Transgender Patients Choose Compassionate Care as their Preferred Treatment

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The current pace of change in the recognition, awareness, and understanding of transgender issues has encouraged more individuals to acknowledge and accept their gender identities today than in any previous generation (Jones, Cox & Navarro-Rivera, 2014). Despite recent progress in the rights of sexual and gender minorities, health care systems and providers around the world are struggling to respond to this unprecedented rise in patients presenting with gender dysphoria. As a result, transgender individuals are often met with significant barriers and challenges in their search for appropriate health care. In addition, they are generally much less likely to seek primary care or attention for life-threatening issues, and much more likely to suffer from poorer health outcomes.

Recent studies have demonstrated that providers generally feel unprepared to offer quality care to transgender patients, illustrating a significant gap in the medical curriculum and training of these professionals (Fallin-Bennett, 2015). In a survey conducted by Kitts et al. (2010), 75% of physicians agreed that issues pertaining to sexual and gender minorities should be covered more often during medical training. 40% of physicians participating in the AMA Collaborative Survey on Physician Experiences Caring for LGBTQ Patients also expressed that they had received no formal training on LGBTQ health during medical school or residency. The majority of those who had reported at least some level of training described it as minimally useful in their preparation for patient care (Vargas, 2014). Although they constitute one of the largest subsets of the health care delivery system, as little as 10% of nurses possess even a basic knowledge of transgender health care (Alegria, 2011). While 79% agree that an understanding of LGBTQ-related health issues is important, an average of 1.5 hours is dedicated to training on this topic (Walsh & Hendrickson, 2015). A variety of studies conducted on osteopathic medical students and physician assistants showed a similar level of knowledge and training dedicated to transgender health (Seaborne, Prince & Kushner, 2015). As a result of this lack of understanding, knowledge, and experience in LGBTQ health issues among medical providers, transgender patients are often expected to lead their own care. In a study including more than 6000 transgender individuals, 50% of participants reported that they consistently educated their primary medical care providers about their health needs (Grant et al., 2007).

In addition to being inadequately represented in the medical curricula and training of physicians, transgender patients often face poor treatment and discrimination in the health care setting. As a result, many patients feel reluctant to reveal their gender identity to their providers, even when this information could be clinically relevant. In a study of discrimination and health care experiences of LGBT patients in the United States, 20.3% of transgender patients reported being blamed for their own health problems, and more than 25% stated that they were blatantly denied care due to their identity (Lambda Legal, 2010). In the medical setting, structural and institutional forms of discrimination are often more insidious and may include neglecting to provide unisex patient bathrooms in clinics and hospitals, and preventing the disclosure of transgender status through new-patient intake forms. Approximately 88.5% of gynecologists surveyed reported that their intake forms did not contain a place for this type of information and many studies have cited this as one of the most challenging barriers to receiving health care for transgender patients (Unger, 2015). Deciding whether the M and F categories on intake forms refer to sex or gender has been shown to create a sense of conflict and vulnerability when seeking care. One patient expressed that “more options on the forms means there is room in people’s minds” (Dutton, Koenig & Fennie, 2008). Transgender patients have also expressed frustration over being addressed using improper names or gender pronouns by medical providers. Denying a request to self-identify or being called by a name not

yet listed on official documents made patients feel humiliated, dehumanized, and treated like second-class citizens (Dutton, Koenig & Fennie, 2008). Results of the National Transgender Discrimination Study reported that 33% of transgender participants have postponed preventative medical care due to fear of discrimination and 28% have postponed care for the same reason when they were sick or severely injured (Grant et al., 2011).

Fear of discrimination and a desire to conceal one's gender identity has contributed to significant consequences for the health of transgender individuals. Despite participating in higher-risk sexual practices, women of sexual minorities are much less likely to report lifetime or routine pap smears (Fallin-Bennett, 2013). 46% of transgender study participants using hormone therapies also report receiving their hormones from someone other than a physician (Xavier et al., 2007). Transgender individuals are known to be disproportionately affected by issues such as substance abuse, sexually transmitted diseases and poor mental health. They are twice as likely to engage in smoking than the general population and approximately 25% of transgender women are known users of non-marijuana illicit drugs such as heroin, cocaine and amphetamine (Reisner, Gamarel, Nemoto & Operario, 2014). Gender minority stressors are critical to understanding higher prevalence rates of substance abuse, and they often include experiences such as internalized transphobia, social marginalization, stress related to interpersonal relationships, and discrimination in employment, health care, and housing. It is also thought of as a coping mechanism in response to violence, victimization, and other forms of prejudice directed towards the community. In addition to experiencing higher rates of substance abuse, transgender individuals are also especially vulnerable to the consequences of using tobacco. For example, the use of cross-sex hormones in smokers increases the risk of heart disease and smoking has been shown to prevent recovery from surgery (Gamarel et al., 2015). Experiencing a global prevalence of about 19%, transgender populations remain disproportionately affected by HIV disease infection (Poteat et al., 2015). Due to significant discrimination in workplace and school settings that contribute to a lack of job opportunities, many transgender populations also resort to engaging in sex work. Experiencing an even higher HIV prevalence rate of 27%, transgender sex workers have been identified by UNAIDS as a significant risk group within the worldwide epidemic response (Roche & Keith, 2014). However, despite being highly affected by HIV and other sexually transmitted diseases, transgender populations often delay or avoid seeking related health care due to perceived stigma and discrimination. They are also often reluctant to reveal clinically important details of their sexual practices to medical providers out of fear of judgment and physician bias (Poteat et al., 2015). Experiences with abuse, discrimination, minority stress and internalized heteronormativity have also contributed to high rates of depression, anxiety, and suicide in these communities (McCann, 2015). In a Canadian study, a remarkable 77% of trans-identified individuals have seriously considered suicide, with 43% reporting an attempt at some point in their lives (Scanlon et al., 2012). An inability to access hormonal and surgical interventions related to the transitioning process has also been reported to adversely impact the mental health of transgender people (Veltman & Chaimowitz, 2014). As a group that is particularly vulnerable to societal stigma and discrimination, health care support and mental health service provision for this population is vital.

Although the rights of lesbian, gay, bisexual, and transgender individuals have recently garnered international media attention, gender minorities continue to face unique challenges in their access to health care. In order to achieve equity in medicine and effect positive change for the health of this vulnerable population, a paradigm shift is necessary. An important step to eliminating avoidable inequalities in health care and fostering an expectation of trust, open-mindedness and comfort across health care encounters is to acknowledge that stigma persists in the health care environment and contributes to barriers in access to care (Foglia & Fredriksen-Goldsen, 2014). Reducing barriers to health

care access also requires the evaluation of structural and institutional factors that contribute to discrimination in these communities. In order to produce health care professionals that are clinically competent and able to serve the needs of transgender populations, it is essential for medical schools and other health care programs to dedicate an adequate amount of time to the education of students on their unique health issues. Creating an inclusive, supportive and accepting health care environment also requires non-gender-conforming individuals to be equally represented and included on patient forms, electronic health records and other registration documents. In addition, they must be able to be respectfully acknowledged by their preferred names and gender pronouns in health care settings. If stigma and discrimination in the health care environment and community at large are effectively reduced, we can begin to make strides in providing acceptable and necessary care to trans-identified patients. This care begins with five simple words: How can I help you?

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