

Health disparities in non-transition-related transgender care

by
Regina Kurapova

A THESIS

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Despite research advancements, the medical field contributes to many health disparities, or situations in which groups that were historically oppressed also experience systematically worse health and greater health risks than more advantaged groups. Although some researchers have paid attention to this population, most studies focus on transition-related care (mostly surgeries or hormone changes) and fail to consider how day-to-day general care may be affected. This thesis demonstrates some types of disparities existing in non-transition-related care by presenting anecdotal evidence from several interviews of transgender-identifying volunteers. The purpose is to inspire future research in identifying and solving problems in comprehensive care of transgender patients.

Key Words: transgender, health care, medicine, humanities, discrimination, disparities, minority

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I understand that my project will become part of the permanent collection of Oregon State University, Honors College. My signature below authorizes release of my project to any reader upon request.

Regina Kurapova, Author

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Chapter 1 - Introduction

Meet Kaden, who was denied healthcare because of his transgender identity (Basic Rights Oregon). As a transgender man, he is still at risk for cervical cancer. Here, in an interview with Basic Rights Oregon, he recounts his experience:

“Over the last three years, I requested a pap smear, which I felt was required: I was already reaching 21 years old. My doctor at that time did not feel that was necessary for me. I finally found a new doctor, got my pap smear almost a year later, and came back with the results that I do have *precancerous cells*. I decided to see a specialist to try to discuss having a hysterectomy, and I got a lot of fight-back from the insurance. They really pushed and said that, ‘We’re not going to approve this because we don’t have a code for this.’ Or, ‘We’re not going to approve this because this doesn’t make any sense. Why would a male have a uterus?’
.... It’s been a battle for over a year and now I have new insurance with my mom’s new company and I am still going on about 3 months trying to get this approved. It’s been kind of this circular battle of trying to just get approval for something that I need that’s a *life-saving surgery*” (my italics).

Kaden’s mom adds, “It was really devastating... I felt like all this time he could have had the ability to fix the situation for the three years that he was begging for medical care. *You shouldn’t have to beg for medical care*”(my italics).

This is just one example of the type of discrimination and refusal of medical care that can happen to people identifying as transgender. As we see above, transgender people may face issues unrelated to the logistics of physical transition. We see that transgender people can face life-threatening discrimination in medical settings.

The transgender community is often overlooked or underrepresented when considering healthcare education, training, or practice. Despite research advancements, the medical field contributes to many health disparities, or situations

in which groups that were historically oppressed also experience systematically worse health and greater health risks than more advantaged groups. An especially disadvantaged but understudied group includes transgender patients, or patients whose gender identity (personal psychological identification of gender) differs from their sex assigned at birth.

Transgender identity is prevalent throughout history and has often been widely accepted and even celebrated: for example, some Native American groups associate transgender individuals with certain spiritual powers (Thomas et al., 2017). Other cultures have also reinforced transgender people as honored individuals, as a third gender is recognized in laws and cultural traditions in multiple countries including Australia, Bangladesh, Germany, India, Ireland, Nepal, and Pakistan (Thomas et al.). However, transgender people tend to be highly stigmatized in modern societies. Although outwardly transgender people are more common in recent times due to gradual increased acceptance in LGBTQ+ and general communities, stigma against transgender folks remains a powerful force that may be contributing to decreased quality of life.

The transgender population suffers health disparities compared to both the LGBTQ+ and the general population. The transgender population is especially understudied in the context of health and medical care. Most current research has focused on physical transition, which often includes hormone alterations or physical surgery. However, physical transition is not a defining factor of transgender identity: some people cannot afford physical changes, while others do not feel the need to physically transition as long as they feel mentally comfortable. Improving the technique and outcomes of physical transition is important, but it is not the only relevant aspect of transgender healthcare, because at its core healthcare for any individual begins with respect, humanity, and empathy. If these factors are missing due to stigma, discrimination, or lack of experience, then quality of healthcare could become severely inadequate.

This Honors undergraduate thesis demonstrates some types of disparities existing in non-transition-related care. As interviewer and author, my primary hope is to broadcast the voices of a misunderstood and vulnerable population. I reorganize

information discussed in interviews and highlight common themes. Although all future opposition to this work cannot be predicted, I attempt to respond to arguments that may arise in an effort to alleviate at least a small portion of the burden transgender people bear when advocating for themselves.

Two questions guide the research and findings presented in this thesis. First, what types of discrimination not related to transition do transgender people face in health care? Secondly, what changes or recommendations do transgender patients have for a more inclusionary health care context? I explain in chapter 2 the methodology of literature review and interviewing processes I engaged in to gain insights into these questions.

I viewed my primary roles in relation to the interviewees as “learner” or “listener,” followed by “translator” to the general public and occasionally even “advocate” for the community. I operate under the assumptions that it is worthwhile to attempt to improve health care, that the transgender experience and identity is entirely valid, and that my interviewees are portraying their experiences truthfully.

I begin my exploration of the topic in Chapter 3, where I review and discuss scholarly literature on the problems transgender patients experience when accessing health care. The following six chapters consist of re-organized excerpts from interviews with transgender volunteers. These chapters serve mainly as a reflection of the interviewee’s thoughts and experiences; I provide my own commentary at the end of each chapter. Chapter 4 provides insight into one of the biggest health care problems—improper language use. Chapter 5 describes harmful assumptions health care professionals make about transgender patients and explores the intersections of these assumptions with mental health. Chapter 6 describes emotional consequences transgender patients experience when advocating for themselves and reporting biased encounters. Chapter 7 describes one of the greatest resulting health risks, which is health care avoidance behavior. Chapter 8 considers transgender health care inconsistency across regions of the U.S. and highlights the importance of examining issues with an intersectional lens. Finally, interviewee recommendations for improving care are presented in Chapter 9, followed by Chapter 10 with my own commentary on future directions and concluding statements.

The purpose of this thesis is to inspire future research in identifying and solving problems in comprehensive care of transgender patients. Non-transition-related transgender healthcare can include complex issues and requires extensive further study in order to foster optimal health for the transgender community.

Chapter 2 - Methodology

First, I identified research questions and composed a plan. Transgender-focused research is scarce, and most of the existing literature focuses on transition (surgery and hormones). Because of this, I chose to focus mainly on the transitional experience. Then, a literature review was conducted by researching and summarizing influential studies related to the study.

I received approval from the Institutional Review Board at OSU before conducting interviews. I recruited study participants with the help of OSU Pride Center staff via the listserv, with the goal of recruiting five study participants. I included no children in the study and I excluded no other populations (only must be over 18 years of age and must identify as transgender). Four interested volunteers contacted the student researcher, Regina Kurapova, to schedule an interview. All four volunteers identified as nonbinary. Not every nonbinary person identifies as transgender, but many consider nonbinary people to fall under the larger “transgender umbrella.” Interviewee 1 identified as nonbinary transmasculine, interviewee 2 identified as nonbinary with a core of female sex, interviewee 3 identified as nonbinary, and interviewee 4 identified as nonbinary genderfluid transmasculine.

I obtained verbal consent to interview and record prior to conducting audio-recorded interviews, which lasted approximately 40 minutes each. I then transcribed the transcripts and placed the interview questions at the end of the thesis in an appendix.

I analyzed the interview results, re-organized them by topic, and discussed in detail. I wrote up the findings in several chapters, after which I identified future directions and made conclusions.

Chapter 3 - Literature Review

Non-transition-related medical care of transgender patients is important for the well-being of the transgender population, but fairly sparse literature exists pertaining to this topic. I will begin by briefly reviewing and discussing literature on three features that both reflect and contribute to significant health disparities among the transgender population: rates of suicide; experience of general discrimination, harassment, and violence; and the prevalence of health-harming behaviors. Then, I will review and discuss literature surrounding specifically non-transition-related transgender medical care, thus providing context for the following personal interviews.

Rates of suicide

Perhaps the most striking demonstration of transgender health disparity is the obscenely high attempted suicide rate: compared to the overall U.S. population's 4.6% lifetime suicide attempt rate and the U.S. LGB population's 15% rate, 41% of transgender respondents to the National Transgender Discrimination Survey (NTDS) reported a lifetime suicide attempt (Williams Institute). The study did not report the number of successful suicides. The authors report a striking finding that the high suicide attempt prevalence occurred across *all* demographics and experiences, showing that the transgender population as a whole is in danger. Even though intersectionality (regarding socioeconomic status, race, and other factors) very likely influences transgender patients' healthcare experience, the high suicide attempt prevalence across the board indicates that being transgender could alone increase vulnerability for harassment, discrimination, violence, and rejection (Williams Institute). Mental health factors and experiences of harassment, discrimination, violence, and rejection may interact to increase suicidal behavior probability for transgender and gender non-conforming individuals (Williams Institute).

These national statistics are wide-reaching, but present a relatively shallow analysis— they provide a snapshot of a population, but don't deeply explore the

factors involved. The NTDS suicide statistics point to the concept that the transgender population as a whole requires increased attention in all aspects of life, which includes healthcare.

General discrimination, harassment, and violence

Because of societal pressures and associated stigmas about nonconforming to gender norms, transgender people alarmingly often face general discrimination, harassment, and violence (Shires & Jaffee, 2015). There have also been some reports that transgender people have faced discrimination from physicians as well as staff, and sometimes have been refused care altogether (Shires & Jaffee). Shires and Jaffee found that over 40% of transgender men responding to their national survey reported discrimination in a healthcare setting (they did not collect data from transgender women in this study). Discrimination rates were even higher for populations with intersecting identities (transmen of lower socioeconomic status or different ethnicities e.g. Native American and multiracial) (Shires and Jaffee). Reports of poor experiences with healthcare professionals or institutions included verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital (Shires & Jaffee).

Shires and Jaffee also discuss intersectionality theory, which is the idea that combinations of various identities have varying impact on experience in the world, in this case the experience of discrimination in healthcare settings. Certain high-status identities, for example high level of education, may be overshadowed by other identities, such as being transgender. In this case, the authors state that the highly educated transgender men in this study were more likely to experience discrimination than less-educated transgender men, likely because physicians felt defensive given the combination of their low experience with transgender healthcare and discomfort with the increased assertiveness of higher-educated individuals.

If discrimination is regularly experienced by transgender people, it is reasonable to speculate that discrimination also extends to healthcare environments and may play a significant role in mental and physical health outcomes. This may be

true whether negative attitudes and actions towards transgender people are intentional or not.

Health-harming behaviors

Although several researchers report that discrimination in transgender healthcare exists, direct links between discrimination and specific poor health outcomes have not been shown. Moreover, besides identifying correlations, mechanisms of poor health need to be understood in order to efficiently improve healthcare. The combination of Shires and Jaffee's (2015) research and Miller & Grollman's (2015) work steps closer to this goal.

Shires and Jaffee (2015) showed that discrimination is occurring in healthcare settings. By analyzing NTDS data, Miller & Grollman (2015) demonstrated a relationship between transgender status and self-harming behaviors (attempted suicide, drug/ alcohol abuse, and smoking) that is in fact mediated by self-reported general discrimination. Miller and Grollman state that "transphobic discrimination has consequences for many aspects of transgender people's lives, including their health and well-being." Miller and Grollman reference *minority stress theory* as a potential partial explanation for LGBTQ+-related health disparities. They use it to help explain the relationship between gender nonconformity, discrimination, and health-harming behaviors. Social environments impact the relatively poor health status of LGBTQ+ people (Miller & Grollman). Members of the LGBTQ+ population experience stressors unique to their status, which in turn contributes to sexual orientation health disparities (Miller & Grollman). Miller and Grollman argue that those who face discrimination may develop less energy to cope with negative social experiences related to gender-based discrimination and thus are more likely to engage in the above-stated health-harming behaviors.

Transgender patients report stigma while accessing healthcare, denial of services, and healthcare professionals not accepting them as patients (Waldman 2016). Waldman argues that medicine will likely continue to play an important role in

transgender people's progress toward political and social change because of gender-affirming medical therapies it may involve.

Miller and Grollman (2015) also mention *stigma visibility*, which may be contributing to increased discrimination—certain publicly visible markers of gender nonconformity can be visible markers of transgender status, which make transgender people more vulnerable targets of harassment, bullying, discrimination, etc. Miller and Grollman confirmed in their studies that stigma visibility results in increased discrimination towards transgender people and is a predictor of increased health-harming behavior.

Overall, Miller and Grollman (2015) learned that limited preliminary evidence shows that stigma can be particularly consequential for transgender people, as associations have been shown between level of stigma visibility and discrimination experienced in general. Limited evidence has also shown that workplace discrimination contributes to transgender people experiencing worse health than cisgender coworkers. General discrimination may be affecting health outcomes by increasing vulnerability and health-harming behaviors (Miller & Grollman). If these relationships have been found in the workplace and other settings, then such relationships may also exist in medical settings (e.g. clinics, hospitals, doctor's offices). These relationships should then be examined in depth and compared between types of medical settings. The patterns observed in medical settings may be similar to previous findings, but important differences may emerge that must be addressed in order to increase the health of the transgender population.

The limitations of Miller and Grollman's (2015) study include lack of information about the transgender population in general—the size and geographic distribution of the transgender population remains largely unknown because of its hard-to-reach status, so even though the NTDS survey is extensive, it still may not be optimally nationally representative. Regardless, indication of any amount of discrimination is good reason to continue investigation in order to improve healthcare and wellbeing.

The humanities of transgender medical care

Having considered some of the health issues experienced by the transgender population, I will now discuss some of the literature that addresses the medical experiences of transgender people with health care professionals and the clinical setting. Rentmeester et al. (2015) explain that transgender patients face multi-dimensional challenges, many of which stem from unknowledgeable healthcare providers. Rentmeester et al. define binary-dominance as “the prevailing assumption that a person must be either male or female to be normal” and characterize it as “a species of cultural imperialism that can influence the quality of clinical encounters.” Transgender people are especially vulnerable in healthcare settings (Rentmeester et al.). Because many patients rely on specific medical care to improve physical comfort and to assist in the expression of their identity, they have to navigate carefully – often in exhausting ways – to receive that care (Rentmeester et al.). The daily stigma experienced by transgender people projects into clinical settings as well, threatening additional harm to their health (Rentmeester et al.).

Clinicians are given the problematic responsibility of evaluating a patient’s need to change their gender expression as “authentic” (Rentmeester et al., 2015). This puts physicians in a position to reinforce binary-dominance and cultural imperialism, which is another way of saying that doctors impose their own ideas of gender on patients and try to place them in proverbial boxes, which can be very distressing to patients (Rentmeester et al.). Three consequences of this system include decreased focus on the actual medical attention the patient is seeking, increased anxiety for the patient which could lead to avoidance and health risk factors, and decreased trust in the physician-patient relationship (Rentmeester et al.).

Rentmeester et al. (2015) highlight two ways in which physicians can overemphasize mental illness in transgender patients. Physicians can question how a patient’s unrelated mental illness could affect their desire to transition, which invalidates the person’s identity and undermines their knowledge and control. Physicians can also require patients to present with a mental illness they don’t actually have (such as gender dysphoria) in order to receive treatment (Rentmeester et al.). As a result, patients avoid treatment or they are coerced into feigning an illness

that they don't have; meanwhile, their real medical issues go untreated (Rentmeester et al.).

Transgender patients commonly encounter inexperienced physicians, verbal abuse, and defensive behavior (Rentmeester et al., 2015). Thus, the patient takes on three roles by default: educator, advocate, and patient (Rentmeester et al., 2015). This puts considerable strain on the patient (Rentmeester et al.). Additionally, physicians may feel threatened and act defensively, which increases patient fears and anxiety even more (Rentmeester et al.). Two things may happen as a result: either the patient avoids healthcare altogether, or the patient receives unsatisfactory care while concealing potentially relevant information because they fear mistreatment (Rentmeester et al.).

Rentmeester et al. (2015) provide five suggestions for reducing inequalities in transgender healthcare. These include providing an inclusive clinical environment, increasing physicians' knowledge of specific risk factors affecting the transgender community, preparing physicians to discuss patient transition goals with care and respect, educating physicians on current laws surrounding legal documentation changes, and preparing physicians to discuss all treatment options. These will be discussed in more detail in later chapters.

Like Rentmeester et al. (2015), Ellin (2016) contends that physicians lack education in transgender care and argues that although not all physicians will know the details of transgender care, everyone should be trained to be competent in being respectful, ethically aware, and able to refer to the correct physician. All doctors should realize when they don't have sufficient knowledge and know how to seek assistance instead of becoming defensive and authoritative (Ellin).

Ellin (2016) cites healthcare problems such as physicians not knowing that genitalia does not have to match gender—for example, transgender men may need pap smears and transgender women may need regular prostate exams.

Ellin (2016) especially focuses on incompetent housing of transgender patients in hospitals. Many patients are referred to by the wrong names and pronouns and are housed with the wrong gender. Often, transgender patients are placed in a private room without asking for their preference, which can induce feelings of

segregation and fears of additional cost. A few hospitals have improved equitable care— both Mass General and Mount Sinai Health System, for example, offer transgender patients the option of a private room or housing according to their gender identity. Although some places like these have made positive steps in transgender inclusion, these changes are not happening everywhere and most medical schools do not prepare students to treat this population. Tari Hanneman, deputy director of the Health and Aging Program at the Human Rights Campaign, emphasizes the importance of preparation: “The first time you think about where you are going to put a transgender patient should not be when they arrive” (Ellin, 2016). Ellin thus provides important insights into required areas of improvement for physician training and preparation, but their overall contributions are limited because Ellin does not mention gender-nonconforming people and the vast diversity of bodies and genders that need to be competently addressed.

In a 2016 podcast at Harvard Medical School (HMS), Halem discusses efforts across HMS and beyond to improve transgender healthcare. Halem explains that “...our first reminder about the barriers that folks are facing in healthcare is that they’re experiencing and expressing gender in a wide range of ways... there are folks who identify clearly as transgender. There’s more often people who are coming to it over time, living in different ways and expressing themselves. In a healthcare setting, some of that can be confusing for providers. We live in a very gendered world.”

The first barrier that she highlights is “...that need for clarity around gender can... create a hardship for everyone involved.” Thus, she refers to many healthcare providers’ need to categorize people, which can be aggravating and unhelpful for patients.

Halem discusses that more often than not transgender and gender nonconforming people are afraid to go to the doctor, resulting in avoidance. Even if they finally are able to find a competent doctor, they may still be hesitant to offer sensitive information pertinent to their health because of past experiences and fear (Halem, 2016).

Halem highlights that different specialties intersect in complex ways, so medicine should be taught this way, too (2016). Halem recommends the integration of

“LGBT people, and transgender people especially, into all of the areas of the curriculum in which doctors are going to be working with patients.” Halem also offers that learning to ask difficult questions about gender and sexuality can improve other conversations such as talking to a black gay man about his masculinity or to straight women about the impact of sexism on their lives— this complex intersectionality should be continuously examined through years of training and beyond. “This is a good way to get at the nuances of intersectionality,” Halem says.

Halem explains that although “101” lunchtime workshops for physicians barely scratch the surface of transgender healthcare, encouraging physicians to bring the information back to their departments to continue the conversation with their colleagues could jump-start more specific changes in various specialties. Overall, Halem emphasizes a physician’s attitude, not necessarily explicit knowledge, to be the most important factor in improving transgender care. Being comfortable with language surrounding transgender issues helps to create a welcoming environment, along with proper language on intake forms, staff training, and even LGBTQ+-oriented magazines that may signal a safe environment to a patient. Halem reminds HMS podcast listeners that minimal research in all aspects of transgender care is also a huge disparity and that although the social environment is somewhat improving with more “out” public personas, it is still very hard to be transgender in America today.

Dietz and Halem (2016) recognize that not all physicians will be qualified for transgender healthcare and discuss optimal referral options. Dietz and Halem present a case of a transgender woman seeking counsel about recent episodes of nausea, potentially relating to her hormone therapy. The patient had a doctor qualified in terms of proper hormone care, but avoided the office because the doctor and staff made her uncomfortable with their language and attitude (Dietz & Halem). Other patients expressed similar concerns. Dietz and Halem comment that access to physical-transition-related services is often essential for transgender patients, but it is important to remember that the many other health care concerns of transgender patients are in many ways identical to those of cisgender (non-transgender) people. Thus, Dietz and Halem recommend referral to a professional that the patient trusts

and feels most comfortable with, even if that professional is not currently the most technically knowledgeable. Dietz and Halem argue that this approach would prevent both physical and emotional harm and would promote continuity of care. “Ultimately, transgender patients need clinicians whom they feel safe and comfortable seeing regularly for all of their healthcare needs. The majority of medical care related to transgender health can be administered by any physician willing to research best practices and create a care plan that centers on an individual patient’s healthcare needs and priorities” (Dietz & Halem).

Dietz and Halem (2016) highlight that we are now understanding gender to be on a spectrum and not binary, so clinical guidelines should reflect that and not require binary expression of gender—this gives the patient control of their health and expression. To further decrease paternalism, Dietz and Halem recommend physicians follow an “informed consent model” instead of requiring approval letters from other professionals to begin hormone therapy.

Overall, the transgender community experiences health disparities, partially demonstrated by high rates of suicide attempts, discrimination, harassment, violence, and health-harming behaviors. These disparities may be propagated by general stigma that presents itself in clinical settings, as well. Physicians are often inadequately educated about transgender health care and are ill-prepared to use proper language, create a comfortable environment for the patient, and refer patients to physicians they can trust. The next six chapters will present interview results highlighting some of the issues discussed in the literature review, as well as additional perspectives offered by the interviewees.

Chapter 4 - Language

“Literally your language and the way that you act in health care may or may not kill someone. And I don’t think that they realize how important that is” (interview 4).

As mentioned previously by Rentmeester et al. (2015), transgender people experience daily stigma that also projects into clinical settings. Dietz and Halem (2016) recommend referral to a professional that a patient trusts and feels most comfortable with, even if that physician is not currently the most technically knowledgeable. This type of approach could prevent both physical and emotional harm and would promote continuity of care. Dietz and Halem demonstrated this concept by describing a doctor who was qualified in terms of proper hormone care, but the patient avoided the office because the doctor and staff made her uncomfortable with their *language and attitude*. The concept of language as a crucial component of an inclusive medical environment is supported by all four interviews.

Misgendering

Misgendering, which is either accidentally or intentionally using the wrong pronoun or name or referring to an individual by the wrong gender, was identified by interviewees as a common language mistake encountered in medical settings. Transgender patients encounter misgendering from all levels of the medical profession, whether it’s from nurses, receptionists, or physicians. Misgendering can have immediately severe emotional effects or can build up over time, causing discomfort, stress, and emotional exhaustion.

Interviewee 2 describes the general effect of misgendering from their experience: “It’s just draining. I know that you’ve heard of microaggressions... that happening all day it tears down self-esteem a little bit, and does not validate your identity in any sort of way. So it’s hard to burden that at the end of the day. But I’ve definitely gotten to the point where I’m just like ‘Fuck y’all, you don’t know me!’”

Definitely in the beginning when I was still trying to figure things out it was pretty hard. And some days if I'm being more sensitive it's just like, 'Ugh.'"

Microaggressions are indirect, subtle, back-handed, or unintentional acts of discrimination or discriminatory statements against members of a marginalized group, in this case transgender people. If they only happened occasionally, they wouldn't be an issue, but they add to other stigma and discrimination that people from marginalized groups are already experiencing. As interviewee 2 explained, they build on each other and create an overall adverse effect.

Interviewee 3 describes the lack of respect misgendering conveys and emphasizes the built-up emotional effect constant misgendering can have: "Basically...it says that... their view of me is getting prioritized over who I actually am. It's just a lot of erasure. I've spent 30 years of my life trying very hard to fit this mold of "she" and it doesn't fit! But you know every time I get that, it's someone trying to force me back into that mold. It just... it builds up over time. If it was once in a while, you just shrug it off and everything, but when it's constantly happening, it's really frustrating."

Misgendering can also have especially strong immediate effects. Interviewee 4 illustrates: "It ruins my whole day! It's like... debilitating... it is really hard for me to do anything afterwards, I get really super depressed and have a lot of anxiety... I don't think people realize the power that misgendering has... because if someone is in that room where I get misgendered and I have to be like 'no these are my pronouns,' there's a very big possibility that I could have violence inflicted on me [on the street or in a clinical setting] if someone overhears that conversation. And I don't think that everyone at student health services recognizes that, so that's really hard. So yeah. It's not a situation I like being in. And there's been times when I've cried coming home from student health services or a doctor's visit... it is really hard for me. And really hard for all the trans people I know."

For some, like interviewee 1, misgendering is a less severe inconvenience: "I got a concussion and no one knew my pronouns or... my name... so that was kind of weird... they took care of me. It was just awkward because... that wasn't my name..." However, they followed that statement with: "...but like also I had a

concussion, so that was more important.” Transgender patients have to prioritize receiving the care they need over sub-par communication.

Interviewee 3 supports this by explaining why misgendering has less of an effect on them personally: “...with as much as I’ve been in and out of the medical stuff, *I’m really assertive*. Which... you shouldn’t have to be able to push your doctors to be able to get good care. But that’s kinda where we are. I don’t have a lot of problems, and you know there’s a lot of cases where if I know I need the care, I’ll just ignore the fact that I’m getting misgendered constantly... I had to find a new dermatologist recently, and it was just constant misgendering. It was just not worth fighting that fight at the moment you know. It’s always kind of a balance of is it worth fighting this or it’s just easier to just ignore it.”

So, some transgender patients become assertive through experience and are able to navigate the oppressive system to receive adequate medical care. However, this is more challenging than for cisgender patients, demonstrating inequality between cisgender and transgender patients receiving satisfactory care. Transgender patients learn to tolerate incompetent language, but this shouldn’t be a criterion to receiving quality care. Patients shouldn’t have to fight to be recognized and believed. “...the biggest thing is I’ve had a different experience from what a lot of people do dealing with insurance and healthcare providers... I just have a lot more tools for dealing with everything than a lot of people do. *And people shouldn’t have to develop those tools*. I don’t want people to have those tools because it means that you’ve gone through so much crap! I want people to be able to go and be believed and get the care they need” (interview 3) (my italics).

Paperwork

The process of misgendering often begins with documentation such as intake forms, which usually allow designation of either “M” or “F” and no other genders. Before a patient interacts with a nurse or doctor, they are already being set up for improper communication.

In addition to lack of diversity, transgender patients' information can be entered wrong in the system: "I definitely find that there is a strong push-back, even from supportive doctors, to leave your marker in their system with whatever you identified with, with whatever your birth certificate originally said. They've got the arguments of, 'We need to know what we're dealing with!' But I'm like... that still doesn't TELL you anything. You know... you want to stick an 'F' on my chart but there's no reason for that! It flags me to tell you, 'Oh! I need to get pap smears!' except for that I don't have a cervix! So I don't need pap smears! And you know with a lot of the other risk factors, it switches to whatever is based on your hormones... the only hormone I have right now is T [testosterone]... I've got more of the male risk factors, not the female risk factors. So it's, it's not telling you anything other than the specific anatomy between my legs. It's not giving you actual good data" (interview 3).

Interviewee 3 continued by describing a model that they believe is superior to the existing system: "And I know some places are starting to try to move towards a model where it's more of kind of an inventory... 'these systems are present in this person that need to be monitored. Do you have a cervix? Regardless of your gender, do you have a cervix, do we need to check it?' And the thing is... that is going to give better care for cis-patients, also! Like, some cis women don't have a cervix either! And don't need pap smears! So this will quit harassing them about it! You know, if you've got a woman who had a mastectomy for her breast cancer, don't have her system flagged for mammograms! There's no reason to have a 'One size fits all' thing. We need to be able to have ways of personalizing it."

As interviewee 3 mentioned, keeping the gender assigned at birth in the chart instead of the patient's actual gender does not necessarily provide useful information. Instead, interviewee 3 recommends an inventory system where specific physical systems are recorded. "Especially with improved technology, it's really not that hard anymore," interviewee 3 says, "...build the database to be that way. And it's also super hard to change any of your information. I was one of the first people to go through the courts here in Oregon for the nonbinary gender designation, and you can't

change it to that in any of the systems! ...it still hasn't propagated out! It's just a huge pain.”

Interviewee 3 continues, “...I just had top surgery at OHSU, and I was getting ‘she.’ I’m like... why would you ever default to ‘she’ for someone who’s having masculinizing chest surgery. Why would you ever default to that? Like, you’re going to get people who still have an F on their charts... and the other weird thing is in their clinic, when I went in for the consults and everything... their system captures your pronouns and everything. So it’s... they have that information! And it’s not getting propagated down to the OR staff. It’s just super frustrating.”

Many systems don’t allow the input of a patient’s correct gender, while others allow it but are not consistent with other systems, even within the same hospital. Even when doctors are seemingly educated about a patient’s gender, their documentation can be surprisingly inaccurate. Interviewee 1 discusses such a case regarding a therapist who they switched to after a bad experience, “...I saw him for like 3 months over the summer... it was a lot better because he wasn’t a gender therapist or anything, it wasn’t his specialty, but he was gay... he was in the community for the most part ... I read the letter that he wrote to support me starting testosterone... he kept using ‘she’ pronouns and my old name and it was very weird... I was like, I talked to him for 3 months about me being trans...” This therapist had spent three months talking to his patient—he was familiar with the pronouns, but refused to use them anyway. Many medical record systems are not compatible with a transgender medical system, which is a problem, but this therapist was writing an open-ended letter—there is no excuse for his behavior.

Other language mistakes

Misgendering was mentioned the most often by all interviewees compared to other language mistakes. However, medical care providers can have other areas of incompetency that can make patients uncomfortable and decrease quality of care. Here, I focus on inability to competently question the patient, clumsy attempts to relate to the patient, and inappropriate body comments.

Interviewee 4 described their search for a new and competent physician when they first moved to Oregon: “So when we first got here and didn’t know anybody, we went to see somebody and she was horrible! ... She was very... ‘Oh yeah I’m from California, I have so many gay friends’ and I’m like ‘that has nothing to do with being trans!!’ Like I understand, but like, what? I know you’re trying to be cool right now, but like, no. She was horrible. She, like, described my parts as ‘lady parts’ and I was like... Stop it!”

In this quote interviewee 4 presents two types of language incompetency: focusing the conversation on themselves and immature referral to body parts. In the first, as interviewee 4 points out, the physician is desperately trying to build rapport, but is doing so in an irrelevant and distracting way. She is attracting attention to herself and not focusing on the patient’s actual medical situation. Additionally, she uses language to describe genitalia that is inaccurate, uncomfortable, and immature. It is especially inappropriate given that the physician knows the patient’s gender identity and preferred pronouns.

Physicians may also avoid asking questions pertinent to a patient’s care, possibly due to their discomfort or inexperience with transgender patients, which can result in lack of important care. Interviewee 1 described such a situation where a physician avoided certain parts of the physical exam instead of inquiring about the patient’s chest binder (an article of clothing used by some to flatten the chest): “Back home, I got a physical done right before I came to school, and there were a couple things that were weird, because... when she was doing the physical I was wearing a binder... and she didn’t, like, acknowledge it, but she also didn’t ask if I could take it off or something so that she could finish doing the exam... she just kinda went over it... she didn’t finish doing a proper breast exam or anything... probably due to her own discomfort, not wanting to ask, but... I feel like they should be more educated on... if they’re gonna work in the medical field- how to deal with people!”

Physicians can distract from proper health care by engaging in political discussions. When asked what they think are the largest barriers to improving transgender care, interviewee 4 answered: “How politicized trans is. Again... there’s a left or a right side to the belief on whether or not a person should be trans, which is

the hardest part about it. Because if you were to be, say, a republican and a doctor, you're taught to believe certain things, I think, about the way trans people are allowed to exist in this world. And even with democrats—like, if you're a democrat, you're taught to believe certain things about trans people. So that's, I think, the hard thing about – our identities are so politicized, and what comes in with that is political conversations with your doctor, which I don't want to have! About whether or not you're allowed to even exist. Which I do. I exist whether or not you have an opinion about it, so. So the political part about it is the hardest part.”

Commentary

One of the biggest language mistakes that health care professionals make is misgendering, which can be intentional or accidental. Intentional misgendering occurs when a person has knowledge of an individual's gender, but refuses to acknowledge it. Regardless of its intent, all misgendering can have a strong effect on transgender people. Accidental misgendering may appear harmless and may appear to happen to everyone, not just transgender people; however, accidental misgendering can have a stronger emotional effect on transgender people than on cisgender people because it adds to and exacerbates the stigma transgender people are already experiencing. It is the proverbial “last straw.” Some may argue that it is impossible to know everyone's gender, but that leads to another language mistake: the inability to ask sensitive questions. Competent question asking is discussed in the section titled “Other language mistakes.” Competently inquiring about a person's preferred name or pronouns helps to create a more comfortable environment and decreases accidental misgendering.

Although learning to ask questions is instrumental in creating a welcoming environment for the patient, it is understandable that not all physicians will be able to master the skill immediately. Interviewee 1 says that they would rather a physician ask a question awkwardly than not at all, because avoiding the question altogether can result in the absence of necessary care, such as completing a physical exam. Although we need to be careful to keep the standard of care high, there does seem to be a ladder

of gradual improvement that a professional could climb, perhaps in this order: do not turn away transgender patients, listen to their concerns, ask questions awkwardly, learn to ask questions competently, advocate for your patients.

Interviewee 4 brought up a fascinating point about politics and health care—although the two may currently be inseparable at the federal level, politics mentioned in the waiting room waste valuable time, exhaust the patient, decrease their chances of returning, and distract from the actual medical issues that need to be addressed.

Chapter 5 - Assumptions, boxes, and intersections with mental health

“Everybody’s transition is different” (interview 3).

Halem (2016) explains that “...our first reminder about the barriers that folks are facing in healthcare is that they’re experiencing and expressing gender in a wide range of ways... there are folks who identify clearly as transgender. There’s more often people who are coming to it over time, living in different ways and expressing themselves. In a healthcare setting, some of that can be confusing for providers. We live in a very gendered world.” Halem highlights the barrier that “...that need for clarity around gender can... create a hardship for everyone involved.” Thus, she refers to many healthcare providers’ need to categorize people, which can be aggravating and unhelpful for patients. The interviewees also discussed difficulties with assumptions relating to their nonbinary identity, including suggesting unwanted procedures, assuming physical appearance based on a traditionally gendered name, and medicalizing their gender identity as a mental disorder. Transgender patients are often placed in metaphorical boxes based on health care providers’ preconceptions which can eventually be detrimental to patients’ mental and physical health.

Assuming the binary

Interviewee 4 discussed issues with building trust with their physicians when discussing their gender identity: “...basically, you have to go to the doctor and give them a Trans 101 and they still don’t believe you, because they’re like ‘nonbinary—whaaattt??’... it’s very interesting, because they just expect a binary, and you come in not being binary and they’re very confused...”

Interviewee 3 explained that everyone has a different journey through gender transition and wants to present themselves in different ways: “And that’s something else that you see normalized. Everybody’s transition is different. Whether it is entirely just presentation, or whether you do hormones or whether you do surgery. For a lot of people surgery is scary.” Despite many transgender people not desiring

hormones or surgery, hurtful assumptions can prevent transgender people from receiving the services they need—for example, Texas requires reassignment surgery in order to change gender on a birth certificate (interview 3). This can be hurtful to people mentally if they cannot change their documentation to match their identity, or it can hurt them both mentally and physically by coercing patients into unwanted procedures. Regardless, as mentioned earlier by Rentmeester et al. (2015), such general assumptions and stigma can creep into clinical settings, as well.

Interviewee 4 described their transition journey as being difficult, partially because many people have assumptions that nonbinary people are not “trans enough” if they do not fit into boxes created by the binary: “...I think there’s this narrative out there that trans people have a starting point and an ending point, and for me that’s not necessarily true. Like, I don’t want top surgery, I don’t want bottom surgery. I just wanted hormones because I identify as genderfluid and nonbinary, and it’s that little area that is a lot more confusing to explain to people...But yeah. There was always this narrative that you have to feel a certain way in order to be trans.”

Interviewee 4 continued discussing their health care difficulties with doctors’ assumptions or efforts to categorize the patient as something they’re not: “...they try to like... eh especially me, I say that I’m transmasculine. That does not necessarily mean that... it just means that I’m leaning a little bit more masculine. It does not mean that I am a man. But people take it as that, and so like even when my therapist wrote my letter for T, testosterone, she wrote it coming from a masculine scale, and I was like ‘Eeeehhhhh! It gets me testosterone, I guess??’ But it wasn’t really saying what I really wanted it to say.” In this way interviewee 4 explained their need to compromise the way they present to a doctor in order to receive certain health care.

Although some may say that this should not matter if the patient still receives the care they need (in this case, testosterone), this type of assumption can have an undesirable mental effect on the patient: “...this moment where you feel like you’re not... trans enough. Which I’ve been talking about with a lot of trans people. Is that like... when you’re nonbinary, you feel like you’re not trans enough. So when your doctor is trying to more masculinize you or feminize you, you feel like you’re

supposed to do that because your doctor is saying that, when that's really not how I feel. But everyone masculinizes me more than I want to be."

Assuming appearance

Interviewee 2 discussed assumptions doctors can make about a patient's appearance based on a traditionally gendered name: "I broke my foot recently, so I was in and out of the doctor's a lot recently, and just *my* biggest thing with the health care system, just because my legal name is still [traditionally female name] and I'm still presenting very masculine nonbinary, and so for example when the radiologist stepped out to get my foot x-ray, he... I knew he was obviously looking for me, but he like scanned the room, skipped over me, and was like "Uhhh is [traditionally female name] here?" And I stand up like 'yeah that's me' and he's like 'Ohh I was looking for someone else!' So I think my biggest thing is like not to generalize what people look like just based off of their name. Because... the name [traditionally female name] is fine as long as I go by [nickname], but... I wouldn't have an issue with it if people didn't have that association of a femme person being named [traditionally female name]."

Interviewee 2 describes the general response people have when they find that their assumption was wrong: "... from what I remember from when I was presenting more feminine, versus now where I'm more masculine... people are now more uncomfortable or uneasy. I guess they just don't know how to interact with me, or it at first throws them off like 'Oh my gosh you have a lot higher pitch voice than I was expecting!' or something like that. So I can definitely see it on their face..." This type of reaction is common in interviewee 2's everyday life and projects into clinical settings as well, making them uncomfortable.

Intersections with mental health

As seen previously, Rentmeester et al. (2015) highlighted ways in which physicians can overemphasize mental illness in transgender patients, one of which is

to require patients to present with a mental illness they don't actually have (such as gender dysphoria) in order to receive treatment (Rentmeester et al.). As a result, patients avoid treatment or are coerced into feigning an illness that they don't have; meanwhile, their real medical issues go untreated (Rentmeester et al.).

Interviewee 2 has been diagnosed with such a disorder in order to receive transition care such as surgery or testosterone. They say that such diagnoses are a problem because physicians are medicalizing something that is not actually a disorder: "And it's...weird... the way that I have to be diagnosed with a disorder in order to get those benefits...it's just... like, it's not medical... it's not a disorder... it is medically necessary just so that people can feel comfortable. .. that's just an issue." In this way, interviewee 2 discussed the difference between diagnosing identity as a disorder and simply offering procedures that a patient desires.

Interviewee 4 has had extensive experience with what they call 'gatekeeping,' which is doctors deciding what is best for the patient instead of the patient being informed about procedures and choosing their best options: "...we call it gatekeeping. There's a lot of stopping along the way with getting health care, especially with trans related care. For instance I had to get a letter from a therapist before I was allowed to go on hormones, even here, which- in San Francisco, and other parts of the nation, is not required. Why do we have to do that? We're not insane if—because we want to change our gender! Like, gender is a social construct!"

Gatekeeping is not only frustrating and burdensome for the patient, but also a financial stressor: "...there's just a lot of gatekeeping. And a lot of people of color, trans people of color, cannot go through every part of that gatekeeping, because with that gatekeeping comes more money and more money and more money, so like- it costs money to go see a therapist. It costs a ton of money to go see a therapist! Like, it is so easy to get it done while you're in school, because you have free therapy, but like... if you want to do that in the outside world. Like \$200 a pop? And even having insurance? Like, what? That's so much money! Especially if you want to go see a psychiatrist. That's- aahhh! So much money!" (interview 4).

Interviewee 4 continued to elaborate on the issue: "...and we don't have the money to do that. We're barely surviving! I can say that for most of my friends... no

one I know is doing well...there's just so much gatekeeping every step of the way, and it doesn't have to be that way. *If we want to be trans, why do we have to go through every hoop to prove that we are that way?* I do not understand... we don't have access to health care, we're not allowed to get the things that will help us be able to thrive as human beings, like trans-related health care. 'Cause we can't access it!"

Commentary

Modern medical care emphasizes informed consent and the decline of paternalistic care, and yet this approach seems to contain a set of disclaimers, because gatekeeping still exists. One of the main issues with gatekeeping is the assumption that a physician understands a person's gender identity more than the patient themselves. This toxic mindset imposes unnecessary financial costs and emotional burdens and removes from the patient control over their own health care.

Categorizing is a human instinct and generally unavoidable, but not everything needs to be categorized. In situations where categorization is helpful, it is necessary to understand that most things do not exist on a binary, including gender. The patient understands their needs best, especially pertaining to their identity; it's past time that doctors use available resources and make true efforts to creating a comfortable environment for their transgender patients.

Chapter 6 - Emotional labor of reporting and educating

“You shouldn’t have to be an activist just to exist” (interview 3).

As mentioned previously, transgender patients often assume three roles in health care: educator, advocate, and patient (Rentmeester et al., 2015). This puts considerable strain on the patient. Physicians can feel threatened and act defensively, which increases patient fears and anxiety even more (Rentmeester et al.). Two things may happen as a result: either the patient avoids healthcare altogether, or the patient continues receiving unsatisfactory care while concealing potentially relevant information because they fear mistreatment (Rentmeester et al.).

We will now focus on the ‘educator’ role. Some people may argue that transgender people should spend time educating physicians since transgender people know their situation best; these same people might ask why transgender folks do not simply report negative experiences. However, educating and reporting can contribute to poor health. In this chapter, interviewees discuss the strain and emotional labor that accompanies educating physicians or reporting biased encounters. Some patients spend excessive energy, others do not know how to report, and yet others avoid educating or reporting altogether because of the associated anxiety.

Educating

When asked whether they ever correct or educate their health care providers, interviewee 2 said: “Never. It’s too draining of a conversation. And it’s usually like... this is going to be stereotyping but... older folk past the millennial generation that haven’t been too exposed or at least- Again, I’m making assumptions... but I don’t bother because it’s just a waste of my energy and time... I only ever really correct people if I’m going to be seeing them more, but that’s like the only time. At least if I get my primary setup, I might be like ‘Yo primary, these are my pronouns. I haven’t had a primary in forever so we’ll see if that happens.” Interviewee 2 continued describing a situation where their radiologist called their name, which is traditionally

female on their documentation, and was clearly looking for someone presenting feminine: “I was almost tempted with the radiologist blatantly scanning over me, just being like ‘Don’t make assumptions that people look like that’ but then I was like ‘Ehh not worth the energy.’”

Interviewee 4 agrees that educating physicians is mentally exhausting: “...it’s emotional labor to have to teach your doctor something they should have learned in school, or should have learned at some conference that they went to. It’s very tiring to have to explain that like all the time. And like, at every visit, too.”

Reporting

Interviewee 2 said that they rarely would educate someone, but they might report if something were to go terribly wrong. However, they wouldn’t know where to go to report, which is yet another barrier to quality care: “I feel like if something did really affect me or bother me, I would report it. I think it would be a means of... how to do so would be the thing... the biggest turn-off is not knowing how to report it. I feel pretty confident that if I knew how, and then something did happen, I definitely would.”

Interviewee 1 avoids reporting instances because often biased encounters are very likely because of gender identity, but impossible to prove: “I would probably report it if I knew for sure that that was the reason... I didn’t report anything with the doctor when I was trying to get the blood panel... I didn’t know for sure what her motivations were... But, if I knew for sure that that was the reason, then I would probably report it.”

Interviewee 3 said that they’re improving their skills in reporting instances: “I’m starting to get a lot more assertive about it, and part of it is, since I’ve started transitioning, my mental health is like... it’s a million times better. So, I’m a lot more outgoing and assertive and a lot more of an activist honestly.” However, they explained that they’ve had to work up to this confidence and that being assertive and willing to fight for equal treatment should not be a prerequisite for quality care: “I’m

really assertive. Which... you shouldn't have to be able to push your doctors to be able to get good care. But that's kinda where we are."

Interviewee 4, in contrast, discussed that they wouldn't report because, even if they know how, it never goes well: "The thing about being trans and mentally ill is that most of us will not do that. Because it's *too much mental and emotional labor* to do something like that. So like every friend that I know that has had a horrible incidence [sic] with a doctor or mental health person has just stopped going. I only know one person in my life who has ever made a report and it never went well. It just became like a 'Oh this trans person like blah blah blah.' It never went anywhere. So like for us there's already institutional harm happening, there's already discrimination happening, even if you brought it to an upper level, it's still going to be discrimination at the upper level, so for us it's like... there's really like nothing to do with that, we just stop going."

Interviewee 4 described that transgender patients are rarely taken seriously when they report negative experiences and that most avoid health care instead of reporting. Interviewee 4 also explained that transgender patients are aware of the consequences of avoiding health care, but resort to avoidance anyway because it is preferable to suffering through the emotional turmoil.

Commentary

The only role a patient should be playing is the role of a patient, yet transgender people often take on 2 additional roles: educator and advocate. Educating physicians on the best way to care for transgender patients can be emotionally exhausting, which can be detrimental to mental health and can contribute to avoidance behavior. Some patients do not report biased health care because they are not sure of how to report and others do not report because they cannot prove that the event happened. Some patients are skilled at advocating for themselves, but that should not be a requirement for adequate care. Overall, educating physicians and reporting inadequate care requires excessive energy and is rarely effective.

Chapter 7 - Avoidance

I avoid going to health care as much as possible because every time I've been has not been a good experience." (interview 4).

As mentioned previously, more often than not transgender and gender nonconforming people are afraid to go to the doctor, resulting in health care avoidance (Halem 2016). Even if they finally are able to find a competent doctor, they may still be hesitant to offer sensitive information pertinent to their health because of past experiences and fear (Halem). Such negative experiences can include improper language use, imposing opinions, and uncomfortable waiting room environments.

Examples of avoidance

Interviewee 3 describes avoiding medical care because of misgendering, "So one of the effects of the Sjogren's syndrome is it dries out my eyes and my mouth and everything, which with dry mouth you run a lot of risk of tooth decay and stuff, and I've been putting off going to the dentist because I didn't want to deal... like especially before my name changed, before I got things changed in my insurance, I just didn't want to deal with it. And it wasn't like an urgent thing that I had to do, so it just keeps getting pushed off. And the same with the dermatologist. I should've been there several months before I actually went, but it wasn't an urgent thing! So that's really how it ends up being. Stuff that I have to have to be able to function day-to-day and not be in pain, that stuff I just deal with it. But you know with the stuff that can be avoided... and I say that as someone who knows how important it is to get preventative care! Like, I know this! And yet, it's just... I'm hoping it'll be a little less miserable now that I've had the top surgery and gotten the name change and all of that... because the name was a huge fight, cause you know having my 'dead name' on everything, it was just... it was awful."

Interviewee 3 described avoiding the dentist, but also avoided the dermatologist for months based on previous experiences with misgendering; the problems continued when they finally went and now they are going to search for a new specialist, potentially re-starting the avoidance cycle: “I definitely won’t be going back to the dermatologist that I recently had. It was just... weird. Because they kept gendering me as female, but I know they saw my driver’s license, which at that point had male on it... everyone just got weird.”

Interviewee 2 described factors contributing to uneasiness seeking medical care. They explained why mustering strength to set a gynecologist appointment may be harder for them than for cisgender patients: “...definitely I feel uncomfortable... making a gynecologist appointment. I don’t want to go there and have all the people in the waiting room be like ‘Yo, what is this masc person doing here?’ Masc- I mean masculine- just to make sure it’s clear on the record... the gynecologist, I am afraid to go to that. I think it’s mostly the... other patients... I imagine a physician would be chill, or I mean fine- like the one I saw before, she seemed very nice, but that was before I was presenting more masculine- but yeah, it’s more a sense of them feeling uneasy or just... awkward.” They mentioned that discomfort starts as early as the waiting room because other patients may judge appearance. Although interviewee 2 had a good experience with the physician before they were presenting more masculine, their experience could be different post-transition.

Interviewee 1 describes a poor experience with a counselor at school, where the counselor inappropriately imposed their ideas on the student, despite the student’s requests to change the subject: “Once in high school I went to go see a [counselor] for... it wasn’t directly regarding gender issues or anything, I had stuff going on with my parents and my then-girlfriend, and I brought up that I thought that maybe I was trans to the [counselor], kinda just because I was talking about things that affected me, and it just was a very negative experience. She kept giving me her opinion on people who are trans and it was just not something that I wanted to hear and after I left... and I also stopped telling her more about it, because I was like ‘I don’t want to talk about this with this person’, and she just kept talking about it. And finally I left, like, time was up... and... I didn’t go to work that day, I kinda just sat with mom and

kinda just talked to her... and it was not a good time... Actually I did not go back to therapy for... I didn't try to go back to therapy for like 7 months." When asked to expand how interviewee 1 was affected emotionally over those 7 months, they explained, "I just kinda dropped trying to process ... feeling that I was trans... that I kinda knew that I was trans, and I just kinda ignored it, because I also didn't want to go through having to talk to somebody about it again, and yeah... I just kind of pushed that aside. Didn't, like, think about it."

After this encounter with their counselor, interviewee 1 avoided their healthcare: they did not attempt to return to counseling or therapy for 7 months, even though they wanted help processing their gender identity. Although school counselors are not trained therapists, I would argue that they are medical professionals in some sense, as students often seek their advice before they attempt traditional therapy. Interviewee 1 avoided professional therapy, which can be useful health care, because they were afraid that the therapist would react in a way similar to the school counselor, which would be distressing.

Consequences of avoidance

Interviewee 3 described the consequences of avoiding medical care: "...there also needs to be an expectation in the community that you have to respect someone's gender. If you got doctors that are misgendering people, *your patients are not gonna come in. That's how it's gonna work. And people are gonna die.* Because they're not getting care. You end up in the mental health field, too. We see a lot of data on the issues with things like conversion therapy for gay and lesbian kids and stuff- that stuff goes on with the trans community, too. You've got to have a standard that says 'care for these people and respect who they are.' And I think that doesn't exist yet, especially... outside of areas like here in the I-5 corridor."

Interviewee 4 and interviewee 2 provided statements supporting Interviewee 3's sentiment regarding the way medical care avoidance affects the transgender community. "I wish doctors would know how important this is. Because there are people who are literally dying... who really need to see a doctor... I know so many

trans people, like, lots of trans people who, because of the history of psychiatry or mental health or going to see a doctor, don't go see them... and there's a lot of salient identities in that, too, like if you have a trans person who's mentally ill, it's really hard to go see the doctor. Especially if you have severe anxiety. Or severe depression, which a lot of trans people have. And so if you even try to go see the doctor, and they do something even slightly off, you're less likely to go to the doctor again. And so I know that like... people do mistakes, and it's happening, but like, they're affecting so many people! From being able to get the health care they need." (interview 4).

Many doctors may not understand how even small mistakes can add up and easily influence a transgender patient. Although physicians are human and everyone makes mistakes, the lack of attention to creating an inclusive environment is driving patients away and contributing to poor health outcomes in the transgender population. "...there's so much that goes into the health care that ... parts of our lives... that many of us don't live past 50 years old. Especially trans women of color. So I would say that... literally your language and the way that you act in health care may or may not kill someone. And I don't think that they realize how important that is" (interview 4).

Both interviewee 4 and interviewee 2 support the idea that unwelcoming medical environments due to poor language or actions can drive away patients, preventing them from receiving care. Additionally, interviewee 2 points out that influencing avoidance behavior detracts from preventative care—instead of preventing medical issues and easily treating small problems, patients wait until symptoms become severe to finally seek help: "...not being heard, or not being validated or supported... that influences people not to come back and then they get sick and they could've gone to something that would have been simple, but then didn't and it got worse, so now it's this big complicated thing. So I think making it a welcoming environment... a more *preemptive* move, does that make sense, than trying to treat the symptoms." (interview 2).

Commentary

Factors such as improper language use, imposing opinions, and uncomfortable waiting room environments can all lead to transgender patients avoiding health care, which can have severe health consequences for the community. Although this hasn't occurred to the four interviewees in this study, avoidance behavior could potentially prevent a person from obtaining life-saving procedures. The interviewees did bring up avoidance of preventative care, which is crucial to the well-being of a patient. Avoidance due to misgendering, uncomfortable language, assumptions, and other inconsiderate medical care can lead to minor preventative care issues that build up and become issues for critical care interventions or chronic care management. Some issues may be extremely inconvenient, while others become situations of "life or death."

It is true that many people, not *just* transgender patients, make determinations about what's "urgent" and what can be "put off," so avoidance due to misgendering, for example, is interwoven with avoidance that most patients do, regardless of gender. Although many people avoid health care, transgender patients have additional reasons to avoid, which can lead to worse health outcomes than for cisgender patients. This is because transgender patients may be avoiding their health care more than the average patient, so exacerbated problems may become that much worse.

Additionally, the average cisgender patient may be avoiding health care out of sheer convenience—going to the dentist, for example, can be physically unpleasant. Transgender patients, on the other hand, avoid health care for the additional reason of emotional discomfort or distress and losing trust in their health care provider. These are very different situations. The latter must be addressed.

Interviewee 2 also stated that they may avoid health care because of judgment from other patients in the waiting room. Many cisgender people may have experienced some form of waiting-room judging; however, this sort of attitude weighs on transgender patients more because of its invalidating nature. Such microaggressions build on previous experiences and general stigma and can exacerbate emotional experiences for an already-vulnerable population.

Chapter 8 - Geography, intersectionality, and privilege

“There’s only one person you can go to in the entire state [Utah] for trans health care!” (interview 4).

All 4 interviews sustained a common theme: health care quality varies vastly across the United States. States such as Oregon and California may generally have better programs and health care for transgender people than other regions around the country; however, they still have problems and health care is inconsistent across the country. As mentioned previously, a few hospitals have improved equitable care—both Mass General and Mount Sinai Health System, for example, offer transgender patients the option of a private room or housing according to their gender identity (Ellin 2016). Ellin also mentioned that although some places like these have made positive steps in transgender inclusion, these changes are not happening everywhere and most medical schools do not prepare students to treat this population. All interviewees praised parts of Oregon’s transgender health care, but criticized other aspects and mentioned regions where care may be less effective. Intersecting identities can also contribute to differences in health care quality, especially for transgender women of color. Unlike other chapters, this one contains categories separated by interview number.

Interviewee 1

Interviewee 1 mostly emphasized their luck with growing up in California and now with living in Oregon. They specifically felt lucky that they had access to decent insurance in their home state: “...in California there’s a law that insurance companies can’t discriminate against any sort of care based on the fact that it’s for trans care, so... pretty lucky to have that... I’ve never had any problem with an insurance company.” They then continued explaining how having good insurance helped them receive most of the care they need: “I haven’t had any major conflicts or difficulties

getting things done. If anything, it has been easier for me than most people just because my parents have very good insurance. So for the most part it's pretty good."

They then remarked that Student Health Services (SHS) at OSU, as well as the Portland area, are probably better than most at providing quality care for transgender students. Interviewee 1 explained that the staff at SHS makes a conscious effort on behalf of transgender patients, which makes interviewee 1 feel more comfortable: "I trust SHS a lot more now just because... just the care that they give, like writing down my name, just little things like that is ... why I... don't have a problem going to SHS."

However, interviewee 1 acknowledged that quality of care varies according to location: "...the fact that not every state is like California, there's not those laws everywhere to keep people from discriminating against... people who are trans." There are locations where interviewee 1 would feel uncomfortable or unsafe seeking medical care: "I feel like I probably would be a little hesitant to go to a new doctor- or go to the emergency room or something- right away, because people are going to react. Also, depending on where I am... like for example my parents moved to Long Beach so I don't have a problem going to a hospital in Long Beach, just because there's a very prominent LGBT community, so I would feel pretty safe. But... I'm going to Iowa with my parents, so... I feel like if something happened there, I'd be... hesitant... to... go to the emergency room..."

Overall, interviewee 1 feels comfortable at many places in Oregon and California, but would be uncomfortable going to a new hospital, especially in other states like Iowa.

Interviewee 2

When discussing geography, interviewee 2 described their luck with health care in Corvallis, Oregon: "At least with being in Corvallis, I'm pretty fortunate. I mostly just go to the Corvallis Clinic and stuff. I don't know how it is at Student Health Services here." As seen in previous chapters, interviewee 2 has experienced issues with health care quality such as misgendering. Regarding SHS, interviewee 2

remarked: "...I feel like that probably they're more accepting... than the Corvallis Clinic... at least they see more queer college students going to SHS. I know a lot of friends at least who are on hormones have gone through Student Health."

Interviewee 2 acknowledged that having access to health care in Corvallis may be a greater privilege than in other areas, but reminded that problems with health care remain in the region.

Interviewee 3

Interviewee 3 explained that they do not often encounter problems with insurance companies—partially because of their experience and assertiveness and partially because of their good insurance plan: "I've got a lot of experience navigating that, but some of it also is we got a lot of things... our plan specifically is... cause I am a graduate assistant here, so I've got the insurance plan that's been negotiated by the union, so that's a really strong plan that we haven't had problems with for me..." They continued describing their health care experience beyond dealing with insurance companies: "I'm still going to get most of the care I need, especially here in Oregon. Other places, I would be more worried. Because the default assumption would be that I was just... a 'butch lesbian.'" Interviewee 3 thus explained that many places would not be prepared to understand their nonbinary identification and would probably be unsupportive.

Interviewee 3 compared their relatively positive health care experience in Oregon with their experience in Atlanta, Georgia. They explained that transgender people tend to move to safer places with better health care, but that not everybody is able to move: "Oregon... especially along the I-5 corridor, is better than a lot of the rest of the country... You do kind of sometimes get groups, because you know... we kind of flock to each other, because it's safe. People that have the *ability*... move to places where they are protected. I'm here. I grew up in the South. Atlanta."

When asked to elaborate about their experience in Atlanta, they remarked: "It was different. There's a lot of things about Atlanta that I miss. There's a lot of things I don't miss. So it's just different... here I can't be arbitrarily fired. I can't be

arbitrarily kicked out of my apartment. And I would not have ever been able to get nonbinary designation in Atlanta.” The daily stigma experienced by transgender people projects into clinical settings as well, threatening additional harm to their health (Rentmeester et al., 2015). Because general stigma tends to show in clinical settings, it is possible that the health care in Atlanta is as biased as the general attitude towards transgender citizens in that region.

Interviewee 3 also expressed concerns with traveling: “I always get worried, you know, I travel to conferences and see family or whatever and I always worry if I get injured or something and have to go to a hospital... what is THAT gonna be like? You know... we get to these states... and they’re passing bills to say a doctor doesn’t have to treat someone that they disagree with, and... you know you get to these things and it’s like... what would happen if I went to a hospital in one of these states? And I know a lot of people don’t travel. You know... for stuff like that. Which is.... No one should be afraid of traveling for these reasons. No one should be afraid to go to the hospital. And... to get regular care! There’s so much stuff that... won’t get to a crisis situation if you have a doctor you can go to before it gets severe. But if you’re facing a doctor that’s constantly going to misgender you, or completely invalidate you, it... it’s awful.”

Although several interviewees’ personal experiences with health care in Oregon have been positive, they acknowledged their various privileges compared to, for example, transgender women of color. Many people of various demographics are not receiving quality care, even in Oregon, which is discussed at the end of this chapter.

Interviewee 4

Interviewee 4 also acknowledged Oregon’s generally better health care compared to other regions: “So...here at Student Health Services, you can get hormones if you want to, there’s recommendations to go to OHSU, right...”

They then contrasted this with the situation in Utah, where they grew up: “...there’s no OHSU in Utah! There’s no place that’s doing really great transgender

health care. There's one person and she has had to learn a lot! ...she went to a conference and that's the only reason that she is like, an 'okay' doctor. She's not like, super great. So... there's only one person you can go to in the entire state for trans health care! So that's why it was very hard— I did not know how to do that, so I didn't start hormones until I got here, 'cause it was too hard to get in... she's like months scheduled out because she's the only trans doctor in the entire state. Utah's just a very different place.”

In addition to discussing the one competent doctor in the entire state of Utah, interviewee 4 explained that religion can play a factor in Utah medical care, obscuring transgender patients' privacy: “I grew up Mormon. I am an ex-Mormon. There's this kind of... fellowshipping that happens with Mormons. So... for instance my partner was seeing a doctor at Student Health Services at our undergrad... we were at the same- we moved out here together. And they were, like, in the same ward as their mom and [the doctors] told their mom what happened in their doctor visits... nothing's a secret in Utah. So... your doctor is a bishop probably who's in someone's ward and will get it back to your parents. So like, there's no secret...” In response to a statement that this kind of action is completely illegal, interviewee 4 exclaimed: “Yeah! I know. They know that, too. They still do it... how I believe Utah Mormonism is, it's very much a cult of... you have to look and act and do certain things and you're going to be socially ostracized... and so that was what it was like going to a doctor: *wondering whether or not the information was going to get back to my family.*”

Intersectionality and Privilege

Both interviewee 3 and interviewee 4 emphasized intersectionality, or the way various combinations of identities or social categorizations such as race and socioeconomic status contribute to varying experiences with bias and discrimination, in this case, in health care. For example, although interviewee 4 is transgender and suffers from health care inequality, they emphasized how the situation for transgender people of color is even worse, because of the additional stigma associated with their

other identities. Interviewee 4 is often afraid of violence that may happen in a waiting room, for example, but says that violence is a reality beyond fear for people of color: "...I'm a white trans person so it's different, but like... it's not that it doesn't happen to white trans people, it's that it happens more often to people of color... trans people of color... but there is a possibility [that it may happen to me]."

Interviewee 4 elaborated on how identities cannot be separated when considering health care because they all contribute to the patient's unique experience: "... especially with mental health care people... there is a long history of causing a lot of harm to different groups, and not just trans people. People of color have been mistreated, lots of groups have been mistreated by the health care industry, and so – you have to recognize also... that if you have a black trans person in your office, you can't separate those issues. They're one person. They are black and trans. And that's a different experience from someone who is white and trans. Or whatever. And so... our salient identities are important to us and you can't separate them. Even the ways that inclusive language and diversity training has to be taught, has to come from an intersectional lens. Or it's not going to be good."

Interviewee 4 believes that one of the greatest health care risks to the transgender community in general is health care affordability, especially for people with less privileged identities: "I think that trans people of color are at risk for being able to afford to see a doctor in the first place. It depends on your salient identities, again. Me as a white trans person, it's a lot easier to see a doctor, especially as a grad student who has insurance... I have a lot more privilege in that aspect. It's really expensive to get health care in the United States."

Interviewee 3 believes that health care in Oregon is generally better than in the rest of the country, but knows that everyone has a different experience, especially because transgender women may face additional problems compared to transgender men: "Oregon... especially along the I-5 corridor, is better than a lot of the rest of the country. We have access to a lot more doctors that can get you hormones, that know how to do this stuff, and will treat you. But even still you know... trans women face huge barriers that the rest of us don't... I see differences between the experience I have versus the experience trans women have. They tend to have a lot more problems

and difficulties with insurance. Because it's kind of the *intersection of transphobia and misogyny* that they get, that I don't get as much of.”

Commentary

Transgender health care may be better overall in California and the I-5 corridor in Oregon compared to much of the rest of the U.S. Interviewees mentioned being uneasy entering any hospital, especially in states such as Georgia, Iowa, and Utah. Although health care in Oregon and California may generally be better than in other states, people have varying intersecting identities, such as transgender women of color, which can contribute to increased stigma and decreased quality of health care anywhere in the U.S. It is important to remember that improved places like regions of Oregon are only at the beginning stages of improvement and harbor many problems associated with intersectionality. When continuing research and improvement of policies and programs, it is crucial to center transgender people and their concerns, especially the most vulnerable members of the population such as transgender women of color.

Chapter 9 - Interviewee recommendations

“Leave your biases at home. You’re in the workplace trying to take care of everyone and everyone should and needs proper health care” (interview 2).

As seen in the previous chapters, transgender health care clearly requires improvement. The interviewees shared additional thoughts on the issues plaguing their health care and potential steps towards more equitable medical treatment, which include equal treatment, inclusive language and openness to change, early education, continuous and intersectional education, and transgender representation.

Equal treatment

Interviewee 2’s main recommendation was simple and general, but a fitting introduction: “I feel like... just... treat me like they would with anyone else! ...I know they’re all human, so it’s hard to separate your bias, but...*that’s what you’re supposed to be doing in the medical field...you leave your biases at home.* You’re in the workplace trying to take care of everyone and everyone should and needs proper healthcare.”

“...at least being open-minded that things are changing and that there are folks that are identifying in this way and that this is relevant to healthcare. Just... not making assumptions” (interview 2).

Inclusive language and openness to change

Inclusive language is a crucial area of improvement. Interviewee 2 emphasized the use of correct pronouns and names, specifically the ability to ask relevant questions. They also recommend changes to intake forms and other documentation: “...it’d be cool on the forms- or if you did come in- or if the RN would you ask you ‘I’m so and so and these are my pronouns’ and that would *give you leeway to introduce yourself and your pronouns*, or if they asked you what your

pronouns are... I feel like any introduction or conversation should start like that... but that's just me. Maybe not just me, but I feel like it'd be a cool thing to associate as the norm. Names and pronouns. I think that's really the biggest thing I could think of as of now because like... *being able to share your gender identity without a big taboo around it*, just weird assumptions or associations around it... Adding the gender marker versus the sex marker. Well keep the sex marker to ... but including intersex, too! There's so much more that you could just add. Just make it more inclusive."

Just as interviewee 2 mentioned the ability to ask about a patient's preferred pronouns, interviewee 1 emphasized the ability to ask sensitive questions: "I feel like... if people are trained not to assume things, if they can ask if people are comfortable with certain things before they just assume them. I feel like there's a lot of ways that people can change about the way they ask things, the way they go about encountering things that they haven't encountered before. I feel like stuff like that would be better, inclusive, just anybody. Like, even if I wasn't wearing a binder...what if I didn't want a breast exam." Here, interviewee 2 was referring to a time when their physician did not complete a physical exam because they were uncomfortable with seeing a binder. Instead of ignoring such obstacles, interviewee 2 recommends learning to inquire about unfamiliar articles of clothing.

Interviewee 1 mentioned another instance where questions were asked in an insensitive way: "I went to go see a gynecologist through SHS And... so this is kind of personal but I feel comfortable telling you... I went up to the front desk and I was like 'I'm here... I wanna see a doctor for like... genital bumps'... and I feel like that was all she needed, but the receptionist was like ... 'was that vaginal, or...' I feel like a better question, and to be more inclusive just to anybody, would be like 'do you want a female doctor.' Or, there's lots of reasons for why people wouldn't want a male doctor if they have a penis, like... there's better ways to ask that question than asking what's in my pants. *Learning to ask basic questions.*"

Interviewee 4 recommends keeping an open mind and altering behavior as soon as it is mentioned, especially because correcting physicians requires excessive energy. Learning quickly and adjusting behavior can help build trust with the patient, even if the physician makes a mistake. Interviewee 4 describes an example of a

physician they feel comfortable seeing: “Even if she messes up with language or whatever, as long as you talk to her about it, she’ll change it. And... she’s an advocate for us in the way that Student Health Services does things – like if we have a horrible experience with staff, like someone misgendered us, [she] will fix it. To the best of her ability.”

Interviewee 4 continues describing this relatively competent physician: “...there’s something at OSU called name-in-use policy, where if you can’t change your name legally, you can change your name in university systems, and that has a hard time connecting to Student Health Services computer software, and that’s where I often get misgendered in Student Health Services...she calls people, like, when I’m in a doctor’s visit, and is like ‘Hey, you need to check this out.’ That makes me trust [her] more... she’s adamant, like ‘This should not be happening to people,’ which is important to me. So that’s why I feel good about going to [her], regardless of- it’s still hard because I still get misgendered sometimes... that’s very very hard. But it’s worth it to see [her].”

Interviewee 3 calls for competent language use and a high standard of care: “There needs to be an expectation in the community that you have to respect someone’s gender. If you got doctors that are misgendering people, your patients are not gonna come in. That’s how it’s gonna work. And people are gonna die. Because they’re not getting care... You’ve got to have a standard that says ‘care for these people and respect who they are.’ And I think that doesn’t exist yet, especially... you get outside of areas like here in the I-5 corridor- because even here you get outside of the I-5 corridor and- to think that Oregon is largely progressive, but a lot of the state isn’t!”

Interviewee 3 says that the change begins in relatively more progressive areas, but recognizes the challenges to reaching other states and more rural areas: “So you get huge swaths of the country where people can’t get care. And that’s gotta change. On a fundamental level. It starts in areas like this and I’m hoping it’ll spread out. But we’re kinda at a point right now where it’s hard to get anything to spread. Because there’s so much going on countering it...” However, interviewee 3 mentioned that

increasing programs where medical schools send transgender-healthcare-competent physicians to work in rural areas and educate locals could be helpful.

Early education

All the interviewees recommend official training and education of health care professionals. Interviewee 2 recommends education to start early—not only in medical school, but in childhood as well, before biased perceptions form: “I think the earlier the better, to be honest! But I know that sometimes that doesn’t happen, so definitely at least in the medical program. I have a friend who’s...a nurse... they’ve been a really cool person in making sure that trans healthcare’s been heard and nonbinary healthcare’s been heard [at their university]... at least telling them that there’s these other people out there... but honestly that might be a little too late, because these are 20-year-old people that already feel like they have a perception of the world and reality and like ‘there’s only two genders’... I think that’s very cool that they’re doing that, but what would be very sweet is if... all the public education included gender education and stuff.

Interviewee 2 continues by explaining the misconceptions the public has about early education: “It doesn’t even have to be- that’s what bothers me so much... they think the queer community is evolved around sex and it’s not all about sex! It’s just about your identity, you as a person, like who you are attracted to. And even with gender identity, that isn’t even about the act of sex. It’s just how you identify and how you want to present yourself to the world. And anyways of course it’d be great to introduce those things but of course there are stigmas. Like, people are ‘Ahh, the children, though!’ But no, you’re just... broadening their minds. Earlier the better would be cool, but at least definitely with the medical field... there being classes about it, having simulations, having different identities or whatever, have it be intersectional... There’s definitely ways to implement it. There really is. It’s just a matter of putting effort into it.”

Continuous and intersectional education

The interviewees recommended education, but especially focused on incorporating transgender health education throughout curricula and enforcing intersectionality: “I bring up the simulation [activities], because you’re doing that every year, yeah? At least throughout the nursing program, so making sure that you have every identity there” (interview 2). Interviewee 2 was referring to incorporating transgender representation throughout the years at medical programs, not only as a short and ineffective unit on “Trans 101.”

Interviewee 4 supports this idea: “It shouldn’t be just a one-time training. And not an hour. It’s going to take several- I think that social justice is an all-your-life learning experience. You have to unlearn the things that you’ve been socialized your entire life to believe, and take that veil over your eyes to believe certain things. And so I don’t think like a week-long diversity training is going to solve anything. You have to be actively engaged in trying to be a better human being and advocate for people who really need you to be that.”

Interviewee 4 explained that they trust physicians who care about their problems; this sort of care develops through long-term investment in unlearning and learning: “I need my doctor to actively care about the injustices that people of color and immigrants and trans people are facing. And I know that’s hard, because doctors have a lot of different political beliefs, but why do politics have to be assigned to an identity? Because those identities are who we are. And so, whether you’re a democrat or a republican or a socialist, your political beliefs do not get to generate how you treat human beings especially in health care settings, because we’re trusting you to take care of us in ways that we need to be taken care of. It’s more than just diversity training. You have to be actively involved in changing and deconstructing the things you’ve been learning your whole entire life.”

Interviewee 4 continued explaining that training and education is not simple. Varying combinations of identities require varying approaches: “...our salient identities are important to us and you can’t separate them. Even the ways that inclusive language and diversity training has to be taught, has to come from an intersectional lens. Or it’s not going to be good” (interview 4).

Finally, interviewee 2 summarizes their recommendations by asking that health care professionals do not make assumptions. They call for increased education and research on the topic of transgender health care.

Transgender representation

Interviewee 3 brought up the important point that in order to truly improve transgender-related health care, there needs to be increased transgender representation in clinical settings: “I think the biggest step is going to be actually talking to trans people...you can’t just have cis physicians making these decisions. You need trans people involved in these processes. Because it’s just stuff that, no matter how involved you are, you don’t think of everything if it’s not your life.”

Interviewee 3 thus explained that although educating physicians and increasing openness of minds is important, transgender people need to be involved in catalyzing change. In order to decrease the mental burden that educating and advocating places on transgender people, interviewee 3 argued that creating space and providing compensation would alleviate some of the obligation and burden: “And you need to pay them. Because this is a community that has huge unemployment problems and underemployment problems...you know you got all these risk factors going into this community...pay these people!”

Interviewee 3 continued to explain why compensation is important by offering personal experience: “I think if you’re paying them... that’s different... everything I’m doing right now I’m doing unpaid, so that’s taking time away from... a PhD engineering student. It’s... I have a lot going on, but I... I have to advocate for myself. It’s dividing my time. And if I was getting paid, it would be a lot easier because then I wouldn’t be stressing about money. Because... as someone who is trans and disabled, I have past medical bills!”

Incorporating transgender health education throughout the medical school curricula should include exposure to the population: “Well with medical schools, they don’t really cover much. And even the schools that do, I imagine there’s a huge discrepancy from one school to the next on what they actually cover and how useful it

is, and you know... exposure is the big thing... have people come in and talk about their experiences in healthcare! Or people who are willing to come in and talk... in detail about their medical stuff. Which brings it back to: bring trans people in and pay them. But it's just exposure to everything that you have to have" (interview 3).

Commentary

These suggestions for a more inclusive and respectful health care setting help in identifying and establishing priorities for future directions in research and clinical applications.

Chapter 10 - Future directions and conclusion

Despite research advancements, clear health disparities remain for the transgender community. Training and education should be increased for health care professionals, public schools should include comprehensive gender education, and increased research should be conducted on health disparities for the transgender population.

As stated before, mental health factors and experiences of harassment, discrimination, violence, and rejection may interact to increase suicidal behavior probability for transgender and gender non-conforming individuals (Williams Institute). More detailed research should be conducted on suicidal behavior in the transgender population— besides numbers of suicide attempts, what fraction of suicide attempts are fatal, and why? Further, in order to decrease transgender suicide, it is necessary to know which factors are directly linked to suicide attempts.

Shires and Jaffee (2015) reported that because of societal pressures and associated stigmas about nonconforming to gender norms, transgender people alarmingly often face general discrimination, harassment, and violence. There have also been some reports that transgender people have faced discrimination from physicians as well as staff, and sometimes have been refused care altogether (Shires & Jaffee). Results from the interviews in this thesis support the findings that stigma and discrimination occur in clinical settings. Shires and Jaffee did find that over 40% of transgender men responding to their national survey reported discrimination in a health care setting and that discrimination rates were even higher for populations with intersecting identities (transmen of lower socioeconomic status or different ethnicities for e.g. Native American and multiracial). However, Shires and Jaffee did not obtain data on transgender women, so further studies should conduct similar surveys which would also include transgender women. As interviewee 4 stated, salient identities are important and inseparable; in order to obtain applicable results, all studies should utilize an intersectional lens.

A major limitation of this study is the low sample number (four interviewees), so the results are definitely not generalizable to the entire transgender population.

Coincidentally, only nonbinary individuals with varying degrees of masculinity volunteered to participate in interviews, so some discussed issues may be unique to this population and may not include other subpopulations such as transgender women, more feminine nonbinary people, or transgender people of color.

Moreover, people who take the time and energy to participate in interviews may be more privileged and equipped to navigate the poor health care system than other transgender people; this study discussed problems exceptionally important to transgender health care, but other severe problems may have been neglected in this study because of nonresponse bias.

Some researchers suggest future directions for research regarding transgender discrimination and health: Reisner et al. (2016) identify a lack of large studies. Specifically, they recommend large prospective observational studies and intervention trials and increased data about the risks and benefits of sex affirmation (e.g. hormone treatments and surgical interventions). They also critique the inconsistent use of definitions across studies—they argue that this inconsistent use hinders evidence-based care for transgender people. Although consistent definitions are important for comparing studies, I would argue that some flexibility must remain because of the vast diversity of transgender identities. Despite the fluidity of gender, it is possible to analyze transgender-related health issues and work towards improvement. Specifically, Reisner et al. suggest ways to improve transgender health research such as "a series of observational and intervention studies aimed at identification, recruitment, and follow-up of transgender people of different ages, from different racial, ethnic, and socioeconomic backgrounds and with diverse gender identities."

Thomas et al. (2017) suggest that in order to make generalized conclusions about aspects of transgender healthcare, we first need better national and international statistics—there are many knowledge gaps and many statistical profiles are incomplete or not generalizable. Secondly, Thomas et al. suggest the need to determine the exact needs of the transgender community, which is partly what this thesis attempts to do. However, extensive surveys and interviews need to be conducted and analyzed in many regions of the U.S., especially incorporating

intersectionality. Thirdly, Thomas et al. identify a need to challenge social barriers responsible for inadequate healthcare access, which can include addressing general discrimination and stigma. This thesis contributes mainly to the second recommendation: transgender individuals' specific healthcare requests, such as thoughts on preferred medical practices, physician affect, or barriers to adequate healthcare, are recorded with the goal of directing future research. As discussed earlier, future research is definitely needed to compile and record the needs of a representative sample of the population. Thomas et al.'s third point should be addressed in future work, such as developing educational materials to be integrated in public schools and medical curricula.

Overall, transgender patients suffer from a variety of issues such as misgendering, various language mistakes, assumptions, emotional labor, avoidance behavior, and geographically inconsistent care. Consistent and intersectional educational programs on transgender health care should be integrated into medical curricula, paid transgender representation in health care should be increased, and more research needs to be conducted on the statistics and specific needs surrounding the health of the transgender community.

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Appendix - Interview Guide

- 1) If you feel comfortable sharing, what is your gender identity?
- 2) In general, what has your experience been in healthcare settings?
 - a) Can you expand on ___ experience?
- 3) Have you ever been misgendered in a medical setting? By which professional type (doctor, nurse, receptionist, etc.)? What impact did this have on you?
- 4) Have you ever felt that you were treated differently in a healthcare setting based on your gender identity? In what ways?
- 5) Have you ever experienced what you thought was discriminatory or unsatisfactory medical care?
- 6) Can you tell me more about it? Was this experience typical or unusual in your interactions with the medical system?
- 7) Have you ever avoided seeking medical care because of fear of discrimination or unsatisfactory care based on gender identity?
- 8) Do you believe your childhood healthcare was affected due to your gender identity? If so, in what ways? Can you explain?
- 9) Did you ever report bias or discrimination? If you did, how did you do so and what reaction did you receive? If not, describe what made you feel uncomfortable or unsafe to do so.
- 10) Have you ever felt distrust for a healthcare provider (based on your perception of their attitude towards you/ your gender identity).
- 11) How have you tried to improve relationships and communication with your healthcare provider? What reaction did they have?
- 12) How has your experience as a transgender individual seeking medical care affected your physical or emotional health?
- 13) What are specific actions you wish your healthcare provider executed differently?
- 14) In your opinion, how could healthcare settings be more inclusive of the transgender community?
- 15) What do you think are the biggest healthcare risks to the transgender community?

- 16) What do you think are the biggest barriers to improving non-transition-related care as well as transgender healthcare in general?
- 17) Is there anything else that comes to mind pertaining to this topic?
- 18) Do you have any questions for me?

