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Transgender Identities & Primary Health Care Services

Abstract

Primary health care is not being adequately used by transgender and transsexual individuals due to widespread stigma, discrimination, economic and social barriers (Cruz, 2014). The low levels of health care utilization by transgender people causes further medical management of medical conditions (Bauer, Hammond, Travers, Kaay, Hohenadel & Boyce, 2009), perpetuated by the cisgender heteronormative paradigm in medical education and practice. The under utilization of health care by trans-persons is

exacerbated by the social, political and economic issues that make trans people invisible, which positions them to be vulnerable to depression and suicide (Ansara, 2015; Bauer, Zong, Scheim, Hammond, Thind, 2015; Newman-Valentine & Duma, 2014; Winter, Settle, Wylie, Reisner, Cabral, Knudson, & Baral, 2016). The physician's office for medical practice is generally identified as the central location for non-emergent services, yet trans-persons struggle to navigate the personal, social and political aspects of receiving care in this environment. This paper undertakes a review of the evidence on trans-persons and primary care with the aim to describe salient themes in the care of trans persons in community based settings.

Keywords: Lesbian Gay Bisexual Transgender Intersex (LGBTI), transgender, transsexual, cisgender, cisnormative, trans woman, trans man, gender-non-conforming (GNC), heteronormative, iatrogenesis. See Appendix A.

Transgender Identities and Primary Care Health Services

The focus of this paper is transgender and gender-nonconforming individuals' experiences through the primary medical health care system, and the intersectional impact of these experiences. Transgender is an umbrella term that includes a spectrum of gender identities and persons with gender expressions varying from the traditional gender binary system (Cicero & Black, 2016). Since transgender is an inclusive term, it is important to highlight that there are distinctions between transgender individuals; transsexual man or woman is one who seeks medical treatment to transition into a gender, genderqueer [or gender-non-conforming] is a person who does not identify with the sex/gender binary of male/female and uses non-traditional pronouns (Cruz, 2014). A review of the literature was conducted to establish common themes and impacts, such as; stigma and discrimination,

barriers to health, erasure, lack of knowledge and cisgenderism. Finally, evidence based recommendations are made on how to make trans inclusive care for all sectors of health care. The reason behind transgender individuals being underserved for their medical needs is the lack of education and quantity on the subject in nursing and medical training (Kellett & Fitton, 2016).

Key themes

Passive erasure

The core reason transgender individuals (TI) have negative health statistics and experiences when dealing with healthcare systems is due to the lack of knowledge about them. The lack of knowledge and training regarding transgender individuals and their health issues stem from the problematic viewpoint that it is not important, which is institutional erasure of transgender individuals (Bauer, Hammond, Travers, Kaay, Hohenadel, & Boyce, 2009; Buchholz, 2015; Lerner & Robles, 2017; Williamson, 2010). The lack of knowledge and training of trans specific health needs comes with assumptions that trans health issues are equivalent to Lesbian, Gay or Bisexual health (Bauer, et al., 2009), which it is not, as these issues are independent but not mutually exclusive. The erasure of transgender health is widespread in US medical schools as indicated in a survey of 150 schools, which on average teach less than 5 hours in total on combined LGBT issues (Giffort & Underman, 2016). This invariably puts the onus on the TI to inform, educate and explain to medical staff what transgender means and their specific health concerns (Poteat, German, & Kerrigan, 2013; von Vogelsang, Milton, Ericsson, & Strömberg, 2016). When TI encounter medical professionals including those at LGBT-friendly clinics, the trans patient gets questioned, is put into an educator role, and body parts are asked to be seen even when not required (Lindroth, 2016). Institutional erasure and relying on TI to educate is

nothing short of cisgenderism in society with the ongoing default position of pathologizing gender (Ansara, 2015; Bauer, et al., 2009; Kellett & Fitton, 2016; Lindroth, 2016). Cisnormativity is ever present in all aspects of society, which affects transgender individuals' social determinants of health (MacDonnell & Grigorovich, 2012). In medical settings, the gender binary is forced onto all citizens, causing TI to be invisible and be coerced into a gender that they do not identify with (Bauer, et al., 2009; Kellett & Fitton, 2016). Whenever social gender roles or expectations differ from the cisgender normativity is where transgender individuals face stigma, bias and discrimination (Kellett & Fitton, 2016).

Stigma, bias and discrimination

Transgender individuals (TI) face unique challenges when encountering the health care system and the rest of society, often dealing with stigma, bias and discrimination (Bauer, Zong, Scheim, Hammond, Thind, 2015; Cruz, 2014; Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012; Winter, Diamond, Green, Karasic, Reed, Whittle, & Wylie, 2016). Discrimination was reported in more than half of the 6579 TI in Europe from 28 countries in healthcare settings (Lindroth, 2016). Transgender women experience rejection, discrimination and stigma in health care (Loza, Beltran, & Mangadu, 2017). Homophobia and transphobia is experienced by transgender patients, either directly or indirectly (Kattari, Walls, Darren, Whitfield, & Langenderfer-Magruder, 2015).

Due to the widespread stigma and discrimination it creates and continues barriers such as instances of unequal treatment, refusal or access to medical care (Cicero & Black, 2016; Lindroth, 2016; Loza, Beltran, & Mangadu, 2017; Selix & Rowniak, 2016; von Vogelsang, Milton, Ericsson, & Strömberg, 2016; Wylie, Knudson, Khan, Bonierbale, Watanyusakul & Baral, 2016). Some TI experience medical professionals' refusal to touch

them even when the medical situation calls for it (Redfern & Sinclair, 2014). Experiences of stigma are higher in transgender and nonbinary/GNC groups which is also correlated with lower health service utilization (Whitehead, Shaver & Stephenson, 2016).

Active erasure.

Transgender individuals are actively erased in the healthcare system by use of violence, intimidation or harm (Bauer, et al., 2009). When transgender individuals do go seek medical treatment it is common to encounter victim blaming (often for unrelated health concerns), shaming and abusive language by health professionals (Poteat, German, & Kerrigan, 2013; Redfern & Sinclair, 2014; Selix & Rowniak, 2016; von Vogelsang, et al., 2016). Invasive questions regarding TI genitalia and sexual practice are asked even when it does not pertain to the medical issue or concern at hand (Cobos & Jones, 2009; Lindroth, 2016). Medical professionals misgendering and lack of sensitivity when providing care for transgender patients is a pervasive issue regarding TI experiences of active erasure (Ansara, 2015; Dutton, Koenig & Fennie, 2008; von Vogelsang, et al., 2016). It should not come as a surprise that based on the active and passive erasure, stigma and discrimination that there is distrust of medical systems to provide adequate care for TI (Wilson, Arayasirikul & Johnson, 2013), this distrust and lower health utilization is higher in transgender persons of color, putting them at an even higher risk for adverse health (Cicero & Black, 2016; Scheim, Zong, Giblon & Bauer, 2017).

When combining the distrust and barriers to care, there are higher rates of stress, depression, suicide, HIV/AIDS, sexually transmitted infections and social isolation in transgender populations (Bauer, et al., 2015; Cobos & Jones, 2009; Giffort & Underman, 2016; Redfern & Sinclair, 2014; Winter, Settle, Wylie, Reisner, Cabral, Knudson & Baral, 2016). Social isolation and mental health issues are often behind much of the substance

abuse; tobacco, alcohol, prescription opioids, amphetamines and illicit drugs in the transgender community (Selix & Rowniak, 2016). The attempting suicide rate for transgender individuals is 41% compared to the cisgender public population's 2%, and the HIV rate is disproportionately high for trans women (Roller, Sedlak, & Draucker, 2015). The paucity of medical information regarding HIV and sex hormones puts TI in further harm (Lerner & Robles, 2017). Each negative interaction that a TI has with medical professionals further shape the point of view and codifies the erasure of being transgender in a cisgender society, which has negative effects on the person's health and wellbeing.

Intersectional impact.

The biggest observation of intersectional impact is that transgender individuals experience negative interactions in various medical offices (Bauer, et al., 2015; Bauer, et al., 2009; Lerner & Robles, 2017; von Vogelsang, et al., 2016). Negative experiences of TI include HIV health organizations that stigmatize, treat patients coldly or provide inaccurate information causing lack in trust and reluctance in accessing care in the future (Wilson, Arayasirikul & Johnson, 2013). Racial discrimination towards TI by medical professionals, results in higher utilization and reliance on Emergency Rooms for primary care services (Kattari, et al., 2015). Transgender individuals of color report high levels of racism and discrimination in healthcare settings, Indigenous trans persons are most likely to not having a family doctor (Scheim, et al., 2017).

Having negative experiences with medical professionals causes transgender patients to be more likely to withhold talking about their specific health issues (Bauer, et al., 2015; Markwick, 2016; Roberts & Frantz, 2014), especially when they are dealing with stigma and transphobia (Kanamori & Cornelius-White, 2016; Loza, Beltran, & Mangadu, 2017; Poteat, German, & Kerrigan, 2013; Redfern & Sinclair, 2014). The negative

experiences of TI in healthcare settings include vulnerability (feeling of being looked down upon), dependence (educating the medical system about trans health in order to transition while hoping for services), the views and opinions of medical professionals (being transgender or transsexual is a 'choice' or questioning legitimacy of trans status), and the lack of support post-transition (von Vogelsang, et al., 2016). The personal dilemma faced by TI when in medical settings is to disclose their trans status and risk refusal of care and/or harm in various forms, or to hide status and risk inadequate care (Redfern & Sinclair, 2014; Bauer, et al., 2009; Wylie, Knudson, Khan, Bonierbale, Watanyusakul & Baral, 2016). Transgender people of color are far more likely to experience refusal of care based on their transgender status being known to the medical professional (Kellett & Fitton, 2016). When TI face stigma and discrimination it can come in the form of simple referrals to other doctors regardless of health issue, the "passing off" of transgender patients, which results in less medical services being utilized (Bauer, et al., 2009).

Social stigma and discrimination affects social determinants of health of TI, including employment and income levels which is crucial in financial access to hormones (MacDonnell & Grigorovich, 2012). Transgender males often feel unsafe and vulnerable regarding their bodies which result in withholding their gender identity and health needs, specifically breast examinations – chest binding is a factor on health and identity, and filling out gender binary forms (Dutton, Lauren, Koenig, Karel, & Fennie, Kristopher, 2008).

The cumulative effects of negative experiences in healthcare settings has led to TI postponing seeking medical care (Cruz, 2014, Kellett & Fitton, 2016; Reisner, Gamarel, Dunham, Hopwood & Hwahng, 2013; Williamson, 2010), a codependent factor being lack of insurance coverage (Roller, Sedlak, & Draucker, 2015). Postponement of medical treatment is exacerbated by insurance companies who often dismiss TI health needs as "pre-existing"

or “medically unnecessary” (Giffort & Underman, 2016). For the TI that do enter the medical system to obtain medical treatment feel compelled to produce disingenuous histories of their transgender identity to secure treatment and further push the sense of need to get access to hormones or surgery in a medical system that relies on the criteria of gender identity [dysphoria] disorder (GID) (Snelgrove, et al., 2012). Reliance on gender identity disorder fails to capture everyone that is transgender, it misses those who are gender non-conforming or non-binary in their identity, which furthers misunderstanding and harm (Lo & Horton, 2016). Obtaining hormones to transition is an obstacle faced by TI when insurance companies or medical professionals are the gatekeepers which often deny services, this causes further harm by forcing many to access hormones from others not in the medical profession (Giffort & Underman, 2016). Access to hormones from outside the medical setting is often from “silicone pumpers” who are medically untrained and allow TI to self-administer in social settings, usually at parties (Winter, et al., 2016). The silicone at these “pump parties” held at hotel rooms are inexpensive, nonmedical grade silicone, which get injected into various body parts that would provide a feminine look for trans women (Williamson, 2010; Loza, Beltran, & Mangadu, 2017). Nonmedical grade silicone under the skin can shift, seep into surrounding tissues, migrate into the lungs causing pulmonary embolism, pneumonia, renal failure and death (Williamson, 2010). The ingredients of the silicone injections are often not disclosed when being self-administered, usually without proper anesthetic or hygienic practice, causing scar tissue to build up, afterwards the injection site is superglued closed, which later on in time causes the skin to atrophy (Loza, Beltran, & Mangadu, 2017).

For transgender individuals who pursue medical intervention in transitioning learn to navigate the healthcare system; which professionals to avoid or where to find an

accommodating physician, do their own research on hormones and/or surgeries, seek out loopholes and use them to obtain health care services (Roller, Sedlak, & Draucker, 2015). When TI are at a medical facility with no unisex bathroom option available, it is a form of structural and social stigmatization that impacts mental health and accessibility (Markwick, 2016; Poteat, German, & Kerrigan, 2013; Roller, Sedlak, & Draucker, 2015).

The structural barriers that TI contend with is the focus of this paper, however there are some barriers that medical professionals face in their role in providing transgender health care. The barriers for health professionals include: availability and access of resources regarding trans health care, lack of medical knowledge and training, ethics of trans medical care (reluctance to provide treatment), and diagnosing versus pathologizing issues (Snelgrove, et al., 2012). The few issues pertaining to pathologizing transgender patients are: the confusion of gender identity disorder with mental health, treatments requiring a medical or mental health condition to be made, and the structure of the health system concept of gender binary medicine (Snelgrove, et al., 2012).

Recommendations.

The evidence based recommendations for improving transgender individuals' experiences in health care is first to address the need for training on transgender identities, further understanding the gender spectrum, awareness of language use and impact on TI, and any refusal of providing care should be a violation of policy (Bauer, et al., 2015; Loza, Beltran, & Mangadu, 2017; Markwick, 2016; Winter, et al., 2016). It is imperative for medical professionals to understand the difference between gender identity and sexual orientation, there are various gender identities that do not fit into gender binary categories (Selix & Rowniak, 2016). Part of the training session should include problematic offensive words, such as; tranny, sex change, pre- or post-op, hermaphrodite, shemale, he-she, and

pretending (Cobos & Jones, 2009). Primary care professionals should know the difference between sex and gender, and learn the basic terminology regarding transgender identities (Kellett & Fitton, 2016). In the medical setting having gender positive language is vital for respect and trust to be established, which is lacking and is why so many TI do not have a complete updated physical examination (Williamson, 2010).

Educational training on gender would help bring awareness of the ubiquitous cisnormative assumptions that are often made, and to prioritize transgender specific health including the subject in medical textbooks and medical settings (Bauer, et al., 2009; MacDonnell & Grigorovich, 2012; Redfern & Sinclair, 2014; Williamson, 2010). The topics for clinical considerations for TI health care are: hormone replacement therapy, gender identity concerns, medical procedures to match gender identity, safety (physical, sexual, and emotional factors), substance abuse, cross-sex hormone side effects, mental health, safe sex practices (HIV/AIDS, [including same sex or gender]), and social issues regarding determinants of health (Redfern & Sinclair, 2014).

After training on gender and transgender specific health issues is to modify the medical forms that are used to be more trans inclusive, as well as limiting the assumptions of a person's gender and pronouns (Bauer, et al., 2009; Cobos & Jones, 2009; Lindroth, 2016; Redfern & Sinclair, 2014; Roberts & Frantz, 2014; Selix & Rowniak, 2016). The next step once limiting the gender assumptions, is to ask all patients - not just suspected transgender patients - what are their pronouns and preferred name, as not all TI are "out" or open about being transgender, this also limits the possibility of misgendering patients causing a negative experience (Cobos & Jones, 2009; Roberts & Frantz, 2014). When changes to medical forms take place, it is necessary to change the databases to include transgender non-binary selection options. In primary medical settings it is important to

have on display Lesbian Gay Bisexual Transgender Intersex (LGBTI) visual artwork as to signify a LGBTI friendly setting (Ansara, 2015; Selix & Rowniak, 2016). Whenever the financial and physical capabilities exist, there should be made a unisex bathroom available to transgender patients, this would remove a structural and social barrier in providing transgender inclusive care (Redfern & Sinclair, 2014; Roberts & Frantz, 2014; Selix & Rowniak, 2016; Williamson, 2010).

The role of the health professional and the interpersonal interactions are critical when providing care to transgender patients. Post training and awareness of trans specific health, it is imperative that the health professional be cautious with their position of power (von Vogelsang, et al., 2016), asking personal questions is invasive, which causes stress in the TI patient and threatens the trust in the relationship. The health professional should be mindful of stereotypes of gender and to attempt to normalize transgender individuals (von Vogelsang, et al., 2016). Providing the most inclusive trans friendly care is one that involves the patient in medical decisions, and does not delay sexual reassignment surgery (SRS) (von Vogelsang, et al., 2016). When medical professionals provide transgender inclusive care, there are opportunities to conduct or participate in longitudinal studies, which is in great need regarding hormones and post-surgery of patients who identify as transgender or transsexual (Reisner, et al., 2013).

Conclusion

Transgender individuals (TI) have negative experiences in society, and there three major themes regarding TI in primary medical care settings (Bauer, et al., 2009). Primarily, the passive erasure of TI which manifests as lack of education, knowledge, awareness and cisgenderism (Ansara, 2015; Kellett & Fitton, 2016; Bauer, et al., 2009). When in medical settings transgender and gender-nonconforming individuals experience transphobia,

discrimination and stigma (Giffort & Underman, 2016; MacDonnell & Grigorovich, 2012; Markwick, 2016). The second theme is the active erasure of TI when there is refusal of care, unequal treatment, violence, harm and misgendering from health professionals (Cruz, 2014; Dutton, Koenig & Fennie, 2008; Loza, Beltran, & Mangadu, 2017; von Vogelsang, et al., 2016). The impact of passive and active erasure of TI is complex, as it is intersectional, which is the third major theme of TI experiences in the healthcare system. The cumulative effects of discrimination lead to postponement of care (Cruz, 2014; Kellett & Fitton, 2016; Reisner, et al., 2013), interpersonal stigma and transphobia which reinforce the medical authority and power structure (Loza, Beltran, & Mangadu, 2017; MacDonnell & Grigorovich, 2012; Poteat, German, & Kerrigan, 2013). The transgender human experiences of medical encounters include: feelings of shame, guilt, self-hate, isolation, depression and suicide (Cobos & Jones, 2009; Roller, Sedlak, & Draucker, 2015; Whitehead, Shaver & Stephenson, 2016). The structures of erasure and its impact on transgender individuals affects their social determinants of health, which causes further inadequate and disproportionate health outcomes (Bauer, et al., 2009). To truly provide care for all patients that seek medical treatment is to capture the size of the transgender population, that is to have an inclusive census and end the institutional erasure that enforces the gender binary (Bauer, et al., 2009; Cobos & Jones, 2009; Kellett & Fitton, 2016). When the biomedical healthcare system ends its passivity of transgender patients' health needs, only then would changes be made to the active erasure, and end the iatrogenesis disease and effects of transgender people (Redfern & Sinclair, 2014; Segall & Fries, 2011).

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Appendix A. Definitions

Transgender - umbrella term that includes anyone whose self-identity, behavior or anatomy falls outside of societal norms and expectations

Transsexual - a person who lives as the sex other than the one they were assigned at birth. They may or may not pursue treatment to bring congruency to their gender identity

Cisgender - anyone who is not transgender, those who identify with the sex assigned at birth

Cissexual - people who are not transsexual and who have only ever experienced their subconscious and physical sexes as being aligned

Cisnormative - the expectation that all people are cissexual, the gender assigned at birth stays consistent through life

Trans woman - a person assigned male at birth but identifies as female, who may use medical Treatments to further align with the female gender

Trans man - a person assigned female at birth but identifies as male, who may use medical treatments to further align with the male gender

Genderqueer - a person who does not identify with either male or female. They can identify with both, neither or somewhere in between

Gender-non-conforming (GNC) - a gender expression that breaks cultural expectations for normativity

Heteronormativity - the belief that heterosexuality is the ideal, thus legal and social structures accommodate heterosexuality

Iatrogenesis - sickness and injury caused by the health care system

(Bauer, Hammond, Travers, Kaay, Hohenadel, & Boyce, 2009; Giffort & Underman, 2016; Markwick, 2016; Newman-Valentine & Duma, 2014; Segall & Fries, 2011).