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Healthcare Disparities Among Transgender Individuals

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Abstract

Disparities among the healthcare experiences of transgender individuals can result in poor health outcomes and decreased quality of life. This qualitative research study explored how three transgender individuals perceived the quality and accessibility of their healthcare experiences. Findings suggest that healthcare disparities disproportionately impact transgender individuals. Two themes emerged: (1) lack of knowledge among healthcare professionals, and (2) mistreatment by medical professionals. The study illustrates the need for medical providers to be competent in providing transgender-inclusive care and conscious of how their professional behaviors and practices may be more inclusive of transgender patients.

Introduction

Problem Statement

In American society, transgender individuals experience violence, institutional oppression, barriers to expressing their sexual orientation, and disparities in accessing resources that address their biopsychosocial and physical health needs. Most noted are disparities that impact their healthcare experiences. These disparities often result in poor health outcomes and a decreased quality of life. Despite this extensive problem, there is little research showing how transgender individuals experience and negotiate the American healthcare system. The purpose of this research was to understand healthcare disparities among transgender individuals. The rationale for this study emanates from the need to understand how transgender individuals make meaning of their healthcare experiences. It aims to increase awareness about the discriminatory healthcare practices that negatively impact transgender people, as well as support the need for further clinician training about transgender-specific health issues to promote quality healthcare for transgender patients. This study was designed to answer the following question: “What factors create health care disparities among transgender individuals?”

Literature Review

Sexual Minority Discrimination

Sexual and gender minority groups have long been the subject of discrimination. In a society where heterosexuality is the norm, lesbians, gay men, and bisexual individuals make up a sexual minority population. Transgender individuals, or people who identify with a gender that does not correspond with their biological sex assigned at birth, are also regarded as gender minorities (University of Michigan, 2016). It is not uncommon for lesbian, gay, bisexual and transgender (LGBT) people to experience discrimination and face stigma from other members of society. A report from the Center for Disease Control and Prevention (2016) show that compared to the general public, sexual minorities are eight times more likely to attempt suicide, six times more likely to report high levels of depression, and three times more likely to use illegal drugs. They are also three times more likely to engage in risky sex behaviors, which may consequently result in becoming infected with HIV or other sexually transmitted diseases.

Homophobia is also the basis for discrimination and hate crimes committed against sexual minorities. In 2007, the FBI recorded 1,265 LGB-biased hate crimes including murder, forcible rape, aggravated assault, simple assault, and intimidation (Marzullo & Libman, 2009). Transgender individuals are particularly vulnerable to prejudice and formally sanctioned forms of discrimination. Similarly to the LGB population, transphobia, or a prejudice against transgender people, is the fuel for many violent hate crimes. A 2009 study found that 17 percent of reported hate crimes against LGBT people were directed against transgender individuals and 50 percent of people who were killed in LGBT hate crimes identified as transgender (Office of Justice Programs, 2014). The Office of Justice Programs (2014) further states that 15 percent of transgender individuals report being sexually assaulted while in police custody or jail, between 5 and 9 percent of transgender individuals report being sexually assaulted by police officers, and 10 percent report being assaulted by health care professionals (although these numbers may be low since sexual assault crimes often go unreported). The risks increase for transgender people of color, people with disabilities, and homeless individuals.

Official Identification Policy

In the United States, many states have strict identification policies that marginalize transgender individuals. In Tennessee for example, in order to update a name or gender on a piece of identification (ID), individuals are required to obtain a physician's note stating that medical procedures have occurred which serve to complete the gender changing process (National Center for Transgender Equality, 2016). While some transgender individuals decide to undergo gender reaffirming surgery, or surgery to change the physical appearance of their genitals, the high risk, cost, and lack of access dissuade many people from undergoing the medical process. In reality, only one in five transgender women and one in twenty transgender men have undergone gender reaffirming surgery; and a large percentage of transgender men and women report that they have no interest in ever having genital surgery, likely due to the associated costs and risks (Sukurs, 2014). In addition, Tennessee, Idaho, and Kansas are among the few states that prohibit amending sex on a birth certificate, regardless of whether an individual has undergone gender reaffirming surgery (National Center for Transgender Equality, 2016). It is clear that these identification laws overlook the needs and realities of many transgender individuals. Having

a license or ID card that does not accurately reflect a transperson's gender identity can be very damaging for their mental health, and can compromise their safety when they are required to present their ID. Moreover, some states such as Indiana require voters to present a government-issued photo ID at the polls. For transgender individuals whose appearance does not reflect their birth gender on their ID, voting can become impossible and lead to harassment. Sukurs (2014) reported that 27 percent of transgender individuals do not have an ID that reflects their current reaffirmed gender; strict voter registration laws in many states, in fact, effectively strip from transgender individuals their ability to vote.

Finally, daily activities are often obstacles to transgender individuals. In North Carolina, simply using a public restroom has become a major safety concern for the transgender population. In March of 2016, North Carolina's legislature passed House Bill 2, or HB2, which prevents transgender individuals from using bathrooms that correspond with their gender and instead force them to use bathrooms that correspond with their biological sex. The bill also prevented cities and counties from establishing different rules for public restroom use (Gordon, et al., 2016). The thought behind North Carolina's House Bill 2 was that transgender individuals posed a threat to women and children in public restrooms. Evidence shows zero reported incidences of transgender individuals verbally or physically assaulting someone in public restroom; although 68 percent of transgender individuals have experienced verbal harassment and 9 percent have experienced physical assault when trying to access a public restroom (Herman, 2013). The U.S. Department of Justice has ruled that the North Carolina bill violates Title IX and Title VII of the Civil Rights Act. However, North Carolina state legislators claim that it is constitutional and the bill has yet to be repealed (Morrill, 2016). The portrayal of transgender people as predators by state and federal legislators demonstrates how transphobia transcends law and health policy.

Health Care Disparities among Transgender Individuals

A major barrier that faces transgender population is a lack of access to healthcare. Scout (2005) describes transgender health disparities as an effect of "compromised survival," or compromised life chances due to unequally distributed societal resources and perceived potential for success. For example, gender dysphoria (a condition where individuals experience discomfort, stress, or other negative emotions because their biological sex

does not match their gender identity (National Health Service, 2016), is often treated with cross-sex hormones, but transgender individuals may have difficulty finding a doctor who is knowledgeable about the treatment and its side effects. If they cannot find a doctor, transgender individuals often inject the hormones themselves, frequently sharing needles. The rate of HIV/AIDS infection among the transgender population is over four times the national average, and they have a higher infection rate than gay men. Transgender individuals also have much higher rates of depression, self-harm, substance abuse, and suicide when compared to the national average (Roller et al., 2015). Scout (2005) argues that these higher rates are caused by societal factors, or social determinants, such as social exclusion, a lack of social support, and stress, specifically noting how stress often leads to drug use and how a lacking support system can have severe negative implications for an individual's mental health.

Another factor that contributes to transgender healthcare disparities is the lack of health care providers who are knowledgeable or willing to provide health services to transgender patients. The discrimination and stigma that faces transgender individuals in the general population is also present in the medical field; up to 27 percent of transgender individuals have reported being turned away by health care providers who refused to provide care for them (National Center for Transgender Equality, 2012). Additionally, 28 percent of transgender individuals reported that they had been harassed in a doctor's office, which can turn the care-seeking process into a life-threatening situation (Human Rights Campaign, n.d.). The process of finding an accepting doctor is enough to keep many transgender individuals from seeking much needed healthcare.

The National Center for Transgender Equality (2012) reports that 48 percent of transgender men have delayed or avoided preventative reproductive health care, including HIV and sexually transmitted infection (STI) screenings and annual pelvic exams, for fear of discrimination or disrespect. Within the healthcare delivery system, there are core elements that create barriers to care for transgender individuals. Electronic Health Records, which are designed to record patient history and needs, can pose a problem as they are not designed to address the documentation needs of transgender patients (Vanderbilt University School of Medicine, 2016). The nature of this system can result in confusion regarding the patient's biological sex and gender (thus potentially compromising medical records)

and patients feeling misunderstood, having their identity exposed to other patients in waiting rooms. Even when doctors who accept transgender patients are available, it is likely that they will not know how to treat transgender-specific health concerns.

Nationwide, 50 percent of transgender individuals reported that they had to teach their health care provider how to provide transgender-appropriate care (National Center for Transgender Equality, 2012). Some health care organizations have begun to use a rights-based approach to explicitly target transgender health care needs, but Marks (2006) notes that the refusal to acknowledge the health care needs of the transgender population continues to persist. To combat the lack of attention to transgender-specific health issues and educate healthcare providers, Goldberg (2006) proposed training frameworks for medical providers that attempt to reduce transgender health disparities by focusing on promoting quality and consistent healthcare.

In an attempt to provide health care options for transgender populations, community clinics have begun to open in underserved and low-income areas. Community clinics provide transgender patients with safe and affordable health care, and many are able to offer hormone replacement therapy (Transgender Law Center, 2012). Community clinics may still face under-skilled or insensitive staff problems, but they are quickly becoming an ally to the transgender community in many parts of the country by providing important medical care when there is nowhere else to go.

Methodology

The purpose of this qualitative research study was to understand the factors that create healthcare disparities among a sample of transgender individuals. Qualitative research is a relevant methodological choice for this study. Inherently, this approach is grounded in a constructionist philosophy, which entails how people make meaning of their experiences, and illustrates that their experiences are constructed in different ways. Ultimately, these meanings help in the formation of themes which lead to insight on how study participants experience some phenomenon (Crotty, 1998). In this study, the findings were generated according to how participants experienced healthcare disparities.

Sampling

This study used a non-probability sampling technique called snowball sampling to recruit and select the study's participants. In snowball sampling, the researcher identifies one potential participant who is then used to refer the researcher to other participants (Atkinson & Flint, 2001). By and large, this method allows researchers to access populations that would otherwise be hard to reach. Hard to reach populations include, but are not limited to, drug dealers, prostitutes, active criminals, gang leaders (Schutt, 2014), and sexual minorities who experience social pressure or marginalization from the larger society (Shaghghi et al., 2011). There exists a personal relationship between the investigator and the first study participant, but there were no pre-existing relationships between the researcher and other participants. Once potential participants were identified, they were sent a recruitment letter via email soliciting their participation in the study. A total of three participants gave consent to participate in this study. The pseudonyms Sarah, William, and Mary were assigned to protect the personal identities of the study participants. Each participant met the inclusion criteria for this study:

- Be over age 18
- Self-identify as transgender
- Willing to talk and share openly about their health care experiences

Data Collection

A university institutional review board (IRB) reviewed and approved the study prior to data collection. In-depth interviews were used as the data collection method to understand the experiences of 3 transgender individuals in the healthcare-seeking process. Each participant took part in one semi-structured interview (which lasted one hour on average), and an interview protocol composed of eight open-ended questions about the participant's healthcare experiences. All interviews were digitally recorded with participant permission and transcribed verbatim after the interviews. Given the nature of this study, any specific references to participants through written documentation used pseudonyms. Written documents remained secure and were maintained in a metal electronic safe. Electronic information was also secured on a private laptop computer with password protection. All information was only accessible to the researcher.

Data Analysis

A general inductive approach was used to analyze the interview data and to identify emergent themes most relevant to the research question (Thomas, 2006). Analysis for this study began with an open coding process. Merriam (2009) noted that open coding is a useful data analysis technique because it allows the researcher to record personal interpretations of the participant data. In this study, data analysis formally began with a thorough review of the interview transcripts which revealed common themes that support the study's question, "What factors create health care disparities among transgender individuals?".

Findings

From the interview data, two themes emerged as key factors in health care disparities among transgender individuals:

Theme 1: Lack of knowledge among healthcare professionals

Theme 2: Mistreatment by medical professionals

Lack of Knowledge among Health Care Professionals

Theme 1 relates to the participants' experiences with health care professionals with little knowledge about transgender-specific healthcare. Two participants in particular expressed discomfort during interactions with medical doctors who, through the participants' lenses, seemed uninformed about transgender-specific healthcare needs. One participant, Sarah, for instance, was met with confusion and frustration when she tried to explain her gender identity to her doctor. William (participant 2) described feeling awkward around his primary care provider. He stated, "She knows [about his gender identity] but she [his doctor] just doesn't understand me." Mary (participant 3) felt embarrassed and uncomfortable during an exchange with a pharmacist who questioned her estrogen prescription. She remarked, "it was embarrassing for me especially for the first time [picking up an estrogen prescription], and it was kind of awkward." Mary felt awkward because the pharmacist drew unwanted attention from customers and pharmacy staff by loudly questioning the validity and purpose for her estrogen prescription.

The collective experiences of the participants suggest a pervasive problem in how health care professionals interact with transgender persons. Their experiences may also indicate that health care professionals

are unwilling to acknowledge and respond to their medical needs. Fundamentally, providers or professionals who are uninformed or insensitive toward transgender patients can be a significant deterrent to care. Sarah, for instance, explained that she struggled with trying to have her hormone prescriptions (estrogen and spironolactone) transferred from a transgender gender-specific provider to her primary care provider. In clarifying her frustration, she shared this message from her provider:

I am really not sure I will be able to manage your transition. It is a lot of new information and will require a significant amount of my time to learn about something that I do not think will be used a lot at [university name withheld].

Sarah's comment seems to indicate that many health care providers perceive that they will probably not encounter and be responsible for managing the healthcare needs of transgender patients. Despite some truth to this perception, still 0.6 percent of adults in the United States identify as transgender (Flores et al., 2016). Even with this small proportion, it seems irresponsible for providers to assume that their lack of knowledge about transgender-specific healthcare will be supplemented by other providers who may have experience and expertise in treating this population.

Because of the shortage of transgender-specific healthcare providers, many transgender people are less likely to receive quality care, and may feel let down by the medical system. Sarah expressed her frustration with the medical system, saying that "I can't get the medication that I need...that I've been taking...because it's an inconvenience for them to learn about it." Seemingly, the ease with which medical providers dismiss transgender healthcare as a niche specialty demonstrates not only a lack of understanding about transgender healthcare, but a willful ignorance about transgender populations as a whole. This lack of provider understanding is detrimental to doctor-patient relationships and can result in feelings of distrust toward the provider and become a major cause of healthcare disparities among transgender individuals (Gay and Lesbian Medical Association, 2006; Grant et al., 2011).

Fear of Mistreatment by Medical Professionals

The second theme relates to fears and anxiety about being mistreated by medical professionals. While studies have shown that these fears are justified, they are not limited to transgender specific healthcare (Robinson, 2010; National Center for Transgender Equality, 2012; Human Rights

Campaign, n.d.). In his interview, William shared his fear of disclosing his gender identity to his gynecologist for fear that he (the gynecologist) would disregard William's medical problems or the reason for his appointment and instead, direct attention toward making sense of his identity. While it is not always medically necessary for patients to be open about their gender identity with their providers, the pressure of having to hide one's identity can have serious negative impacts on the patient's overall mental health and treatment outcomes. Patients who do not feel comfortable being open with their providers may experience a lessened quality of care as a result.

It is important to note that discrimination and judgment from medical professionals can affect more than just the patient under care. Mary shared her experience with trying to access healthcare for her young daughter, a situation which she described as "very disheartening." Although Mary was not the patient in this situation, she faced hostility from her daughter's surgeons and doctors who were only interested in speaking to her daughter's biological mother. Mary's poor treatment in this situation caused her to feel excluded from her family and her daughter's care team. It is clear that provider judgment and bias had a negative effect on Mary, but it likely also caused strain on her family and her daughter during what was already a difficult time.

Both Mary and William discussed feelings of being treated with suspicion by healthcare providers. Mary described a time when she pulled several ligaments in her arm, which caused severe pain and disrupted many of her normal activities. She shared that despite seeing three or four different doctors, none of them would provide her with pain medication while she was taking hormones. Mary felt that the doctors associated her hormone use with drug abuse, a speculation that allowed them to deny her pain management. After being held in a Midwestern hospital following a second reconstructive chest surgery, William shared that he was told to take Advil for his pain. Thinking back on the experience, he said, "I was in the hospital for a really extended period of time, and they didn't manage my pain, they didn't take care of me at all." The experience of being treated with suspicion by medical providers is not new for many transgender individuals, and it likely stems from medical professionals' biases and ideas rooted in negative stereotypes of transgender individuals. Mary and William both felt that they were not being treated effectively, which

can put strain on patient-provider relationships and have negative medical consequences.

Discussion

The study's findings were congruent with the literature showing that healthcare disparities disproportionately impact transgender individuals (Scout, 2005; Grant et al., 2011). The lack of knowledge about transgender issues among healthcare providers, personal fears of discrimination from medical professionals, and experiences of being treated with suspicion by providers all contribute to these disparities. When medical providers are uninformed, the burden of knowledge falls on the patient to articulate their personal health circumstances. All three participants described circumstances where they had to clearly express their needs to their provider; including requests for hormone prescriptions. Providers who are uninformed about the treatment regimen and potential side effects of hormone replacement therapy rely on their patients to provide them with that information.

The participants in this study were between 30 and 55 years old, college educated, and one participant had an extensive background in medical and scientific knowledge. These factors provided the participants with the privilege and agency to make their own informed decisions about their healthcare. The nature of doctor-patient relationships and authoritative knowledge, however, means that many younger or less educated transgender patients may feel uncomfortable and be unable to express their needs to their healthcare providers.

Conclusion

This study illustrated the need for more medical providers who are competent in providing transgender-inclusive care. Cultural competency and sensitivity training for healthcare professionals could potentially improve the quality of care that transgender patients receive, and would likely lead to more providers offering transgender-specific care. Similar to cultural competency training for racial and ethnic minorities, sensitivity training for working with transgender patients should be led by transgender physicians, scientists, or other medical professionals. Although most providers do not receive this type of training while in school, any training that they do receive is likely taught by cisgender, heterosexual providers. Ensuring that there is representation in the medical field is a major step to ending

healthcare disparities among transgender populations. Continuing education training regarding cultural sensitivity and transgender healthcare concerns is also necessary for practicing providers to ensure that they remain current on best practice policies.

From a practice standpoint, the knowledge from this study can be used to ensure that patients are not being disrespected or mistreated by medical professionals. The experiences shared by the participants outline negative interactions with medical providers, and these accounts should allow providers to analyze their own behaviors and practices in order to make their services more inclusive to transgender patients. The participant interviews also revealed underlying notions of racism and sexism, which had an effect on the participants' healthcare experiences. The participants made several comments alluding to the idea that transgender women have a harder time navigating the healthcare system than transgender men. Additionally, issues of racism play into both healthcare experience and accessibility. This intersectionality means that transgender women of color likely experience the greatest amount of discrimination in healthcare settings. Qualitative research on the healthcare experiences of transgender women of color is needed to fully understand the roles of race and sex within the medical system.

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