1973), which required donors to consent before biological material could be used in the treatment of others; a law allowing abortion on demand (1978); the Physicians’ Act (1980), which introduced patients’ right to information, access to their medical records, and participation in treatment decisions; and an act related to municipal health services (1982), which stated that everyone staying in a municipality had the right to necessary health care. In a 1992 bill, it was recommended that patients have the option of obtaining a second opinion in treatment decisions, but provision of the service was not mandatory.⁴² These shifts culminated in the Patients’ Rights Act of 1999, which included a paragraph on the right to a second opinion. It is against this backdrop that the question of the right to a second opinion for patients denied sex reassignment must be interpreted. Dahl recalled that “at that time, the question of human rights had begun to emerge. . . . The European Union had enacted a law enforcing the right to live according to one’s self-defined gender. That included a right to appeal.”⁴³ It was no longer possible to organize health services, including services for trans people, without taking patients’ rights into account.

The psychiatrists who reported the patient complaint did not state that this was the first such complaint ever made; rather, they called it the first *formal* one: “We have recently had the first formal complaint on the rejection of sex change.” The complaint in question concerned a trans woman who had changed her name after approval by the County Governor. An endocrinologist had initiated hormonal treatment, but her application for genital reconstruction surgery was rejected by the working group.⁴⁴ She had had several “heterosexual relationships” and did not fulfill the criteria for a “true transsexual” (*ekte transseksuell*), the experts wrote. In addition, her “older age was an important contraindication for the procedure.” Furthermore, her “height and weight” and other pronounced “phenotypical traits” would “not give a very convincing representation in the role.”⁴⁵ There were, in other words, two important underlying preconditions for accessing treatment. To meet the diagnostic criteria for “true transsexualism,” a trans woman could not have relationships with another woman, a trans man could not have relationships with another man, and patients would have to live heterosexually *after* transitioning. In addition, the patient’s physique and stature had to meet certain gendered criteria and norms of masculinity or femininity, to the extent that “successful” passing in society could be envisioned. In interviews, several doctors involved in treatment denied that partner choice, sexual orientation, or physique were decisive for therapeutic decisions. But since this case directly contradicts their insistence, it arguably demonstrates the way different arguments and criteria were mobilized in individual cases to justify diagnostic and therapeutic decisions, and it underscores the opacity of the diagnostic and therapeutic regime. As only some patients were ultimately given access to hormonal and surgical treatment, numerous patients who sought help were rejected; and they were left on their own, as there were

⁴¹ Asbjørn Kjønstad, *Kompendium i helserett* (Oslo: Gyldendal, 2003), p. 53. See also David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic, 1991).

⁴² NOU, nr. 8 (1992), *Lov om pasientrettigheter* (Oslo: Sosialdepartementet), p. 86.

⁴³ Alv A. Dahl, interview with Ketil Slagstad, Oslo, 25 Sept. 2019. In 1989 the Council of Europe recommended that member states introduce legislation to enable people legally to change their name or sex and protect their private life in the case of “irreversible transsexualism,” and in 1992 the European Court of Human Rights condemned France for not giving a trans woman the option of a legal gender change. See Council of Europe, “Recommendation 1117 (1989)—Condition of Transsexuals”; and European Court of Human Rights, “Case of B. v. France, Application no. 13343/87” (1992).

⁴⁴ Dahl and Grünfeldt to Norwegian Board of Health Supervision, 30 Dec. 1994, NBHSA. This case history is based on numerous letters exchanged among the working group, the patient’s lawyers, and the Norwegian Board of Health Supervision. To avoid compromising the person’s anonymity, the archival material is not described in any further detail. All materials originate from no. 1995/6160, NBHSA.

⁴⁵ Working Group to Chief County Medical Officer in Oslo, 1995/6160, NBHSA.

few specialists who could address their needs. The story also underlines the sovereignty of doctors in clinical decision making and the way their decisions were based on clinical judgment.

The doctors did share their experiences with colleagues in neighboring countries, which means that the working group could have sent patients to clinicians elsewhere for a second opinion in cases of doubt.⁴⁶ When they refrained from doing so, a likely explanation is that the idea of a right to a second opinion remained irrelevant to medical thinking until the 1990s. Only then did the question of institutionalizing health services for medical transition as a national function activate the matter of patients' rights, in a medico-political context where patients' rights, including the right to a second opinion on treatment decisions, had gained traction. By the turn of the century, Rikshospitalet had reached the conclusion that "if the working group rejects a patient, we recommend that the Nordic centers for sex conversion can offer a second opinion."⁴⁷ This never happened.

This chapter of history demonstrates that the co-production of patient autonomy and formalized health services to secure patients' rights had unintended consequences. Paradoxically, while the debates about patients' rights propelled the institutionalization of a clinic for trans medicine, the birth of that clinic in the early 2000s cemented the monopoly over such medicine without increasing patient rights, such as the right to a second opinion; nor did it improve the transparency of therapeutic reasoning and decision making. In 2020, when the Directorate of Health published new guidelines on the organizational structure for this type of treatment, the lack of a second opinion was one of the justifications given for breaking up this very monopoly by regionalizing some of the services.⁴⁸

The inevitable effect of the processes leading up to the formalization of the clinic was that the doctors' elbow room was constrained. Yet the informal regime of trans medicine in the preceding decades had also contributed to a very restrictive practice. The working group followed a "strict policy for the indication of sex change treatment," Grünfeld wrote, a policy that was justified by a concern that the complicated and demanding surgical procedures would in some cases make the patient's life worse. That a patient might come to regret hormonal and surgical interventions that had irreversible bodily effects would be a catastrophe for the team, as it would indicate that the diagnostic evaluations had not been conducted thoroughly enough in the first place, jeopardizing the credibility of the medical practice and the practitioners. The nondisciplinary functioning of the team was rooted in the experts' medical knowledge and professional ethics, not in institutionalized guidelines or protocols: "We have always followed a policy that we should be free to make the decisions in this type of treatment, regardless of who referred the patient for examination and assessment," wrote Grünfeld.⁴⁹ Since doctors handled these requests in addition to their usual practice, and because they lacked support from a formalized public structure or institution, the pressure to make the right decision increased: the informal nature of trans medicine helped to enact a restrictive medical practice—another example of how bureaucratic requirements shape medical routines and calcify medical practice.

III. ENABLING THE PUBLIC: ACTIVISTS, BUREAUCRATS, JOURNALISTS, DOCTORS, SCALPELS, AND HOSPITALS

Why, then, was the service for medical transition formalized in the early 2000s but not earlier, when similar attempts were made? Twice, in the 1950s and the 1970s, the Director General of

⁴⁶ Oslo Health Council minutes, "Transseksualitet," 5 Dec. 1979, Homofile-transseksualitet folder, OCA.

⁴⁷ Director Åge Danielsen and Medical Director Arnt Jacobsen, Rikshospitalet, to Ministry of Health and Social Affairs, Vedlegg 1, 7 June 2001, p. 3, no. 1999/2202, NBHSA.

⁴⁸ Helsedirektoratet, *Kjønnsinkongruens—Nasjonal faglig retningslinje* (Oslo, 2020), p. 27.

⁴⁹ Grünfeld to Chief County Medical Officer in Oslo, 1995/6160, NBHSA.

Health blocked doctors' attempts to formalize an administrative routine for sex change or a health service for medical transition. The health authorities succeeded in their strategies because the media was not aware of these matters and there were no activist groups to represent patients' interests. By the end of the century this situation had changed, and trans medicine now assembled and engaged a range of actors and objects: medical professionals, patients, the Norwegian Board of Health Supervision, Rikshospitalet, and the Directorate of Health. Nonetheless, no fresh resources were set aside for the formalization of the working group or for the establishment of a clinic. Even though the question of formalizing the service continued to circulate among ministries, directorates, and hospitals throughout the 1990s, the issue did not seem to gain enough traction to lead to any actual change.

In 2000 matters took a radical turn as, for nine months, all diagnostic assessment and treatment of patients seeking medical transition was abruptly stopped. Ninety-five patients waiting for help suddenly had no health-care service, and many wrote desperate letters to Rikshospitalet, to the health authorities, and to the Minister of Health. Even the ombudsman from Norway's second largest county weighed in, arguing that the abrupt closure had provoked deep psychological crises among patients.⁵⁰ The reason for the closure was as follows. That same year Rikshospitalet relocated from the center of Oslo, where it had been since 1883, to a new site in a residential area at the border of the large forest surrounding the city. In the relocation process, the medical needs of trans patients were forgotten—or at least neglected—as the hospital administration did not keep this patient group in mind when planning the new department of plastic surgery.⁵¹ According to one surgeon in the working group, the chief of the department did not see trans surgery as a priority and originally wanted to shut it down.⁵² In addition, major conflicts between the plastic surgeons and the chief of the department had broken out; owing to professional disagreements and dissatisfaction with the head's leadership style, all but one surgeon left the department between 1990 and 2000. Eventually, the only surgeon who had been responsible for genital reconstructive surgery also left.⁵³ Finally, the capacity of the working group's psychiatrists, who had been serving on a volunteer basis, had long since been exceeded, and when Berthold Grünfeld retired an impasse was inevitable.

Economic factors also played a part. In a letter to the Ministry of Health and Social Affairs, Rikshospitalet representatives stated that the plan had been to formalize a team and service for trans medicine, but the hospital lacked money.⁵⁴ In the years leading up to the crisis, the model for funding public hospitals had undergone major changes. In 1997, a share of these hospitals' source of funds was replaced by an activity-based system where the state reimbursed hospitals for costs according to a set of diagnosis-related groups (DRGs).⁵⁵ A major portion of the budget of Rikshospitalet—at that time still the only state-owned hospital, as public hospitals were operated by the county councils—was still based on yearly block funding, but neither framework grants nor activity-based funding took into account the need to establish new health services or expand and redevelop old ones, such as gender confirmation therapy: "Reimbursement via the system of activity-based funding does not cover the establishment of such services." No specific DRG rates

⁵⁰ Health Ombudsman in Hordaland Grethe Brundtland to Ministry of Health and Social Affairs, 20 July 2000, no. 1999/2202, NBHSA. For the patient letters see no. 1999/2202—pasientbrev, NBHSA.

⁵¹ Danielsen and Jackobsen to Ministry of Health and Social Affairs, 11 May 2000, no. 1999/2202, NBHSA.

⁵² Skolleborg interview (cit. n. 22).

⁵³ Petter Frode Amland *et al.*, "Plastikkirurger og yrkesetikk," *Tidsskrift for Den Norske Lægeforening*, 2003, 123:3086–3087; and Knut Skolleborg, "Plastikkirurgi og etikk," *ibid.*, p. 3088.

⁵⁴ Danielsen and Jackobsen to Ministry of Health and Social Affairs, 16 Aug. 2000, no. 1999/2202, NBHSA.

⁵⁵ For the history of DRGs see Rick Mayes, "The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System," *Journal of the History of Medicine and Allied Sciences*, 2007, 62:21–55, <https://doi.org/10.1093/jhmas/jrj038>.

existed for such surgical procedures, the hospital administration explained to the government, and “based on experience with other specialized procedures, the disparities between the DRG reimbursement and the actual costs per procedure are huge (20,000–50,000 kroner).”⁵⁶

Expensive and specialized genital surgery therefore exemplified an inherent problem with hospital funding that had paradoxical consequences: when the hospital used its own budget or external funding, such as grants, to research and develop new diagnostic methods or advanced forms of therapy, the expectations of the population regarding these same interventions and therapies grew. The hospital thus took part in creating new groups of patients with needs that it lacked the capacity and funding to take care of. “When this becomes established treatment,” the hospital administration reasoned in reference to new, advanced forms of therapy, “the patients have already lined up.”⁵⁷ The deadlock led doctors in the working group to lobby members of parliament: this patient group was “utterly deprived socially and economically,” and they demanded that the Storting intervene. When a parliamentarian stepped in to ask whether the Minister of Health could guarantee that patients who had begun the process of medical transition would be allowed to complete it, the question of the future of trans medicine was brought to the highest political level.⁵⁸

Concomitantly, and partly as a response to this complex situation, activists began to organize. In the United States, the 1990s witnessed a rise in trans activism and visibility in media and society, but in Norway this happened somewhat later.⁵⁹ For instance, Esben Esther Pirelli Benestad, a general practitioner and trans activist who would be celebrated nationally and internationally through their son’s prizewinning film *All About My Father*, was becoming a public figure, and in 2001 they published a scholarly book about gender and sexology, *Kjønn i bevegelse* (*Gender in Motion*), that received much media coverage.⁶⁰ Furthermore, the first activist organization for people seeking sex reassignment—the Landsforeningen for Transseksuelle (LFTS) (National Organization for Transsexuals)—was established in January 2000. Although there had been occasional stories in the press about medical transition in the preceding decades, it was not until the founding of the LFTS that journalists had somewhere to direct their questions. This occurred at the same time that outspoken activists were giving trans people a public face—for instance, in newspaper stories with headings such as “Soon a Woman.”⁶¹ Activists increasingly managed to set the agenda. The media then began to report on the deadlock at Rikshospitalet, and newspapers and the main broadcasting channel told stories about people who had committed suicide while in the operation queue (“Committing Suicide While in Queue Waiting for Surgery”) or patients who had been waiting years for surgery (“Transsexuals Are Denied Treatment”). Up to ten patients committed suicide while waiting for assessment or treatment, a shocking number for such a small patient group.⁶² The team of doctors also cooperated directly with

⁵⁶ Danielsen and Jackobsen to Ministry of Health and Social Affairs, 11 May 2000, no. 2000/00824, NBHSA; and Danielsen and Jackobsen to Ministry of Health and Social Affairs, Vedlegg 1, 7 June 2001, NBHSA.

⁵⁷ Danielsen and Jackobsen to Ministry of Health and Social Affairs, 11 May 2000, no. 2000/00824, NBHSA.

⁵⁸ Grünfeld and Ira Haraldsen to Olav Gunnar Ballo and Annelise Høegh, 12 Apr. 2000, no. 1999/2202, NBHSA; and Høegh, written question to Minister of Health Dagfinn Høybråten, 8 Feb. 2000, dokument nr. 15:189 (1999–2000), Storting Archives (online).

⁵⁹ Meyerowitz, *How Sex Changed* (cit. n. 5), pp. 283–286; and Stryker, *Transgender History* (cit. n. 5).

⁶⁰ Esben Esther Pirelli Benestad and Elsa Almås, *Kjønn i bevegelse* (Oslo: Universitetsforlaget, 2001). For the media reception of the book see, e.g., Tone Foss Aspevoll, “43 millioner kjønn—og enda noen til,” *Klassekampen*, 21 June 2001, pp. 14–15; and Annicken Vargel, “Alias pappa,” *Dagbladet Magasinet*, 7 July 2001, pp. 40–43.

⁶¹ Thomas Ergo, “Snart kvinne,” *Dagbladet Magasinet*, 26 May 2001, pp. 16–22.

⁶² For media reports on the deadlock at Rikshospitalet see, e.g., “Tar livet sitt i operasjonskø,” *Bergens Tidene*, 24 Dec. 2000, p. 6; “Transseksuelle nektes behandling,” *Klassekampen*, 15 Nov. 2000, p. 7; and *Fakta på lørdag: Manndomsprøven*, NRK, 6 May 2000. The figure on patient suicides is from a statement by Ira Haraldsen in Ergo, “Snart kvinne,” and she has confirmed the number in private email communication.

the activists to stir up attention from the media: this situation led to completely new alliances between activists and medical professionals.⁶³ In other words, the deadlock created momentum for action that could be used to mobilize media and public attention.

Although the issue had landed on the agenda at the highest political level, the Minister of Health made no promises to provide extraordinary state funding for the service.⁶⁴ As the sole hospital in Norway offering this type of treatment, Rikshospitalet had the responsibility, he stated, to ensure that necessary health-care services were available: “Rikshospitalet is a net budget cooperation where it is expected that various tasks are solved within the net grant and other general financial arrangements.” While the minister forced Rikshospitalet to develop a plan to secure future health-care services for trans people, the LFTS’s lawyer wrote that “there was now a complete lack of confidence between the LFTS and Rikshospitalet”—referring not to the clinicians involved in sex reassignment but to the head of the plastic surgery department. Finally, in May 2001, the health authorities summoned representatives from Rikshospitalet and the Norwegian Board of Health Supervision, along with experts and activists, to discuss the future structure of the health services.⁶⁵ This meeting and the resulting plan for the future organization of health-care services for patients seeking medical transition initiated a process that ultimately led to the establishment of the Gender Identity Disorder Clinic in 2001/2002.

Importantly, at the end of the century proper health services for trans patients had become a topic that united politicians across party lines.⁶⁶ Even the Minister of Health from the Christian Democratic Party weighed in. Looking back on this episode, he wrote in his memoirs that “I have found much meaning in my political work meeting people who use their own experiences to help themselves or others in spite of the constraints posed by their illnesses or disabilities.”⁶⁷ As it would still be several years before Norwegian lesbian, gay, and bisexual organizations adopted transgender rights as part of their agenda, it was unproblematic for Christian and conservative politicians, who otherwise opposed gay rights such as marriage and adoption, to defend the rights of a patient group seeking medical treatment. At the time, this was not a question of rights for sexual and gender minorities that threatened the nuclear family, the heterosexual order, or even a binary understanding of sex, but a matter of patient rights and the provision of care for a group of psychiatric patients. Norwegian activists at that time did not mobilize *trans* as an identity; rather, they positioned themselves as patients denied medical care, which enabled them to gather support across the political spectrum more easily.

As the issue of medical transition raised numerous political, medical, and ethical questions, doctors throughout the second half of the twentieth century repeatedly sought to anchor the procedures in a public institution; but for the exact same reasons—the issue’s delicate and complicated nature—the health authorities opposed such formalization or institutionalization. For the latter, it was much more convenient to construct the question as a strictly medical one and leave it to the medical profession to settle. At the turn of the new century, in contrast, the issue of formalizing a health-care service for medical transition not only mobilized established institutions but engaged new actors as well. It had become a matter of public concern through an assemblage

⁶³ Arbeidsgruppen for transseksuelle, memo, 28 Jan. 1999, Ira Haraldsen private archive.

⁶⁴ Minister of Health Tore Tønne to Høegh and Ballo, 29 May 2000, no. 1999/2202, NBHSA.

⁶⁵ Ministry of Health and Social Affairs to Rikshospitalet, 3 Nov. 2000; Harald Stabell to Ministry of Health and Social Affairs, 11 June 2001 (“lack of confidence”); and Ministry of Health and Social Affairs to Rikshospitalet, 28 May 2001 (meeting summons): no. 1999/2202, NBHSA.

⁶⁶ Jens Stoltenberg, from the Social Democratic Party, became Prime Minister on 17 Mar. 2000. Tore Tønne was appointed as Minister of Health, replacing Dagfinn Høybråten from the Christian Democratic Party. See Gyri Aure, “Transer feiret Tønne,” VG, 19 Mar. 2001, p. 25.

⁶⁷ Dagfinn Høybråten, *Drivkraft* (Oslo: Cappelen Damm, 2012), p. 53.

of activists, patients, bureaucrats, politicians, doctors, journalists, documents, hormones, scalpels, and hospital buildings.⁶⁸ Ultimately, the relocation of the hospital created an acute situation that generated momentum for action.

In this new, more complex and confusing landscape, doctors were no longer the only experts with authoritative knowledge on the topic. This story is therefore an example of how democratic processes and public involvement in modern knowledge societies have become inseparable from scientific and technological questions.⁶⁹ The increased importance of patient autonomy and rights in the medical discourse of the last decade of the twentieth century narrowed doctors' room to maneuver. Activists now demanded that their voices be heard when bureaucrats and politicians weighed in on the future organization of health services. The liberalization and reform of the public health-care system and the welfare state, including the introduction of DRGs and the centralization of expensive medical procedures, further challenged doctors' latitude in defining the frame for medical practice.

IV. SHIFTING FORMS OF EXPERTISE: THE NEED FOR OBJECTIVITY

When the clinic was finally institutionalized in 2001/2002, it signaled more than the simple formalization of a practice that had become routine in previous decades. In the process of creating a clinic for trans medicine, the whole diagnostic and therapeutic structure and authority for making treatment decisions shifted from a multidisciplinary group of doctors to expert psychiatrists. In this sense, the Norwegian history of trans medicine differed from that in neighboring countries such as Sweden, Denmark, and Finland, where psychiatrists were the primary conductors of these assessments all along.⁷⁰ At the beginning of the 1990s, the Rikshospitalet plastic surgery department still emphasized that it was the team of experts that together made communal decisions about who would have access to treatment. In the annual report from the turn of the millennium, however, the role of the team was all but absent: "Psychiatrists observe, diagnose, and decide treatment indication. . . . Our surgical services depend on psychiatric assessment, pre-treatment and post-surgical follow-up."⁷¹ Compared to the situation only a few years earlier, the different roles of the specialists—their expertise and responsibilities—were now compartmentalized in completely new ways. The assessment of patients became the task of the psychiatrist, and as the psychiatrist took center stage the other medical professionals were merely consulted for medical services. The role of the surgeon, for instance, became simply to carry out surgical-technical procedures at the recommendation of the psychiatrists. "The patients have been regarded as surgical patients," the hospital administration stated; but at the turn of the century the plastic surgeons had come to a different conclusion. "These are psychiatric patients"; surgery was only "part of the total treatment." The hospital "had not taken sufficient account of the fact that it is a psychiatric clinical picture," but this was about to change.⁷²

⁶⁸ On matters of concern see Bruno Latour, "From Realpolitik to Dingpolitik: How to Make Things Public: An Introduction," in *Making Things Public: Atmospheres of Democracy*, ed. Latour and Peter Weibel (Cambridge, Mass.: MIT Press, 2005), pp. 14–44.

⁶⁹ Sheila Jasanoff, *Designs on Nature: Science and Democracy in Europe and the United States* (Princeton, N.J.: Princeton Univ. Press, 2005).

⁷⁰ Alm, "Ett emballage för inälvor och emotioner" (cit. n. 8); Holm, "Fleshing Out the Self" (cit. n. 8); and Parhi, "Boyish Mannerisms and Womanly Coquetry" (cit. n. 8).

⁷¹ Borchgrevink, "Transsexualisme som landsfunksjon" (cit. n. 22); and Øyvind Borch Bugge and Frank Åbyholm, "Transseksualisme, Årsrapport 2000," Plastisk kirurgisk avdeling, Rikshospitalet, no. 1997/4054, NBHSA.

⁷² Danielsen and Jackobsen to Ministry of Health and Social Affairs, Vedlegg 1, 7 June 2001, NBHSA; and Bugge and Åbyholm, "Transseksualisme, Årsrapport 2000."

In the plan for health services for trans patients that Rikshospitalet provided to the Ministry of Health and Social Affairs in June 2001, psychiatrists played the role of administrators in charge. Although the plan suggested that various medical specialists would meet every five weeks to discuss the patients, the psychiatrist and the psychiatric nurse made up the team's "permanent base." This was no metaphor but a matter of fact. In the organization envisioned for the clinic in the future, the hospital psychiatrist was placed at the center of the organizational map, and all other specialists—endocrinologists, plastic surgeons, and gynecologists—were boxed off with unidirectional arrows pointing to that figure: "These three—a leading psychiatrist, a psychiatric nurse and a secretary—will serve as quality assurance for all other health services involved in the treatment and follow-up of this patient group." Only a few years earlier, a new edition of the international guidelines on medical care for transgender people, *The Standards of Care for Gender Identity Disorders*, had been published, underscoring the role of mental health professionals in diagnosing and selecting patients for medical transition and providing support through psychotherapy. When the hospital requested more funding to formalize a health service for sex reassignment, and specifically for a full-time psychiatrist, it invoked these guidelines. Furthermore, both the plastic surgeons' annual report and the plan for the future organization of health services made arguments for funding the position of a psychiatrist as head of the new clinic: the hospital representatives wrote to the Ministry of Health and Social Affairs that Rikshospitalet was "without a psychiatric department and therefore in need of a position for a psychiatrist."⁷³

At that time, new positions for doctors were allocated by a national council on behalf of the ministry, and the Norwegian Medical Association exerted significant influence over these decisions.⁷⁴ Rikshospitalet had neither the authority nor the funding to create a new position for a psychiatrist; to circumvent this obstacle, the administration appointed the psychiatrist who would become the head physician of the Gender Identity Disorder Clinic to a position on the hospital's administrative staff.⁷⁵ As already noted, the DRG system did not allow for full reimbursement of surgical interventions; therefore, as a last resort, the hospital created a new clinic under the leadership of a psychiatrist and hoped that the government would supplement the yearly block grant. In other words, the regulatory regime of DRGs and the funding framework, combined with the fact that Rikshospitalet had neither a psychiatric department nor the authority to establish a position for a specialist, all ultimately contributed to the creation of a new therapeutic structure for trans medicine with psychiatry in the leading role. The Working Group for Transsexuals/Transsexualism had dissolved, leaving a vacuum for the expert psychiatrists to fill. All these processes contributed to conceptualizing transsexualism as a psychiatric disorder belonging to the realm of psychiatrists.

Activists also played a crucial role in this shift. As all treatment was shut down, the LFTS wrote the Minister of Health that "it is not defensible that an increasing number of people with a psychiatric diagnosis walk around without a treatment option." Activists pointed to the lack of treatment as a potential risk to society, as trans people were mentally ill: "Transsexualism is a psychiatric diagnosis with a surgical solution," they wrote, arguing that psychiatric assessment was "a crucial and central part of the treatment of transsexuals." In an interview, Tone Maria Hansen, the first head of the LFTS, recalled that doctors in the 1980s used the term "transsexual" and that she therefore had referred to herself as a transsexual woman. "That was understood as something

⁷³ Danielsen and Jackobsen to Ministry of Health and Social Affairs, Vedlegg 1, 7 June 2001. For the international guidelines see Harry Benjamin International Gender Dysphoria Association, *The Standards of Care for Gender Identity Disorders*, 5th ed. (Düsseldorf: Symposium, 1998); this text can be found in the World Professional Association of Transgender Health Archive (online).

⁷⁴ See Per Haave, *I medisinsens sentrum—Den norske legeförening og spesialistregimet gjennom hundre år* (Oslo: Unipub, 2011), pp. 333–360.

⁷⁵ Ira Haraldsen, interview with Ketil Slagstad, Oslo, 9 Oct. 2019.

different than a woman. I therefore do not use transsexual anymore. I am proud of my history, and if needed, I can explain that I am a woman born in a boy's body. To me, it is important to preserve my fundamental identity as woman."⁷⁶ Nevertheless, whatever they thought about the roles and status thus assigned, activists took on the role of psychiatric patients to fight for access to the health care they needed, thereby stabilizing transsexualism as a psychiatric condition. For the activists and patients, this was the only way out of the deadlock: the only way to access health care was to mobilize medicalizing and pathologizing terms. The path to normalization went through pathologization.

How can this major displacement of expertise in relation to the question of medical transition in the early 2000s be understood? Several political, economic, and bureaucratic processes and historical actors were involved; thus, simply describing the complex changes in all-encompassing and homogenizing medical sociological terms such as "psychiatrization" offers little to a refined historical analysis. Rather, the shift can be seen in light of a much broader medical and scientific crisis of legitimacy. From the early 1980s, the decisions regarding which patients should have access to hormonal and surgical treatment were made by a team of medical professionals who resolved these clinical questions in an informal manner—often meeting privately after work hours. "These meetings, it was a lot of bingo," the psychiatrist Ira Haraldsen said about the working group's decision-making process.⁷⁷ She joined the group in the late 1990s and later became the first director of the new gender identity clinic. However, the ways in which the medical experts made decisions, which in retrospect—understandably but somewhat nonchalantly—could be characterized as "bingo," in reality reflected a different medical logic, a logic rooted in professional clinical judgment regarding care and good medicine.

Indeed, Alv A. Dahl, a former professor of psychiatry, explained that the working group did not use diagnostic instruments, even though, in the 1980s, they were well aware of the *DSM-III* and the accompanying SCID interviews, as well as the diagnostic criteria set forth in *ICD-9*: "We used clinical interviews and had a solid, professional gestalt as to what transsexualism was." A general practitioner who worked at the Oslo Health Council in the late 1970s also recalled that they did not use diagnostic criteria such as those proposed in the *ICD* or the *DSM* in their clinical decisions, adding laconically that "at that time, at the end of the 1970s, it was not like in psychiatry today where you cannot talk to anybody without first finding a scale or a questionnaire. Most things, also in other areas than what we are talking about now, were much more informal, much more based on clinical judgment."⁷⁸ By the turn of the century, however, with the increased liberalization, centralization, and bureaucratization of medicine, this logic had lost its credibility. The new psychiatric diagnostic regime, which replaced the former "nondisciplinary" practice based on clinical judgment, involved an enormous number of questionnaires and diagnostic instruments. People who went through the new diagnostic procedures explained in interviews that they had to fill out some seventy to eighty pages consisting of various diagnostic instruments and tests.

⁷⁶ LFTS to Minister of Health and Social Affairs, undated, archived 31 Oct. 2000, no. 1999/2202, NBHSA; and Tone Maria Hansen, interview with Ketil Slagstad, Oslo, 1 Oct. 2019.

⁷⁷ Haraldsen interview (cit. n. 75).

⁷⁸ Dahl interview (cit. n. 43); and Kirsti Malterud, interview with Ketil Slagstad, 24 Oct. 2019. *DSM-III* is the *Diagnostic and Statistical Manual*, 3rd ed., published by the American Psychiatric Association (1980); SCID is the Structured Clinical Interview guide for making diagnoses according to the criteria in *DSM-III*; *ICD-9* is the *International Classification of Diseases*, 9th ed., published by the World Health Organization (1975). For the history of the classification of these diagnoses see Jack Drescher, Peggy Cohen-Kettenis, and Sam Winter, "Minding the Body: Situating Gender Identity Diagnoses in the ICD-11," *International Review of Psychiatry*, 2012, 24:568–577, <https://doi.org/10.3109/09540261.2012.741575>.

I suggest that this shift in the psychiatric assessment of trans patients must be viewed against the backdrop of more general developments within psychiatry at that time. Historians of science and medicine have carefully documented how practices of standardization and classification have come to play a key role in modern medicine and psychiatry.⁷⁹ For psychiatry, this gradual change has been intimately tied to the increased importance of the *DSM* and the epistemological shift from the psychoanalytic-inspired second edition to the “atheoretical,” operationalist third edition.⁸⁰ These changes, however, account only for shifting epistemologies within psychiatry and do not explain why a new psychiatric regime based on diagnostic instruments, questionnaires, and quantified knowledge replaced the cross-disciplinary, clinical judgment–based system for sex reassignment in the first place.

Yaron Ezrahi has proposed that the modern liberal-democratic state has appropriated science and technology as a resource for shaping and legitimating political authority and that scientific knowledge has provided modern Western democracies with the tools to uphold a “neutral,” objective, depersonalized kind of power. Similarly, the historian of science Theodore Porter has argued that in modern societies where democratic political culture is based above all on interests, *objectivity* or “strategies of impersonality”—that is, “knowledge that does not depend too much on the particular individuals who author it”—has become *the* most important defense against attempts to undermine a field.⁸¹ This explains modern societies’ “trust in numbers” or, in this particular story, the new diagnostic regime of trans medicine based on psychiatric questionnaires, tests, and instruments.

It is along these lines that the shift in expertise in trans medicine must be understood. In the late twentieth century the issue of medical transition entailed, on the one hand, political interests, bureaucratic autonomy, activists’ demands, and media attention. On the other hand, medical professionals’ latitude was increasingly challenged by patients’ rights activists and liberalized financial systems. In this increasingly complex but restricted landscape of medical transition, the clinical judgment–based authority that had regulated the field since the middle of the century no longer enjoyed sufficient credibility. The working group had become an archaic entity in an increasingly specialized and standardized version of medicine. Neither endocrinology nor plastic surgery had the diagnostic competence or legitimacy to serve as a future home for trans medicine. Social medicine was a dying profession, and there were no experts in social medicine ready

⁷⁹ Fritz Handerer *et al.*, “How Did Mental Health Become So Biomedical? The Progressive Erosion of Social Determinants in Historical Psychiatric Admission Registers,” *History of Psychiatry*, 2020, 32:37–51, <https://doi.org/10.1177/0957154X20968522>; and Stefan Timmermans and Marc Berg, *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care* (Philadelphia: Temple Univ. Press, 2003).

⁸⁰ Stuart A. Kirk and Herb Kutchins, *The Selling of DSM: The Rhetoric of Science in Psychiatry* (New York: Aldine de Gruyter, 1992); Sing Lee, “Diagnosis Postponed: Shenjing Shuairuo and the Transformation of Psychiatry in Post-Mao China,” *Cult. Med. Psychiat.*, 1999, 23:349–380, <https://doi.org/10.1023/a:1005586301895>; Jackie Orr, *Panic Diaries: A Genealogy of Panic Disorder* (Durham, N.C.: Duke Univ. Press, 2006); Orr, “Biopsychiatry and the Informatics of Diagnosis: Governing Mentalities,” in *Biomedicalization: Technoscience, Health, and Illness in the U.S.*, ed. Adele E. Clarke *et al.* (Durham, N.C.: Duke Univ. Press, 2010), pp. 353–379; Martyn Pickersgill, “Standardising Antisocial Personality Disorder: The Social Shaping of a Psychiatric Technology,” *Sociology of Health and Illness*, 2012, 34:544–559, <https://doi.org/10.1111/j.1467-9566.2011.01404.x>; and Josef Parnas and Pierre Bovet, “Psychiatry Made Easy: Operation(al)ism and Some of Its Consequences,” in *Philosophical Issues in Psychiatry III: The Nature and Sources of Historical Change*, ed. Kenneth S. Kendler and Parnas (Oxford: Oxford Univ. Press, 2015), pp. 190–212. The processes of standardization were not uncontested and should not be seen as a singular revolutionary process. See Nicolas Henckes, “Magic Bullet in the Head? Psychiatric Revolutions and Their Aftermath,” in *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century*, ed. Jeremy A. Greene, Flurin Condrau, and Elizabeth Siegel Watkins (Chicago: Univ. Chicago Press, 2016), pp. 65–96.

⁸¹ Yaron Ezrahi, *The Descent of Icarus: Science and the Transformation of Contemporary Democracy* (Cambridge, Mass.: Harvard Univ. Press, 1990), esp. pp. 29–30; and Theodore M. Porter, *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life* (Princeton, N.J.: Princeton Univ. Press, 1995), p. 229.

to pick up the baton after Berthold Grünfeld retired. The only way to protect the legitimacy of medical decisions regarding medical transition and safeguard a future for trans medicine was to anchor it in the new “objective,” quantified diagnostic regime of psychiatric expertise.

CONCLUSION: MEDICINE AS BUREAUCRACY

This essay has examined the assessment of people seeking medical transition in the second half of the twentieth century with a particular focus on important changes taking place in the 1990s. Throughout this time period, trans people were pathologized under various psychiatric labels in the major international diagnostic manuals (*ICD* and *DSM*).⁸² That would remain the case until the WHO removed the category of “gender identity disorder” and the diagnosis of “transsexualism” from the classification of diseases in 2019 and instead included a new category of “gender incongruence” in a chapter on sexual health. The Norwegian Directorate of Health responded by creating new guidelines for the future organization of health care for trans people in which the health services were decentralized, thereby breaking up the former monopoly, while psychiatric or psychological assessment or examination would no longer be obligatory.⁸³ As several historians of science and medicine and STS scholars have emphasized, practices of standardization and diagnostic classification systems are constitutive of modern lives and societies, and these radical changes in the organization of trans health care stand as striking examples of the power of diagnosis in modern medicine, famously characterized by the historian of medicine Charles E. Rosenberg as “the tyranny of diagnosis.”⁸⁴

At the same time, the Norwegian example complicates this argument, and it calls for careful historicization of nosological categories, expert knowledge, and professional authority in local and national contexts. In Norway, it was not until the turn to the twenty-first century that trans medicine became firmly anchored in psychiatry. The creation of a gender identity clinic demonstrates how medical practice in national contexts can develop independently of seemingly hegemonic international trends or classificatory structures, problematizing the notion of modern medicine as a “coherent whole” and highlighting its conglomerate nature—what Annemarie Mol and Marc Berg describe as an “amalgam of thoughts, a mixture of habits, an assemblage of techniques.”⁸⁵ In Norway, the organization of health services for trans people and the expertise on medical transition—and therefore ultimately the knowledge production of trans medicine—were inextricably tied to the reformation of the welfare state.

The Norwegian story represents a particular example of how nosological negotiations unfolded in the context of a welfare state and a public health-care system. For most of the second half of the twentieth century, trans patients were attended to by a multidisciplinary group of medical experts. These doctors had a clear understanding of what transsexualism was and defended their decisions based on clinical judgment. Nevertheless, as this was a fairly marginal field of medicine bolstered by little clinical research that would serve to justify the soundness of their decisions, the doctors sought to anchor the practice in a formalized public health-care structure.

⁸² Drescher *et al.*, “Minding the Body” (cit. n. 78).

⁸³ *ICD-11* (WHO, 2019), Ch. 17: “Conditions Related to Sexual Health”; and Helsedirektoratet, *Kjønnsinkongruens* (cit. n. 48).

⁸⁴ Charles E. Rosenberg, “The Tyranny of Diagnosis: Specific Entities and Individual Experience,” *Milbank Quart.*, 2002, 80:237–260, 10.1111/1468-0009.t01-1-00003. See also Geoffrey C. Bowker and Susan Leigh Star, *Sorting Things Out: Classification and Its Consequences* (Cambridge, Mass.: MIT Press, 1999); Annemarie Jutel, “Sociology of Diagnosis: A Preliminary Review,” *Sociol. Health Illness*, 2009, 32:278–299, <https://doi.org/10.1111/j.1467-9566.2008.01152.x>; and Anne Kveim Lie and Jeremy A. Greene, “From Ariadne’s Thread to the Labyrinth Itself—Nosology and the Infrastructure of Modern Medicine,” *New England Journal of Medicine*, 2020, 382:1273–1277, <https://doi.org/10.1056/NEJMms1913140>.

⁸⁵ Annemarie Mol and Marc Berg, “Differences in Medicine: An Introduction,” in *Differences in Medicine: Unraveling Practices, Techniques, and Bodies*, ed. Berg and Mol (Durham, N.C.: Duke Univ. Press, 1998), pp. 1–12, on p. 3.

The health authorities, however, feared that such a formalization would lead more people to seek treatment and preferred that the medical, ethical, and legal questions raised by sex change be solved on an *ad hoc* basis at the discretion of the medical profession. This contributed to a particularly restrictive model of trans care in the welfare state. In a tightly regulated drug market and health-care system, there were very few other options for trans people to access hormones and surgery. Some managed to obtain hormones through acquaintances, but only the most affluent could possibly afford to travel to Casablanca, in Morocco, to undergo surgery in the clinic of the famous surgeon Georges Burou.

By the end of the century, a new medical regime for medical transition arose; its medical logic has been unpacked by this essay. As the century closed, medical transition was negotiated by medical professionals, patients, bureaucrats, politicians, journalists, and activists in the context of a public health-care system put under pressure from different angles, including economic framings, institutional frictions, public debates, activism, and medical experts' positioning. In an increasingly liberalized, centralized, and standardized health-care system, the medical professionals' room to maneuver was restricted by numerous factors: economics (reimbursement based on diagnosis-related groups), the legal system (activists and the new era of patients' rights that they helped to usher in), medicine (standardization of diagnostic practices and treatment courses), and politics (governmental regulation of specialized medical services). These discourses framed trans medicine as a highly specialized type of care: only specialized doctors in one physical location should and could offer such treatment. In this restricted situation, doctors enacted sex reassignment as a whole to protect the integrity of the therapeutic model, thereby precluding a personalized approach to trans health care. The process of reforming the welfare state and the public health-care system and the hormonal and surgical practice of medical transition shaped each other in co-productive ways; since sex change was enacted as an either/or, one-size-fits-all regime, the binary model of sex was stabilized.

The new era of patient autonomy and emerging activism put pressure on the discretionary power of medical experts and the tradition of justifying decisions regarding who should gain access to medical transition via the logic of professional judgment. The restricted room to maneuver and increased demand for unbiased, "objective," and dispassionate medical practice created a vacuum filled by expert psychiatrists—weaponized by a battery of "objective" diagnostic instruments. By the end of the century, as doctors and psychiatrists increasingly organized clinical practice around diagnostic instruments and classifications, medical transition had to find a home in a specialized field of medicine. Ultimately, medical authority over trans medicine shifted in favor of psychiatric expertise. A strict pathologizing model rooted in psychiatry became the only way to provide trans care that conformed to the system of the reformed welfare state.

Canguilhem reminded us that "a norm offers itself as a possible mode of unifying diversity, resolving a difference, settling a disagreement."⁸⁶ The birth of the gender identity clinic in Norway demonstrates that, in the modern welfare state, the norms of medical practice and knowledge production are shaped not only within the walls of the clinic but increasingly through the machinery of bureaucracy.

⁸⁶ Canguilhem, *On the Normal and the Pathological* (cit. n. 12), p. 147.