Abstract

This paper explores the various types of marginalization transgender individuals experience on a daily basis and its direct impact on the aggregation of health disparities for this population. In addition, responses from the healthcare community to the documented injustices of transgender people are analyzed at a federal, systems, and academic level. Conceptual frameworks are also evaluated to further understand and care for transgender clients. Using a phenomenological approach, this research describes the lived experiences of a transgender individual with healthcare, specifically how they navigate discrimination and stigma with providers, nurses, administrative staff, and facilities. Analysis revealed four themes, both with navigating healthcare and social interactions that have influenced his sense of self and state of health. These themes are (a) calculating the disclosure of a transgender identity, (b) managing discomfort of self and others, (c) respect and validation from others, and (d) lack of healthcare access. Practical implications for healthcare providers are also investigated, including opportunities for furthering the advancement of the healthcare profession as it relates to caring for the transgender community.

Keywords: transgender, trans, gender, gender identity, LGBT, discrimination, stigma, healthcare, Healthy People 2020, health disparities, lived experiences, phenomenology

A transgender individual's lived experiences: Navigating discrimination and stigma in healthcare

Introduction

Healthy People 2020, the nation's ten-year blueprint for health promotion and disease

prevention, represents a historic and legendary announcement unveiled by the U.S. Department

of Health and Human Services in December 2010. For the first time, this framework for public

health priorities for prevention and actions acknowledged health disparities of LGBT (lesbian,

gay, bisexual, and transgender) individuals and the negative impacts to health status, a symbolic

milestone. *Healthy People 2020* illustrates issues affecting the health of LGBT people by placing

emphasis on the affects of discrimination, importance of widespread cultural competency, and

the need for routine and comprehensive data collection on sexual orientation and gender identity

(U.S. Department of Health and Human Services, 2010). The inclusion of LGBT people in this

resource shifted the collective attention within the healthcare community. Organizations like the

Institute of Medicine, the Joint Commission, the National Center for Transgender Equality, and

the National Gay and Lesbian Task Force responded to the call for action with detailed

assessments, identified gaps in knowledge and resources, and outlined recommendations for the

healthcare industry in order to achieve the goals of *Healthy People 2020* (Institute of Medicine,

2011; Joint Commission, 2011a; Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011).

Individuals classified as LGBT experience unique health disparities (Institute of

Medicine, 2011). However the health needs of the community are often inappropriately

categorized together. Existing LGBT research focuses primarily on lesbian and gay populations,

with little research conducted on transgender individuals (Bauer, Hammond, Travers, Kaay,

Hohenadel, & Boyce, 2009). The existing body of research on transgender populations has

numerous limitations. Rates of lifetime suicide attempts for the transgender community are more

than double that of gay and lesbians and nearly ten times the general U.S. population (Haas,

Rodgers, & Herman, 2014). When transgender individuals are refused medical treatment due to

their identity, the prevalence of lifetime suicide escalated to 60% (Haas et al., 2014). These

figures indicate an epidemic of suicide among transgender people, not reflected in most research

that lumps "T" with "LGB" and are the basis of this qualitative study conducted to reveal the

lived experiences of a transgender individual as they navigate discrimination and stigma in

healthcare.

This paper will explore the various types of marginalization transgender individuals

experience on a daily basis and its direct impact on the aggregation of health disparities for this

population. In addition, responses from the healthcare community to the documented injustices

of transgender people are analyzed at a federal, systems, and academic level. Conceptual

frameworks are also analyzed to further understand and care for transgender clients. This

research project will also examine an individual case study, illustrating the lived experiences of a

transgender man navigating healthcare and his transgender identity. Practical implications for

healthcare providers are also considered, including opportunities for furthering the advancement

of the healthcare profession as it relates to caring for the transgender community.

Background

The acronym LGBT groups both sexual orientation (lesbian, gay, bisexual) and gender

identity (transgender) together. Sexual orientation refers to the physical and emotional attraction

to others along a continuum. Men that are primarily attracted to other men are gay, and women

predominantly attracted to other women are lesbians. Individuals attracted to both sexes are

bisexual. However, gender identity is not determined by physical or emotional attraction, but by

one's sense of being male, female, or other gender. Individuals born with their gender identities

aligned with the sex assigned at birth are considered cisgender; while those with incongruent

alignment are transgender (Joint Commission, 2011a). The term transgender also represents

individuals with gender expression varying from the gender binary system, also known as gender

non-conforming. Transgender people are diverse in physical presentation and sexual orientation.

Some choose to medically alter their bodies to affirm their gender identity (gender affirmation

surgery or gender reassignment surgery) while others choose minimal changes (changing their

birth name) with no desire to transform their body's appearance. Access to healthcare,

knowledgeable providers, insurance coverage, and financial circumstances shape transgender

individuals' inclination towards any physical changes requiring medical intervention (Grant et

al., 2011). In 2011, the Williams Institute of UCLA estimated that 0.3% of adults in the United

States identifies as transgender. This statistic may underrepresent the population, because some

transgender individuals are reluctant to self-identify due to societal stigmatization of transgender

people. Additionally, methods for counting transgender people are deficient and inconsistent.

Often demographic health forms or administrative intake forms neglect including transgender

identities (Bauer et al., 2009). Institutions use data collected from these forms to understand the

population they serve, to shape policies and programs, and to develop community outreach

initiatives. Another challenge in determining the number of transgender people is how data

collectors define transgender. Some data collection attempts have stipulated that some form of

physical change, or transition, is mandatory to be considered transgender (Gates, 2011). Under

these restrictions, the transgender population is underrepresented in demographic collection

methods.

Transgender is an umbrella term that refers to all of identities within the gender identity

spectrum (i.e. transgender, genderqueer, genderfluid, transsexual, gender nonconforming, two-

spirit) (Grant et al., 2011). For the purposes of inclusion, the use of "transgender or trans*" in

this paper will represent the entire gender identity spectrum and embrace the full range of bodies

and physical presentation preferences.

Review of Literature

Every day, transgender and gender non-conforming people face adversity and encounter

discrimination in all aspects of their lives – from grocery shopping to employment and even

healthcare. Grant et al. (2011) reported pervasive discrimination in employment (not being hired,

denied a promotion, or fired), housing (denial of housing), and in public settings (verbally

harassed and denied equal treatment by government agencies or officials) because an individual

identifies as transgender. "Trans people represent one of the most marginalized groups in our

society" (Bauer et al., 2009). This discrimination is based on their gender identification or

expression that unfortunately creates both economic and social marginalization. The inequalities

experienced may be heightened for transgender people of color and ethnic minorities when

coupled with other factors such as education level, income, geographic location, language,

immigration status, religion, and cultural beliefs (National Coalition for LGBT Health, n.d.).

In 2011, the National Center for Transgender Equality partnered with the National Gay

and Lesbian Task Force to evaluate transgender discrimination in the United States. *Injustice at*

Every Turn: A Report of the National Transgender Discrimination Survey (2011) highlights

various aspects of oppression, including numerous undesirable and potentially harmful

interactions with healthcare. The health disparities revealed in the report (2011) disclosed

challenges in accessing culturally competent health services, frequent occurrences in refusal of

care, delayed or substandard care, mistreatment, and barriers to equitable care. *The National*

Transgender Discrimination Survey (NTDS) included 6,450 study participants. Fifty percent

reported a lack of provider knowledge about transgender individuals, resulting in the patient

teaching their medical providers. Nineteen percent were refused medical care based on their

trans* status or because of provider bias. Twenty-eight percent reported experiencing harassment

in medical settings. Twenty-eight percent postponed medical care due to discrimination by health

care providers. Thirty-three percent delayed or did not try to get preventative healthcare due to

discrimination by health care providers.

Injustice at Every Turn (2011) explores numerous social, economical, and environmental

determinants of health. It highlights many challenges for transgender individuals such as: living

in extreme poverty, an exceedingly high prevalence of suicide attempts, jobs lost due to bias,

bullying and harassment in schools, and a higher preponderance of sexual and physical assault.

In addition to these profound findings, the report also communicates the transgender community

experiences a rate of unemployment double that of the general population (Grant et al., 2011).

Trans* people are denied housing, employment, insurance coverage, and healthcare based on

identifying as transgender, which compound the health disparities they experience. These health

determinants and disparities can be linked back to the societal stigma, discrimination, and

violence associated with being transgender (U.S. Department of Health and Human Services,

2010; Grant et al., 2011).

In January 2014, the American Foundation for Suicide Prevention and the Williams

Institute of the University of California School of Law revisited the NTDS data to analyze the

prevalence of suicide attempts among respondents. The new analysis revealed a staggering

percentage of suicide attempts, 41% for trans* identified people, much higher than in the general

population and among lesbian, gay, and bisexual individuals. To add perspective to this statistic,

4.6% of the general U.S. population reported attempting suicide while 10-20% of lesbian, gay,

and bisexual adults reported suicide attempts (Kessler, Borges, & Walters, 1999). Additionally,

lifetime suicide attempts were lower (36%), but still well above the general population, when

people were unaware or could not tell if the respondent was transgender. When transgender

people disclose their transgender status to everyone, the prevalence of suicide attempts was

elevated (50%). Furthermore, a higher prevalence (60%) of suicide attempts was discovered

among those that were refused medical treatment due to their trans* identity (Haas, Rodgers, &

Herman, 2014). Discrimination, victimization, rejection, or violence trans* individuals

experience when accessing healthcare are key characteristics and experiences that increase

lifetime suicide attempts.

The Federal Government acknowledged the discrimination transgender people face with

the inclusion of transgender-specific health priorities in *Healthy People 2020* (U.S. Department

of Health and Human Services, 2010). For the first time, transgender health was federally

recognized and set as a national priority. *Healthy People 2020*, like the NTDS, emphasizes the

impact of discrimination, the importance of widespread cultural competency, and the need for

routine and comprehensive data collection on gender identity. It also increases the public

awareness of the health determinants and disparities trans* people face in the United States.

Healthy People's overall mission brings much needed attention and resources to eliminate

disparities while improving the health of all transgender individuals.

The Joint Commission proactively responded to *Healthy People 2020* by urging U.S.

hospitals to improve healthcare quality for transgender patients and their families by creating a

more welcoming, safe, and inclusive environment. *Advancing effective communication, cultural

competence, and patient-and family-centered care: A roadmap for hospitals*, a monograph

released by the Joint Commission in 2011, outlines best practices for hospitals to ensure their

organizational readiness when serving the LGBT population. This invaluable resource identifies

how to provide culturally competent care to LGBT patients including: provisions of care,

treatment, and services; organizational leadership and policy development; workforce incivility

towards LGBT employees; staff competency trainings; data collection; and environmental

concerns for inclusivity (Joint Commission, 2011a). The Joint Commission will not tolerate

transgender discrimination within a hospital setting. A nondiscrimination standard (RI.01.01.01,

EP 29) based on sexual orientation and gender identity was placed into effect on July 1, 2011.

Failure to adhere to the nondiscrimination standard will jeopardize a hospital's accreditation

(Institute of Medicine, 2011; Joint Commission, 2011b). The Joint Commission is leading the

way with guiding principles for hospitals to execute and render healthcare equity with the

implementation of this standard.

Individuals classified as LGBT experience unique health disparities, however the health

needs of the community are often inappropriately categorized together. Often, research focuses

primarily on lesbian and gay populations, with little research conducted on bisexual or

transgender individuals (Bauer et al., 2009). The existing body of knowledge related to

transgender healthcare is extremely sparse and has been identified as a research opportunity

(Bauer et al., 2009; Grant et al., 2011; Haas, Rodgers, & Herman, 2014; Institute of Medicine,

2011). To further complicate matters, many researchers report findings pertinent to the entire

LGBT community when only studying lesbians and/or gay individuals. In essence, lesbian and

gay populations are researched and bisexual and transgender populations are not. Reporting

research findings as LGBT is misleading since bisexual and transgender data are not included.

Inaccurate representation of research findings in scientific journals regrettably further depletes

the dearth of clinical findings and evidence available for the transgender community. In a study

by Rondahl (2009), the knowledge level of undergraduate nursing and medical students was

assessed when caring for lesbian, gay, bisexual, and transgender patients. In this study, it was

reported that only 10% of undergraduate nursing students were found to have a basic level of

knowledge regarding the care of the lesbian, gay, bisexual, and transgender population (Rondahl,

2009). The research participants of this study were asked questions pertaining to understanding

of patients' sexuality and sexual behavior. This line of questioning only focuses on knowledge

regarding sexual orientation (gay, lesbian, bisexual). Rondahl did not inquire about the students'

familiarity or knowledge of gender identity or caring for transgender people. Unfortunately,

when Rondahl (2009) reported their findings, knowledge about caring for transgender clients

was included. Overall, Rondahl misrepresented the findings by including the "T" in LGBT and

used LGBT as a synonym for lesbian, gay, and bisexual. This inaccuracy perpetuates the

confusion, mistreatment, and discrimination trans* people face while sustaining the

misconception between sexual orientation and gender identity. The health disparities and

determinants for gays and lesbians are not the same for transgender individuals.

This is not the only instance of improperly presenting research findings on trans*

identities. *Nursing's Silence on Lesbian, Gay, Bisexual, and Transgender Issues* (2010)

references research performed by Carla Randall (2006). This article (2010) argues that

transgender issues and LGBT health topics were missing in nursing textbooks, but material

pertaining to caring for lesbians was included. Randall's (2006) paper documents findings in

nursing textbooks and the lack of content concerning caring for lesbian patients and only lesbian

patients. Using the acronym LGBT when citing Randall's research is misleading. Randall (2006)

only examined textbook content concerning lesbians. Gender identity or other sexual orientations

(gay and bisexual) were not explored. This blunder is not exclusive to nursing literature and

research. "The term *transgender* is appearing more frequently in education journal articles, it

usually appears at the end of the long list 'lesbian, gay, bisexual, transgender' or 'LGBT.' In

most of these articles, the main focus is on lesbian and gay individuals while transgender issues

are ignored" (Rands, 2009, p. 421).

   With the focus of healthcare shifting to reduce and eliminate the health disparities and

determinants faced by trans* people, is the nursing profession prepared to meet the challenge?

The simple answer is no. "Nursing, as a profession, has been slower than other health disciplines

in changing policies to include sexual orientation and gender identity and has been silent when

other professional groups have issued statements about topics…" (Eliason, Dibble, & DeJoseph,

2010). Accompanying the profession's conservative approach to policy development for LGBT

individuals, many currently licensed nurses are not proficient in providing competent, primary

care for transgender individuals as evidenced by the epidemic-like, lifetime suicide attempt rates

and discrimination encountered within healthcare settings. This is an unfortunate truth, but it is

not surprising since there is a lack of transgender education provided in baccalaureate nursing

curricula (Brennan, Barnsteiner, Siantz, Cotter, & Everett, 2012).

   The Essentials of Baccalaureate Education for Professional Nursing Practice (2008), also

known as *The Essentials,* serves as the framework for creating a baccalaureate nursing

curriculum. This document specifies the core knowledge and traits of nursing graduates should

have after completing a baccalaureate program. *The Essentials* does not on specific curriculum

content, instead giving undergraduate nursing programs latitude to design individual curricula,

including specific course content materials.

   The Essentials (2008) outlines the professional values that should guide the baccalaureate

prepared nurse when providing quality patient care. These values are: altruism, autonomy,

human dignity, integrity, and social justice. Social justice is also a central concept in patient

advocacy (American Association of Colleges of Nursing, 2008). According to *The Essentials*,

the baccalaureate program prepares the graduate to "advocate for social justice, including a

commitment to the health of vulnerable populations and the elimination of health disparities"

(American Association of Colleges of Nursing, 2008, p. 25). While this broad statement should

include care for transgender individuals, *The Essentials* (2008) does not mention "gender

identity" or "gender" in their definition of "social justice" (American Association of Colleges of

Nursing, 2008, p. 28).

The increasing diversity within the United States' population commands the attention of

baccalaureate nursing programs' curricular content (American Association of Colleges of

Nursing, 2008). *The Essentials* (2008) includes the following terms when explaining diversity:

culture, spiritual, ethic, gender, and sexual orientation. The use of "gender" refers to a person's

biological sex, whereas "gender identity" pertains to "one's sense of oneself as male, female, or

transgender" (American Psychological Association, 2006, "Difference between sex and

gender"). This limiting interpretation of diversity impacts how baccalaureate nursing programs

create their curriculum because it does not include transgender identities.

The Federal Government identified the transgender community's health as a national

priority, and the Joint Commission evaluates hospital compliance with standards for effective

communication, cultural competence, and patient/family-centered care for transgender patients;

but baccalaureate nurses are graduating without knowledge on providing basic primary care for

the trans* community (Brennan et al., 2012; Joint Commission, 2011a; Joint Commission,

2011b; U.S. Department of Health and Human Services, 2010). However, nursing schools in the

United States claim their baccalaureate graduates are adequately prepared to meet the needs of

diverse populations. This is an important distinction and contributing factor towards transgender

health disparities. Nurses receiving proper education on caring for transgender patients are better

equipped to reduce such disparities. Bedside nurses are well-positioned to affect trans* patient's

healthcare experiences. Nurse leaders are also able to impact institutional practices and

protocols, eliminating institutional erasure and discrimination (Bauer et al., 2009). With the lack

of curriculum content, nurses are not able to meet the needs of the population they serve and

implement changes to improve healthcare delivery.

Nurses have an enormous opportunity to positively impact the healthcare system. They

are pivotal in creating a healthcare system where all people, including trans*-identified, have the

opportunity for safe, compassionate, and effective care. The Nursing Code of Ethics (2001)

outlines the ethical obligations, duties, and commitments of the nursing profession. This code is

broken down into nine provisions, acting as a framework of ethical standards for nurses in all

roles and settings. Overall, the patient is the primary commitment and focus of the nurse. All

aspects of the patient's unique life must be taken into consideration when providing care. This

patient-centered approach includes being a patient advocate to ensure the delivery of competent,

ethical, and legal care by all members of the healthcare team or system. The nurse has a moral

obligation to preserve the integrity and accessibility of healthcare. This responsibility extends

beyond the treatment room or one-on-one patient encounter. Nurses must assess the healthcare

environment, the competency and healthcare delivery of their colleagues. Nurses also contribute

towards the advancement of the their profession and social changes to improve healthcare.

Overall, the fundamental ethical principle nurses must embody – providing care that transcends

all individual differences. Respecting and caring for patients is at the very core of what the

nursing profession stands for; "an individual's lifestyle, value system and religious beliefs should

be considered in planning healthcare with and for each patient. Such consideration does not

suggest that the nurse necessarily agrees with or condones certain individual choices, but that the

nurse respects the patient as a person" (American Nurses Association, 2001, Provision 1, para 3).

This serves as the nursing framework for creating healthcare equity for transgender clients.

Within this review of literature, several themes emerged. First, there is widespread

discrimination and stigma for trans* individuals. Transgender people experience injustices every

day and in all aspects of their lives, including when seeking and accessing healthcare. This

discrimination and adversity not only add to the community's health disparities, it directly

impacts the lifetime suicide attempt rates for transgender people, which are ten times higher than

the general population. As discrimination and adversity negatively impacted the health

disparities of transgender people, these factors also are key characteristics and experiences that

increase lifetime suicide attempts. Second, The Federal Government and The Joint Commission

acknowledged the health disparities and injustices trans* people face when accessing healthcare.

Healthy People 2020 set transgender health as a national priority and The Joint Commission

provided hospital safe patient standards when caring for transgender individuals. Third, the

existing body of knowledge related to transgender healthcare is extremely sparse and has been

identified as a research opportunity. In addition to the knowledge gap, researchers often report

findings pertinent to the entire LGBT community when their studies are only relevant to lesbians

and/or gay individuals. Lastly, the nursing profession is in a very unique position to positively

impact healthcare experiences of transgender people, but most baccalaureate prepared nurses are

not educated on caring for the trans* community.

Conceptual Frameworks

In order to reduce and eliminate the knowledge gap, multiple conceptual frameworks

may be applied to further understand and care for transgender clients. The *life-course perspective*

model, minority stress model, intersectionality, social ecology model, and the *concept of erasure*

form a holistic lens to better understand the trans* patient's perspective (Bauer et al., 2009;

Institute of Medicine, 2011). These frameworks examine how the intersection of multiple

identities along with environmental, social, and institutional discrimination influence healthcare

access, health status, and health outcomes. These frameworks provide further insight into how an

individual's lived experiences impact their health, a shortcoming in the scientific clinical

literature.

The life-course perspective identifies how experiences during every stage of an

individual's life impact subsequent experiences with four key dimensions of correlation: 1)

linked lives (relationships with others influence an individual's perspective), 2) life events as part

of an overall trajectory (previous life experiences are impressionable), 3) personal decisions

(decisions are unique to an individual's environmental conditions), and 4) a historical context

(generational influences on perspective) (Cohler & Hammack, 2007).

The *minority stress model* was originally developed for lesbians by Brooks (1981) and

later for revised for gay men (Meyer, 2003). This model includes two categories of stress, distal

and proximal stress processes (Meyer, 2003). Distal stress encompasses actual experiences of

discrimination and violence. Proximal stress is solely based on an individual's perception and

often refers to self-directed stigma as a result of society's acceptance of the individual's identity

(Meyer, 2003). Meyer (2003) explained that when both proximal and distal stressors are

experienced, a higher prevalence of anxiety, depression, and substance use is common. Evidence

supports the validity of this model for the transgender population because several studies propose that stigma can negatively affect the mental health of trans* people (Nemoto, Iwamoto, & Operario, 2003; Nemoto, Sausa, Operario, & Keatley, 2006)

Transgender individuals possess multiple social, ethnic, racial, and economic identities. These identities simultaneously interrelate, shaping dimensions of inequality, discrimination, and marginalization. An *intersectional perspective* takes this into account and focuses on how each identity influences the others while adversely impacting health (Gamson & Moon, 2004).

The *social ecology model* explores how behavior affects the social environment and the environment's affect on behavior. Within this model, families, relationships, community, and society are environmental subcategories (McLeroy, Bideau, Steckler, & Glanz, 1988).

The last theoretical framework focuses on the impact of information and institutional *erasure* of trans* identities. Bauer et al. (2009) found two key domains to the pervasiveness of trans* eradication: informational systems and institutional policies and practices. Within these domains, *erasure* could be passive (i.e. lack of provider competency) or active (i.e. visible discomfort or refusal of services). The knowledge gap and lack of research available on the lived experiences of trans* people and healthcare is an example of *informational erasure*. These deficiencies impact healthcare curricula and standards of care, which perpetuate the cycle of *erasure*. Consequently, marginalization and stigma within the trans* community increases (Bauer et al., 2009). Another example of *informational erasure* is the imprecise incorporation of gender identity concepts with sexual orientation material, as described in the literature. "This *erasure* reflects the priorities, biases, and oversights of writers and publishers who function in a cisnormative system" (Bauer et al., 2009, p. 353). *Institutional erasure* accounts for the lack of policies and protocols to accommodate trans* identities. This includes demographic intake

forms, the lack of safe, trans-inclusive spaces within the hospital, and institutional infrastructures

that omit the existence of trans* identities. The residual effects of *institutional erasure* extends

beyond policies. The important healthcare needs and the overall existence of trans* identities are

subconsciously removed from the minds of healthcare providers and staff (Bauer et al., 2009).

Erasure of trans* identities creates a healthcare system where trans* patients are viewed as an

anomaly. This directly influences the extensive discrimination experienced by transgender

individuals when seeking healthcare.

Methods

This qualitative research design attempts to gather data through a phenomenological

approach. Phenomenology is the study of individual's lived experiences using personal narrative

to gain a deeper understanding of a phenomenon (Van Manen, 1990). Personal narrative

illuminates the reality endured by accurately documenting personal and intimate occurrences of

one's experiences. In this study, a phenomenological approach was utilized to describe the lived

experiences of a transgender individual with healthcare, specifically how they navigate

discrimination and stigma with providers, nurses, administrative staff, and facilities.

In order to discover the intricacies of a transgender individual navigating the healthcare

system, I used convenience sampling to perform a case study of one individual. Criteria for

inclusion were: self-identified as transgender; has undergone physical transition to affirm present

gender identity, and transition may be defined as any hormonal, surgical, and/or non-medical

alternation to physical appearance; English-speaking with adequate fluency to respond to

interview questions; previous interactions with healthcare professionals as a transgender

individual; and 18 years of age or older. Volunteer recruitment efforts were focused to outlets

with current transgender initiatives located inside the Triangle.

Research Procedures

Prior to this study's initiation, IRB approval was sought and subsequently the Office of

Human Research Ethics of UNC Chapel Hill determined that this study did not constitute as

human subjects research and IRB approval was not required. One qualifying individual was

enrolled and participated in a single face-to-face interview, lasting approximately 90 minutes and

conducted in their home. The participant signed a consent form and verbally authorized their

permission to record, transcribe, and report on the data collected during the interview. The

participant was permitted to decline to answer any question or terminate the interview at any

point. Given the flexibility of an exploratory study, the participant was able to navigate the

interview to the topics that revealed their lived experience with healthcare and their transgender

identity. A list of general questions (Appendix A) was prepared prior to the interview session and

used to guide the research participant in the event such guidance was needed. The interview was

recorded and transcribed, with a copy of the transcription provided to the participant for

verification, clarification, and validation of the information. The information collected in the

interview is acknowledged as truth and the participant's memory is assumed accurate.

Preliminary data analysis began during the interview and continued throughout its

transcription (Sandelowski, 1995). As the primary investigator reviewed the transcription,

themes and ideas were processed in relation to the research participant's input during the

interview. After the research participant endorsed the interview transcript, the interview's raw

data was placed into a three-column table. The far left column represented the primary

investigator's questions and comments and the center column for the research participant's

responses. The far right column was designated for any notes, themes, or ideas collected by the

primary investigator during the interview and its transcription. Any comments or responses were

interpreted as significant were indicated with a bold typeface. In order to revel themes from the

interview, the boldface type data was extracted from the original interview and further analyzed.

This analysis consisted of clustering like data or concepts into categories (Sandelowski, 1995).

This process provided an opportunity to uncover specific themes from the research participant's

lived experiences.

Sample

In this study, one transgender man's experiences and perceptions regarding his identity

and interactions with healthcare were explored. The research participant (RP) is a masculine,

Caucasian man in his late forties who elected to transition using hormone replacement therapy

when he began to identify as a transman, approximately five years prior to this study. Before his

transition, he identified himself as an "out, butch lesbian, living as a woman" for over thirty

years in the same geographic region as he does today. His physical appearance and demeanor

align with societal norms and expectations for men, thus his transgender status is concealed upon

initial visual impression. Within the transgender community, this is often referred to as *passing*

and occurs when a person's gender presentation matches their gender identity and they are not

perceived as transgender by strangers. With the diversity among the transgender population and

the influence of intersectionality, documentation of the research participant's physical

presentation is important when interpreting their lived experiences and their ramifications. It

should not be used to fixate upon their anatomy. As Laverne Cox (2014), a transgender activist,

so eloquently articulated,

> "the preoccupation with transition and with surgery objectifies trans people and then we
>
> don't get to really deal with the real lived experiences. The reality of trans people's lives
>
> is that so often we're targets of violence. We experience violence disproportionately to

the rest of the community... when we focus on transition we don't get to talk about those

things."

Research Findings

Analysis revealed several themes in RP's experiences as a transman, both with navigating

healthcare and social interactions that have influenced his sense of self and state of health. These

themes are (a) calculating the disclosure of a transgender identity, (b) managing discomfort of

self and others, (c) respect and validation from others, and (d) lack of healthcare access. These

themes offer context for RP's life and use of healthcare. When nurses understand the context of

patients' lives, they can deliver more comprehensive and compassionate nursing care (American

Nurses Association, 2001; Bauer et al., 2009; Institute of Medicine, 2011; World Health

Organization, 2011). A thoughtful decision was made to keep direct quotes intact in order to

convey RP's emotional responses to questions regarding sensitive and highly emotional lived

experiences.

Calculating the Disclosure of a Transgender Identity

Transgender individuals experience socially-constructed stigma in all aspects of their

lives related to others' perceptions of their transgender status. RP's physical appearance conceals

his stigmatized identity, because his transgender status can be kept hidden from others. However,

his identity is still associated with social devaluation, as described by Quinn and Chaudoir

(2009). To understand the attributes of a concealable, stigmatized identity, attention must be paid

to the characteristics of a stigmatized identity – the mark of failure or shame which taints oneself

in the eyes of others (Goffman, 1963). Incidence of stigma is associated with both concealed and

visible trans* identities. RP experiences considerable stressors and psychological challenges due

to a threat of potential discovery by others. He devotes considerable energy to the strategic

management of divulging personal information, as noted by Pachankis (2007). RP must navigate

conversations with family, friends, and strangers; deciding whether to reveal his identity first

and, if so, then how to present his stigmatized identity. At times, RP feels forced to disclose his

transgender status to community members who knew him prior to transition, when he lived as a

woman. He describes his experience:

> *"You don't think about going down to the corner store where they have known you for 10*
>
> *years as a girl, and all the sudden you go in there and your voice has gotten lower, and*
>
> *you started to sprout facial hair, and you don't think how that's gonna impact you. Even*
>
> *my next door neighbors, I haven't actually said, 'Hey, guess what, I'm trans* now.' It is*
>
> *just like, yeah. It is uncomfortable for me to say that to people."*

Often others initiate these discussions of disclosure without warning, further adding to

RP's stress on a daily basis. Such invasions of privacy are something RP encounters often. He

acknowledges these impromptu conversations are grounded with good intention and support of

his identity. When others openly discuss his personal details without his consent, RP feels

violated. Pachankis (2007) suggests that emotional suffering occurs when shame or fear of

rejection are motivating factors in keeping the stigmatized identity concealed. Individuals may

experience distress if they feel that they are keeping a secret. Trends in the NTSD report (2011)

reflect 57% of respondents experience significant family rejection and 63% encounter serious

acts of discrimination or contributing events which impacts an individual's quality of life. These

factors have influenced RP's interactions with others and his vigilance with the language he

chooses in conversations surrounding his identity.

> *"I think when I was a butch lesbian I was very much willing to tell people, 'No, I'm a*
>
> *girl.' And now that I'm trans, its much more difficult to say, 'No, I'm trans*.' It is*
>
> *uncomfortable for me to say that to people."*

Even after RP's father lost his battle with cancer, he was unable to tell his mother he is trans*.

> *"She kept asking me, 'How are you doing this? How are you not breaking down?'*
>
> *Finally, I said 'because I am taking testosterone.' I never really said I was trans*. I just*
>
> *said I was taking testosterone because I couldn't get out the 'I'm trans* part.'"*

Navigating how and when to disclose his transgender identity is grounded in self preservation and circumventing the elusion of anticipated negative impacts of discrimination and stigma by the intended recipient. These negative impacts are a fundamental cause of health disparities (Grant et al., 2011). The examples RP provided regarding carefully maneuvering conversations and remaining mindful of his language are examples of the life-course perspective framework. Every interaction RP encounters surrounding disclosing his transgender identity; he quickly considers previous interactions before engaging in the present moment (Cohler & Hammack, 2007).

Managing Discomfort of Self and Others

Not only does RP regularly negotiate choosing to communicate his transgender status, he has altered his behavior in an attempt to remain comfortable and safe without exposure of his true identity. He shared a story of what many consider a normal occurrence, dropping off his car at his mechanic's shop. For RP, this routine errand was plagued with contemplation and fear which ultimately led to a poor decision. RP elected to drop off his car the night before and subsequently his tires where stolen from his vehicle.

"All because I didn't want to drop my car off in the morning where I had to go in and talk

to my mechanic. Because I don't look the same way as I used to and I didn't want to have

that conversation. It was just my level of discomfort that led me to do something that I

should not do. I would rather my tires get stolen then have to go in and say that in front

of all the people in my mechanic's office."

Upon further introspection and reflection, RP compares his life lived as a lesbian versus

now as a transman. He feels *"it was easier when I was a butch lesbian…."* and suggests that

repercussions stemming from decisions made as a transman are different than as a lesbian. RP

experiences discomfort when declaring his transgender identity to others. He also recognizes

uneasiness in others after his admission of being trans*. This visible discomfort from others is a

form of passive erasure and may impact RP's perception of himself by increasing self-directed

stigma as illustrated within the minority stress framework (Bauer et al., 2009; Meyer, 2003).

From time to time, other's discontent is outright evident and intolerable, causing RP heartache.

RP recounts how his godson's family reacted to RP's physical transition from female to male.

"When they realized I started taking testosterone, they just flipped out. His mom said I

was never to see him again. I have been able to see him but I have to shave every time I

go over there. I don't talk normal. I try to raise my voice. I try to be as feminine as

possible. He is 15 now. I have to hide the fact that I am trans because they will not accept

it and the relationship that I have with that kid is more important to me at this point."

Regulating one's emotions by carefully choreographing their day-to-day decisions is a daunting

task. RP not only adapts his conversations and actions to conceal his transgender identity, he

attempts to modulate any unfavorable reactions of others to his identity. RP shares a recent

interaction he had with his mother and his discretion not to correct her poor choice of words.

"She calls me her daughter and she still says 'she' when she refers to me. But she'll say,

'well you know you will always be my daughter' or 'whatever it is you are.' I don't feel

right taking the place of her son because her son died. I would have felt more

comfortable in urging her to refer to me as 'he' or things like that."

RP elected not to correct his mother in this example, but her word choice still echoes in

his memory. His mother's intent was not to harm RP, but her aversion to acknowledging RP as a

man is a form of discrimination. The stigma and discrimination RP encounters and attempts to

avoid throughout conversations with others negatively impacts his mental health (Meyer, 2003;

Nemoto et al., 2003; Nemoto et al., 2006).

Respect and Validation From Others

RP spoke of several incidences of institutional erasure, specifically the lack of policy

adherence that accommodate trans* identities (Bauer et al., 2009). Arriving at facilities that are

unprepared to embody patient requests as simple as a preferred name or pronoun leaves RP

feeling disrespected and invalidated. In return, these injustices impact the quality of healthcare

received and influences his decisions when seeking care. These occurrences transpired after the

Joint Commission's recommendation to use and document a transgender patient's preferred

name even if not the legal name by all staff. "Note the patient's preferred name prominently in

the patient record to make sure that staff address the patient appropriately. Staff should be aware

that patients who identify as transgender may have a name preference that differs from their legal

name and may or may not have altered their bodies medically" (Joint Commission, 2010, p. 14).

"Can't you just request that they call me [first name]? Or just call me by my first and last

name? They were real hesitant to do that. I've said, 'Why do you have to say Mr. or Ms.,

can't you just say first name and last name?'"

The Joint Commission (2011a) further suggests that this is an essential component of patient

safety. RP recounts several encounters at outpatient healthcare facilities refusing to acknowledge

his request to use male pronouns or his first and last name instead of Ms. The facilities argued,

"We can't do that. We need to go on what your ID says." Even as RP sits in the waiting room, he

ignores the calls for Ms. [RP last name] and adds, *"if they call out [first and last name] then I*

stand up. And they are like – OH."

Often, the registration and admitting process create barriers for trans* patients. A

transgender individual will not always have legal documents or health insurance cards matching

their physical gender presentation or preferred name.

> *"Being in a vulnerable state and then being disrespected and then feeling like people*
>
> *really didn't care about your physical well-being. You merge yourself so your outward*
>
> *appearance matches the way you feel on the inside and you are still not getting the*
>
> *respect that you feel that you deserve after you have gone through all this f*****g*
>
> *trouble and all this expense and you are still getting disrespected."*

Encountering challenges upon arriving at a facility will negatively impact the relationship

between the patient and healthcare team. Such challenges will not only impact a therapeutic

relationship, it may also discourage trans* people from seeking healthcare (Grant et al., 2011).

RP's experiences unfortunately are common occurrences for transgender individuals (Grant et

al., 2011) and a form of institutional erasure (Bauer et al., 2009).

Lack of Healthcare Access

Access to healthcare is a universal right, but many transgender individuals struggle to find

facilities, competent providers for basic healthcare needs, and appropriate healthcare insurance

coverage. The NDTS (2011) findings document a widespread ignorance about the health needs

of trans* people, discrimination, violence, and denial of services when seeking care. The

accumulation of these unfortunate realities cause some trans* people to avoid seeking care,

which includes routine care and implementing preventative healthcare measures. RP insists that

finding a provider who is trans* competent and comfortable caring for his anatomy is a

challenge. He performed countless hours of research to identify a gynecologist in the area for a

routine pap smear. He explains that while he still has the anatomy of a cisgender female, some

offices are not willing to accept transmale patients to their all-female practice.

RP also encounters providers who lack general knowledge on transgender individuals.

Navigating healthcare and making informed decisions about his health becomes difficult. He

explains that he receives "*conflicting information about, having female anatomy, still having a*

uterus and ovaries, and how menopause is going to affect me." Proper standards of care for

transgender clients is insufficient due to the lack of research. The dearth of longitudinal studies

researching the impact of hormone replacement therapy in transgender men with ovaries as they

approach menopause is an example of informational erasure. Also, combining the lack of these

standards and inadequate provider knowledge on trans* people leaves RP feeling doubtful about

the medical information he receives from healthcare sources.

> *"He [urologist] felt very uncomfortable with the whole trans* thing even though he did my*
>
> *exam. I could just tell he wasn't very comfortable with the idea. It made me concerned that I*
>
> *wasn't getting the proper care, that I wasn't getting all the information that I could have*
>
> *gotten."*

To further complicate healthcare matters, trans* people are less likely than the general

population to have health insurance and almost all transition-related care is not covered by

insurance (Grant et al., 2011). The desire to medically transition varies by person. There are

numerous surgeries available for transmen and transwomen. The type(s) of surgery elected varies

from individual to individual. However, the ability to afford the treatment is highly dependent

upon the individual's financial stability and source of income. RP explains how he is impacted

by financial constraints and lack of healthcare insurance benefits.

> *"If I had access to it [top surgery or bilateral mastectomy], I would totally have it tomorrow,*
>
> *but it's out of my price range. I just can't afford to put down eight thousand dollars to have*
>
> *surgery, nor could I afford to take out a loan. If I had eight thousand dollars, I would get a*
>
> *new roof in my house, and I would get the leak in my basement fixed. I would get two*
>
> *thousand dollars of work that has to be done on my car –those things so I can live day to day.*
>
> *It would be great if that was covered under insurance because then I wouldn't have anything*
>
> *to worry about it. Insurance covers f*****g Viagra."*

Compilation of Themes in One Healthcare Encounter

RP shared numerous lived experiences throughout the interview session. One profound

encounter stands out from the rest. It represents the previously explored themes and conceptual

frameworks while revealing vulnerable and cruel realities many transgender people endure when

accessing healthcare. In November 2011, RP had experienced a health predicament that brought

him to a Triangle area hospital's emergency room. RP was experiencing an extremely elevated

blood pressure with severe anxiety of unknown origin, possibly due to a medication interaction.

A close friend accompanied RP to a level one trauma center located within the Triangle to rule

out two serious medical emergencies, a heart attack or stroke. During a very vulnerable life

event, RP experienced significant barriers, ridicule, and inhumane treatment at this hospital, even

before he was evaluated by a healthcare team member. The check-in process presented

systematic and personal challenges for hospital staff. These gatekeepers were not prepared when

RP handed them his drivers license. His license reflects a female gender marker, though he

presents as a masculine male. In addition to this discrepancy, RP previously was in their

electronic medical records as female. After RP provided his driver's license, the staff member

consulted another sitting nearby and then she walked away. As RP described this situation during

our interview, his emotions were heightened. His tone shifted sharply from a friendly

conversational tone to expressions of anger and sadness.

> "*The girl gets up and goes in the back and brings three or four people with her. They*
>
> *come up and she's like, 'That's a girl.' Pointing at me saying, 'No, that's really a girl.' It*
>
> *wasn't business-like at all. I was a spectacle. I was a freak show at the circus. It was*
>
> *definitely to draw attention to the fact that my outward appearance didn't match [my*
>
> *identification]."*

In the emergency room, the focus became gender/appearance mis-match, rather than RP's health

condition.

After waiting hours to be triaged, RP finally was assessed by a nurse. During the

evaluation, the nurse listened to RP and his friend recount the spectacle created during the check-

in process. She listened and validated their experienced. RP recounts this memorable moment:

> "*The nurse was apologizing for them, that most people at the facility are not like that.*
>
> *She was awesome because she was matter of fact. She was concerned with my care. That*
>
> *[being transgender] didn't matter to her. What mattered was making sure I was*
>
> *physically OK. That was very reassuring."*

The nurse focused on the health assessment which put RP at ease, especially the multiple blood

pressure readings within normal limits. After the assessment, RP was redirected back to the

check-in desk where he had another degrading experience with a different staff member. This

employee continued to call RP "*Ms. [last name]*" even after he and his friend interjected, "*He*

goes by he." The staff member ignored their requests and numerous corrections to her

inappropriate choice in language. "*She was blatantly being disrespectful. I just wanted to get out*

of there. This is b******t. We ended up leaving without seeing a doctor."

   After leaving, RP thought this experience was over. A few weeks after the emergency

room visit, he received a call from a hospital supervisor from the level one trauma center. The

call was initiated after RP's friend filed a formal complaint. Initially RP was thankful for the call,

but in his opinion, the supervisor's remarks added an additional layer of disrespect. They

supported their staffs' decision to use female pronouns and refer to RP as Ms. [last name].

> "*The supervisor over these people in the office was just a f*****g moron. They really*
>
> *didn't give a s**t. They didn't care. I don't think she took it very seriously, and she pretty*
>
> *much wanted to make excuses for the people that were under her.*"

   The emergency department experience was unfortunate and appalling for RP. The

disrespect and ignorance from the supervisor was unacceptable. Both circumstances deviate from

a patient-centered healthcare approach while violating patient safety standards (Joint

Commission, 2011a). While these infractions may not be apparent to RP, he will always

remember feeling disrespected and inconsequential. Previous life experiences leave lasting

impressions, especially during vulnerable times, as suggested by the life-course perspective

(Cohler & Hammack, 2007). The experiences of discrimination and disrespect toward RP will

lead to him choosing not to return to that hospital.

> "*It definitely makes me weary of going to an emergency room again. I refuse to go to that*
>
> *specific place. I have never had anything happen like that, experience in the ER. That*

was stuff you read about, that you never think is going to happen to you. I didn't really

realize that it could happen, but it did."

The long-lasting implications of his choices are difficult to predict, but according to the

minority stress model, RP's health will be impacted (Meyer, 2003). The minority stress model

suggests an increase in anxiety, depression, and self-directed disapproval of RP's transgender

identity because of the emergency room experience (Meyer, 2003). After the incident, RP

repeatedly replayed the events in his head. The mental and emotional stress of reliving the

experience amplifies the existing stress of RP's existing day to day. He grapples with remaining

positive, "*Me being angry isn't going to change it. It's just a cultural shift that has to happen."*

RP highlights a powerful perspective all healthcare providers must keep in the forefront of their

mind,

>*"At a hospital, especially in an emergency room, you shouldn't be concerned with*
>
>*somebody's gender identity. You shouldn't be concerned with how they present. You*
>
>*should be concerned with their health. And that should be the bottom line."*

This one encounter is an example of the challenges and circumstances so many

transgender people endure when accessing healthcare (Grant et al., 2011). RP's lived experiences

illuminate the multiple system breakdowns in providing safe, compassionate, patient-centered

healthcare. The positive interactions between RP and the triage nurse are overshadowed by the

blatant acts of discrimination and disrespect from other staff members. The nurse's apology was

simply not enough to create a welcoming and safe environment for RP.

Implications for Care

Circumventing healthcare obstacles trans* people face is a daunting task that requires a

multidisciplinary approach. Attention must be focused on eliminating barriers to accessing health

services and also educating current and future healthcare professionals on caring for the

transgender community. The lack of access not only speaks to the absence of health insurance for

primary care and trans-specific needs but also to the scarcity of competent, knowledgeable and

compassionate providers. These examples of informational and institutional erasure continue to

perpetuate the stigma associated with being trans* (Bauer et at., 2009) and add to the

community's health disparities (Cohler & Hammack, 2007; Grant et al., 2011; Meyer, 2003;

Nemoto et al., 2003; Nemoto et al., 2006).

Social and healthcare environments must improve to help eliminate the adverse reactions

of being a member of a marginalized and stigmatized identity. These environments have created

increases in rates of suicide ideation, depression, and anxiety for trans* people (Grant et al.,

2011; Haas, Rodgers, & Herman, 2014; Meyer, 2003). Furthermore, as interventions are

concentrated to eliminate the health adversities, revamping our public health infrastructure to

establish critically needed research, and consistent and all-inclusive data collection tools in

pursuance of evidence-based guidelines for hormone replacement therapy, primary care needs,

and trans*-specific healthcare are required. Researchers that unintentionally misrepresent data

should be held accountable for their role in creating and perpetuating transgender discrimination.

Changing the entire landscape of healthcare to properly care for and acknowledge

transgender identities will require time. Fortunately, some smaller changes in healthcare require

less of a time investment while positively impacting the lives of trans* people. The aggregation

of these expeditious enhancements will create the overall change needed within the healthcare

arena. Healthcare systems can develop policies and protocols to accommodate trans* identities

within their facilities. They must focus on eradicating their acts of institutional erasure by

including trans-inclusive spaces within their hospital, updating both demographic forms and

electronic medical records to recognize transgender identities, and educating all staff members

on appropriate communication with transgender people.

Innovative approaches to change occur the moment a person no longer accepts the

limiting beliefs surrounding them. This change agent can be a nurse, a physician, or an

administrative support representative. Innovative approaches are necessary to propel the

healthcare field forward to remove the barriers trans* people encounter when seeking care.

Considering the life-course perspective, previous life experiences and environmental conditions

impact subsequent experiences (Cohler & Hammack, 2007). RP's interactions with

administrative personnel resulted in him choosing never to return to that facility for care. These

interactions did not pertain to any medical advice or treatment. RP felt disrespected, devalued,

and subhuman because several individuals did not understand how their approach to providing

patient-centered care was lacking and insensitive. Educational sessions explaining basic

communication approaches are relevant for all types of employees working in the healthcare

setting. In order to help reduce the occurrences of trans* discrimination in healthcare, I

conducted a series of educational seminars for providers, nurses, healthcare administrative staff,

nursing students, and nursing faculty. I spoke to these various target audiences about how they

can all work towards healthcare equity and to reduce other trans* experiences like RP's. I

configured presentations (Appendix B) using trans* healthcare resources from the Center of

Excellence for Transgender Health at the University of California, San Francisco, the Joint

Commission Field Guide, and the National Center for Transgender Equality's *Injustice at Every*

Turn. The Center for Excellence for Transgender Health develops and provides access to

comprehensive, effective and affirming healthcare services for the trans* population (Center of

Excellence for Transgender Health, 2013).

For these interventions, I used an informational approach to deliver not only introductory

concepts of transgender identities, but also functional knowledge healthcare members can

incorporate into their respective roles. I focused on helping the learners by anticipating their

future experiences with transgender clients in clinical settings. This practical knowledge

supported a deeper understanding while positively impacting the intervention's effectiveness and

audience engagement. Introducing and illustrating a portrait of transgender identities,

terminology, and multiple aspects of societal stigmatization became the foundation of the

presentation. Once this groundwork was delivered, I transitioned into educating others on

patient-centered, compassionate, safe, and comprehensive care for transgender patients.

Educating healthcare providers and staff on the impact of appropriate communication

approaches does advance the field. This is a step forward; one of the many steps needed to

sufficiently transform a broken system. "It is simply not acceptable for patients to be harmed by

the same health care system that is supposed to offer healing and comfort" (Kohn, Corrigan, &

Donaldson, 2000).

Limitations

This in-depth look into one individual's lived experiences should not be generalized as

representation for the entire transgender community. This study is foundational work, paving the

way for future research with larger sample sizes. It is also important to note the research

participant of this study is an educated, able-bodied Caucasian masculine male. Inequalities

experienced are heightened for people of color, females, and those with disabilities (Grant et al.,

2011; Institute of Medicine, 2011; National Coalition for LGBT Health, n.d.). Social

interactions, field settings, participant's perceptions of the chosen topic, and current events all

may impact the validity of this study. Also, the methods used to select a research participant may

exclude subjects who are not known to the primary investigator.

Closing

The fundamental focus of healthcare professionals is to do no harm by providing

atraumatic care. According to the facts, the healthcare system fails to meet the basic objective of

patient-centered care for transgender individuals. Transgender people deserve fair and equal

treatment without bias, especially as it concerns healthcare. One's health is a basic physiological

need, universal to all humans. Transgender people should not experience harm when seeking

healthcare because of other's biases about their gender expressions or identities. The multiple

breakdowns in our country's healthcare system must be fixed to eliminate the heath disparities

experienced by transgender people. Healthcare systems should consider both institutional and

informational forms of erasure when identifying areas to rectify within their facilities. When

these systems consider implementing new evidence-based practices, close examination of the

literature is necessary since researchers often report findings pertinent to the entire LGBT

community when their studies are only relevant to lesbians and/or gay individuals. Research

champions embarking on increasing the existing body of knowledge related to transgender

healthcare require support and funding. Nurses and nursing school faculty should understand the

populations they serve, especially the populations deemed a national priority by *Healthy People*.

Baccalaureate nursing programs must also reexamine their approach to curriculum development

by considering The Federal Government's assessment of the nation's health priorities. We are all

capable of creating the change needed. You must be willing to do what it takes to no longer

allow the norm to be acceptable.

References

American Association of Colleges of Nursing. (2008). *The essentials of baccalaureate education*

for professional nursing practice. Retrieved from: http://www.aacn.nche.edu/education-

resources/BaccEssentials08.pdf

American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*.

Retrieved from: http://www.nursingworld.org/codeofethics

American Psychological Association. (2006). *Answers to your questions about transgender*

individuals and gender identity. Retrieved from: www.apa.org/topics/transgender.html

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I

don't think this is theoretical; this is our lives": How erasure impacts health care for

transgender people. *Journal of the Association of Nurses in AIDS Care*, *20*(5), 348-361.

Brennan, A. M. W., Barnsteiner, J., Siantz, M. L. D. L., Cotter, V. T., & Everett, J. (2012).

Lesbian, gay, bisexual, transgendered, or intersexed content for nursing curricula.

Journal of Professional Nursing, 28(2), 96-104.

Brooks, V. R. (Eds.) (1981). *The theory of minority stress. In Minority stress and lesbian women.*

Lexington, MA: Lexington Books.

Center of Excellence for Transgender Health, University of California, San Francisco.

http://transhealth.ucsf.edu

Cohler, B. J., & Hammack, P. L. (2007). The psychological world of the gay teenager: Social

change, narrative, and "normality." *Journal of Youth and Adolescence.* 36(1):47–59.

Cox, L (January 6, 2014). Money myths busted. [Television broadcast]. *Katie Couric Show*. New

York City, NY: ABC's TV1 Studios. Retrieved from:

http://katiecouric.com/videos/orange-is-the-new-black-laverne-cox/

Eliason, M. J., Dibble, S., & DeJoseph, J. (2010). Nursing's silence on lesbian, gay, bisexual, and

transgender issues: The need for emancipatory efforts. *Advances in Nursing Science*,

33(3), 206-218.

Gamson, J., & Moon, D. (2004). The sociology of sexualities: Queer and beyond. *Annual Review

of Sociology.* 30(1):47–64.

Gates, Gary J. (2011). How Many People are Lesbian, Gay, Bisexual and Transgender?. *UCLA:

The Williams Institute*. Retrieved from: https://escholarship.org/uc/item/09h684x2

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at

every turn: A report of the national transgender discrimination survey*. National Center

for Transgender Equality.

Goffman, S. (1963). Notes on the Management of Spoiled Identity. *Englewood Cliffs, New

Jersey: Prentice-Hall*.

Haas, A. P., Rodgers, P. L., & Herman, J. L. (2014). Suicide Attempts among Transgender and

Gender Non-Conforming Adults. *American Foundation for Suicide Prevention and

UCLA The Williams Institute.* Retrieved from:

http://www.escholarship.org/uc/item/8xg8061f

Institute of Medicine. (2011). The health of lesbian, gay, bisexual, and transgender people:

Building a foundation for better understanding. Retrieved from:

http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-

Transgender-People.aspx

Joint Commission. (2010). *Advancing effective communication, cultural competence, and

patient-and family-centered care: A roadmap for hospitals*. Joint Commission. Retrieved

from:

http://www.jointcommission.org/assets/1/6/aroadmapforhospitalsfinalversion727.pdf

Joint Commission. (2011a). *Advancing effective communication, cultural competence, and*

patient-and family-centered care: A roadmap for hospitals. Joint Commission. Retrieved

from:

www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf

Joint Commission. (2011b). R^3 Report. Requirement, rationale, reference. Joint Commission.

Issue 1, February 9, 2011.

Kessler R. C., Borges G., Walters E. E. (1999). Prevalence of and Risk Factors for Lifetime

Suicide Attempts in the National Comorbidity Survey. *Arch Gen Psychiatry*. 56(7):617-

626. doi:10.1001/archpsyc.56.7.617.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To err is human: building a*

safer health system (Vol. 627). National Academies Press.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual

populations: Conceptual issues and research evidence. *Psychological Bulletin*.

129(5):674–697.

McLeroy, K. R., D. Bibeau, A. Steckler, and K. Glanz. (1988). An ecological perspective on

health promotion programs. *Health Education Quarterly*. 15(4):351–377.

National Coalition for LGBT Health. (n.d.). All of the above: *LGBT people of color*. Retrieved

from: http://lgbthealth.webolutionary.com/sites/default/files/LGBT%20POC.pdf

Nemoto, T., Iwamoto, M., & Operario, D. (2003). HIV risk behaviors among Asian and Pacific

Islander male-to-female transgenders. *The Community Psychologist*. 36:31–35.

Nemoto, T., Sausa, L. A. D., Operario, & Keatley, J. (2006). Need for HIV/AIDS education and

intervention for MTF transgenders: Responding to the challenge. *Journal of*

Homosexuality. 51(1):183–202.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: a cognitive-

affective-behavioral model. *Psychological bulletin*, *133*(2), 328.

Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The

impact of anticipated stigma, centrality, salience, and cultural stigma on psychological

distress and health. *Journal Of Personality And Social Psychology*, *97*(4), 634-651.

doi:10.1037/a0015815

Randall, C. (2006, October). *Don't believe everything you read: What nursing students learn*

from nursing textbooks about lesbians. Paper presented at the Annual Conference of the

Gay and Lesbian Medical Association. San Francisco, CA.

Rands, K. E. (2009). Considering transgender people in education: A gender-complex approach

Journal of Teacher Education, 60(4), 419 - 431. doi:10.1177/0022487109341475

Rondahl, G. (2009). Students inadequate knowledge about lesbian, gay, bisexual and transgender

persons. *International Journal of Nursing Education Scholarship*, 6, 1-17.

Sandelowski, M. (1995). Qualitative analysis: What it is and how to begin. *Research in nursing*

& health, *18*(4), 371-375.

U.S. Department of Health and Human Services. Office of Disease Prevention and Health

Promotion. (2010). Healthy people 2020. Retrieved from:

http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive*

pedagogy. Suny Press.

World Health Organization. (2011). Mental health: A state of well-being. Retrieved from:

www.who.int/features/factfiles/mental_health/en/

Appendix A

Interview Guide

- How did you discover your gender identity? How did you decide on the steps appropriate

    to live as your authentic self (transition)?

Pre-Transition

- Prior to identifying as a transgender individual, Please describe your experiences with or

    concerning healthcare, specifically any interactions with staff and/or providers.

- When X happened, please provide some insight into how you were feeling, your mood,

    emotions, state of mind.

- When you spoke about X, could you share more about the parts of that experience that

    stands out in your mind?

- It may help to close your eyes and focus on X event. In your mind, think about that day

    when X happened. Tell me more about how you felt. What thoughts were going through

    your mind? What was happening around you? Can you tell me more about the sights,

    sounds, and smells?

- How did you react?

- Explain, if you can, what if any effect this event had on your thoughts about your

    healthcare.

- After the experience you described, how has it influenced any present-day need to seek

    healthcare?

Post-Transition

- Please describe your experiences as a transgender individual with or concerning

    healthcare, specifically any interactions with staff and/or providers.

- When X happened, please provide some insight into how you were feeling, your mood, emotions, state of mind.

- When you spoke about X, could you share more about the parts of that experience that stands out in your mind?

- It may help to close your eyes and focus on X event. In your mind, think about that day when X happened. Tell me more about how you felt. What thoughts were going through your mind? What was happening around you? Can you tell me more about the sights, sounds, and smells?

- How did you react?

- Explain, if you can, what if any effect this event had on your thoughts about your healthcare.

- After the experience you described, how has it influenced any present-day need to seek healthcare?

- Clarifying questions: In what way? Can you give an example? What was it like to discover X? What did it feel like? What was it like to tell others about X? How did you feel when X happened?

Appendix B

Healthcare Education Presentation - Communicating and Caring for Transgender Patients

Communicating and Caring for Transgender Patients

[Student Name]
BSN Honors Student, School of Nursing
[University Name]
[Date]

Objectives

- Describe terminology used within and about transgender populations, including: sex, sexual orientation, gender expression, and gender identity.
- Understand the health disparities and health determinants for transgender individuals.
- Explain strategies for improving clinical environments for transgender clients and family members, including the provision of culturally sensitive care.

We are taught…

- To be culturally aware to meet the needs of an increasingly diverse population patients and colleagues
- To provide a safe space for patients utilizing trust, respect, and nonjudgmental patient-centered care and inclusive care
- To be patient advocates by treating the "entire" patient

But how do we deliver on these principles?

Why is this important?

The Joint Commission's approach to LGBT patient-centered care
- In 2011, JCAHO urged US hospitals to create a more welcoming, safe, and inclusive environment that contributes to improved health care quality for lesbian, gay, bisexual, and transgender (LGBT) patients and their families.
  - *Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community.*

Healthy People 2020
- For the first time, specific objectives were included for improving the health, safety, and well-being of lesbian, gay, bisexual, and transgender people.
  - Efforts include: Providing medical students with access to LGBT patients to increase provision of culturally competent care.

Discrimination in Health Care

National Transgender Discrimination Survey (2011)
National Center for Transgender Equality & the National Gay and Lesbian Task Force

- Lack of provider knowledge
  - 50% reported having to teach their medical providers
- Negative experiences in health care
  - 19% were refused medical care
  - 28% were subjected to harassment in medical settings
  - 28% postponed medical care due to discrimination by health care providers
  - 33% delayed or did not try to get preventative health care due to discrimination by health care providers.

If medical providers were aware of the patient's transgender status, the likelihood of that person experiencing discrimination increased.
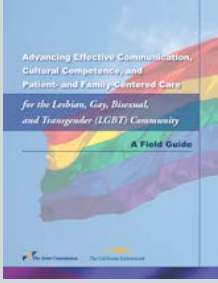
Standards of Care Resources

- Center of Excellence for Transgender Health University of California, San Francisco
  - Current EBP clinical guidelines, online learning center, research, reports, fact sheets
- The Fenway Institute: The National LGBT Health Education Center
  - Educational programs, Grand Rounds, Webinars, Learning modules, Online courses
- WPATH: World Professional Association for Transgender Health

A Valuable Resource from The Joint Commission

- Cultural competency trainings
  - Professional and administrative staff
- Display posters, flyers, or brochures that include and serve the LGBTQ community
- Be prepared with referral and resources for your clients
- Gender neutral bathrooms
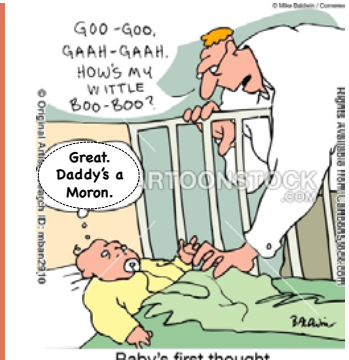- Forms
- Inclusive health education materials

Heavy lifting completed...

- The Joint Commission
- Center of Excellence for Transgender Health, University of California, San Francisco
- Gay and Lesbian Medical Association
- Fenway Health Institute

Words are Powerful

Basic Definitions

Term	Definition
Sex	assigned at birth based on the appearance of external genitalia.
Gender Identity	One's basic sense of being male, female, or other gender.
Gender Expression (Presentation)	Characteristics in appearance, personality, and behavior, culturally defined as masculine or feminine.
Sexual Orientation	Physical and/or emotional attraction to the same and/or opposite gender.

Sexuality and *Gender* are two very different concepts.
Who you are sexually attracted to *__is not__* dependent on
your gender identity or expression.

Basic Definitions - *Continued*

| Term	Definition
Transgender	an umbrella term that describes a wide variety of cross-gender behaviors and identities.
Transsexual	a medical term applied to individuals who seek hormonal (often, but not always) or surgical treatment to modify their bodies so they may live as members of the sex category opposite to their birth-assigned sex.
Transvestite	a psychiatric term applied to male-bodied people who wear female clothing for sexual gratification. A pejorative term. "Cross-dresser" should be used instead.
Genderqueer	one who defies or does not accept stereotypical gender roles and may choose to live outside expected gender norms. They may or may not avail themselves of hormonal or surgical treatments.
Cisgender	A label for individuals who have a match between the gender they were assigned at birth, their bodies, and their personal identity.

Transgender-Related Terms

Term	Definition
Female-to-Male (FTM)	describes the trajectory of a person who is changing or has changed their body and lived gender role from a birth-assigned female to an affirmed male. Also used: trans male, trans man, or transman.
Male-to-Female (MTF)	describes the trajectory of a person who is changing or has changed their body and lived gender role from a birth-assigned male to an affirmed female. Also used: trans woman or transwoman.
Trans	shorthand term for a variety of transgender identities. Also used: trans people or transpeople.

Transgender-Related Terms

Term	Definition
Transition	period of time when a transgender or transsexual person is learning how to cross-live socially as a member of the sex category opposite their birth-assigned sex, or is engaged in early hormone use.
Passing	Trans people being perceived as non-trans people, in their gender identity. Most trans people strive for this.
Stealth	When a trans person chooses not to disclose their trans status to others. This can be done for numerous reasons including safety, or simply because the trans person doesn't feel other people have the right to know.

Diagnostic Terms

Term	Definition
Gender Identity Disorder	DSM IV – perceived psychologically abnormal or unhealthy
Gender Dysphoria	DSM V – revised definition intended to depathologize. Focus on feeling of incongruence vs behavior. Not a sexual dysfunction.
Transsexualism	Medical diagnosis. Also used: Unspecified endocrine disorder.
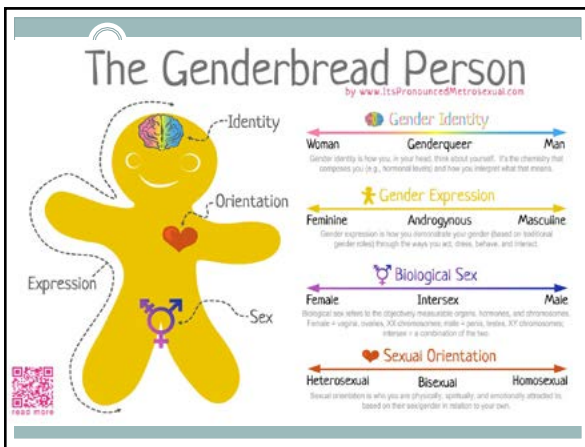
To treat me, you have to know who I am

Stressful psychosocial realities
- Harassment
- Family rejection
- Discrimination
- Poverty
- Homeless
- Sexual assault
- Hate crimes
- Sex workers

Physical Presentation

Transgender people present themselves to the world in a variety of ways

- Some medically or surgically alter their body to affirm their gender identity
- Some change hairstyle and dress
- Some make no changes to their appearance
- Most, but not all, will change their given name

An unfortunate truth

"…preoccupation with transition and surgery objectifies trans people and then we don't get to really deal with real lived experiences; the reality. By focusing on bodies we don't focus on the lived realities of that oppression and that discrimination."

Laverne Cox

Interview with Katie Couric - January 6, 2014

What does it mean to Transition?

- A range that can vary from person to person
- Does not necessarily include surgery or hormones
- Minimal – clothing, name, or pronoun choice
  ○ Chest binders, padding, packers
- Complete – hormones, anatomical reconstruction
  ○ Estrogen, testosterone, surgeries, legal documents amended
  ○ Gender affirmation, gender confirmation

What does it mean to Transition?

- Includes not only physical changes but may include

  ○ Hormonal   ○ Surgical
  ○ Linguistic   ○ Social
  ○ Psychological   ○ Emotional
  ○ Intellectual   ○ Legal
  ○ Spiritual

  Many times the individual's gender presentation, preferred name or pronoun do not match the information found on their medical insurance card or driver's license.

Considerations for compassionate care

- Past experiences with provider insensitivity and hostility can produce intense fears of disclosure of transgender status, causing many to avoid health care altogether.
  ○ Developing trust and rapport may take longer.
- Providers must look at the entire picture and understand the context of the patient's life in order to provide comprehensive compassionate care.
- To provide patient-centered care, we must understand our patients.

Cultivating a supportive environment

- It is not always possible to know someone's gender by their name or how they look or sound.
- If you are unsure about a person's gender identity, or how they wish to be addressed, ask politely for clarification.
  ○ It can be uncomfortable to be confused about someone's gender.
  ○ It can also feel awkward to ask someone what their gender is.

  "I'd like to be respectful – how would you like to be addressed?"

  "What name would you like me to use?"

Cultivating a supportive environment

- Be cognizant of pronoun usage
  ○ Avoid using Mr/Mrs/Ms/Miss
  ○ Ask how they prefer to be addressed.
  ○ Use patient's preferred name and pronouns even when they are not present.

  Addressing transgender persons in a gender-appropriate manner can further help cultivate trust and build rapport.

Cultivating a supportive environment

- Often the name and gender on records do not match their preferred name and gender.
  - Legal name and gender marker changes regulated by state
  - Lengthy and complicated process
  - At times, medically necessary treatments may not be covered by insurance companies if anatomy does not match gender marker.

  "Could your chart be under a different name?"
  "What is the name on your insurance?"

Cultivating a supportive environment

- You will slip-up with pronouns and names. Expect it.
  - Apologize and ask the patient what they prefer. Patients will appreciate your sincerity and good intentions.
  - Be conscious of your communication

  "I apologize for using the wrong pronoun/name.
  I did not mean to disrespect you."

Healthy People – A closer look

- Access to health services
  - Medical provider discrimination, hostility, and insensitivity
  - Lack of health insurance and coverage for trans-specific needs
  - Lack of FDA approval for transgender hormonal therapy

- HIV/AIDS prevention
  - HIV infection is highest among transwomen of color and on the rise
  - CDC's meta-analysis of 29 studies found between 45-65% of HIV positive transgender women were unaware of their HIV status (2008).

Healthy People – A closer look

- Injury and violence prevention
  - In 10 studies, 16-60% were survivors of physical assault or abuse, and 13-66% were survivors of sexual assault.
  - Trans youth are at risk for anti-transgender violence, with MTFs of color at greatest risk
  - Trans identity is often hard to keep hidden
- Mental health
  - SI, depression, and anxiety are widely reported with a strong association of gender-based discrimination and victimization
  - Treatment barriers; Family rejection
  - 41% of people who are transgender or gender-nonconforming have attempted suicide sometime in their lives, nearly nine times the national average

Healthy People – A closer look

- Public health infrastructure
  - Absent from curriculum of medical and nursing schools
  - Traditionally viewed as a mental disorder
  - Limited number of competent providers
  - Evidence-based guidelines extremely scarce
  - Poor data collection methods
- Sexually transmitted diseases
  - Lack of surveillance, but some research has found high rates of syphilis, gonorrhea, chlamydia, herpes, and HPV.

Healthy People – A closer look

- Substance abuse prevention
  - High rates of alcohol and substances (marijuana, crack, meth)
  - Barriers to treatment

- Tobacco use
  - Need for tobacco cessation programs for trans people
  - High rates of use – living with a social stigma increases use
  - MTFs smokers taking estrogen have an increased risk for blood clots.
  - FTMs who take testosterone increase their risk of heart disease, and smoking increases that cardiovascular risk.
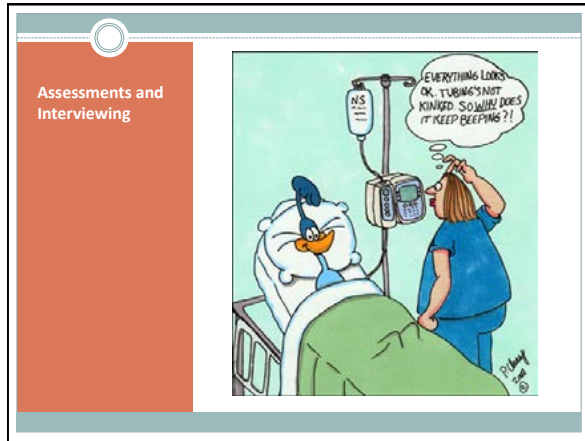
Assessments and Interviewing

Patient interview

- Address sensitive topics carefully, yet treat as routine.
- Chief complaint may not be the main reason for the visit.
  - Do you have any other problems or questions, or want anything else checked out while you are here?
- Let patients use their own terminology. Ask them to explain what their terms mean to them.
  - Discuss choice of language, especially for their anatomy
  - Listen and echo back the language heard

Patient assessments

- Transgender individuals may be very uncomfortable with physical exams that involve their genitalia – be extra sensitive.

  "What can I do to make you more comfortable?"
  "Would you like someone else in the room?"

Patient assessment – Don't assume

- Avoid assumptions about sexual orientation and gender identity by the patient's appearance
  - Do not rely on external appearances to identify a patient.
  - Information regarding sexual orientation and/or gender identity should **only** come from the patient.
  - It is not always possible to determine by appearance if a patient is transgender or is struggling with gender identity.
  - Gender identity is distinct from sexual orientation (don't assume transgender people are all homosexual).

  Incorrect assumptions can interfere with the establishment of a trusting therapeutic relationship.

Patient assessment

- Ask open-ended questions
  - Tell me about yourself.
  - Who lives in your home with you?
  - Are you involved in a relationship?
- Use non-judgmental communication
  - Ask questions that do not assume heterosexuality
  - Listen to how your patient describes themselves and their family, then follow their lead

*If you are not sure what terminology to use, **ask your patient.***

Patient assessments

- Be frank and direct
  - Do you still have a penis? Do you use it for sex?
- Questioning should be restricted to addressing the patient's chief complaint
  - Asking about a patient's genitals is not necessary if the patient is being treated for an ear infection
  - If in doubt, ask patients what terms they prefer. Be curious without worrying about offending patients.
- Use gender-neutral language whenever possible

  How a question is phrased can communicate acceptance and normalcy.

Gender-neutral communication

- Use neutral and inclusive language in interviews and when talking with **all** patients.
- Acquiring personal histories
  - "Are you married" vs "Who are the important people in your life?"
  - Partner, significant other, SO, lover, spouse
  - Sibling, parent, parental unit, child, offspring
- Be mindful of language that labels
  - Body parts: "persons with ovaries" vs "females", chest, genitals
- Health issues, preventative measures, and health screenings related to anatomy
  - Ex: mammogram, colonoscopy, testicular exams, pelvic and pap test, etc
  - "persons with vaginas" or "persons with penises" vs "females" or "males"

Assessment: Medications and surgeries

- Include questions regarding hormones and other feminizing or masculinizing agents
  - Do you take hormones or other substances that may have feminizing/masculinizing effects?
  - Have you acquired hormones from nonmedical sources?
- Include an inquiry into surgical history, specifically in relation to transition
  - Have you had any pelvic surgery, breast surgery, genital surgery?
  - Have you had any other surgical procedures to alter your body/ appearance?

Assessment: Medications and surgeries

- Physical and lab exams should be based on current anatomy, medications, and comorbidities, rather than birth sex or gender presented.
  - Routine screening on all organs present
  - Testicular exams and education for self exams
  - Breast exams and education for self exams
  - STI screenings, immunizations

Assessment: Sexual history

- Transgender people express the same range of sexual behavior and identity as non-transgender (cisgender) people
  - *"Have you been sexually involved with anyone during the past year, including oral, vaginal, or anal sex, or other kinds of sexual practices?"*
  - *"Have you ever been sexually involved with men, women, or both?"*
  - *"Are you currently involved with women, men, or both?"*

  Sexual behavior and identity can change over time in any direction and "sex" has different meanings to different people.

Patient interview – Sexual activity

- I am going to ask you some questions about yourself and I want you to tell me how you feel, not how you think others see you or how others think you should feel. These are questions I ask all my patients.
- There are many ways of being sexual or intimate with another person: kissing, hugging, touching, having oral sex, anal sex, or vaginal sex.
  - Have you ever had any of these experiences? Which ones? Were they with boys, girls, or both?
- What term (if any) do you prefer that I use to best describe your sexual orientation?
  - For example, do you consider yourself gay, lesbian, bisexual, heterosexual, or are you not sure?

Patient interview – Mental health

- SI screening and support
  - Over the past few weeks, have you ever felt down or depressed?
  - Have you had less interest in doing things that you normally enjoy?
  - Have you ever thought about hurting yourself?
  - Have you ever actually tried to hurt yourself? What did you do and tell me what happened?
- Who do you turn to when you are down, lonely, or need someone to talk to?
- Have you ever thought about seeing a counselor or therapist? Do you think that might be helpful?

  Homeless youths are at higher risk of SI and attempts.
  57-62% report suicide attempts vs 29-33% of non-LGBTQ youth
  (Suicide Prevention Resource Center, 2008).

Patient interview – Tobacco, alcohol, etc

- Do you currently smoke cigarettes?
  - How much and for how long? Have you ever tried quitting? Do you need or want help quitting?
- Do you drink alcohol? How often?
  - Where do you get it, and who do you drink with? How many drinks do you typically have? Do you ever get drunk?
- Have you ever used any drugs such as marijuana, cocaine, ecstasy, GHB, crystal meth, etc?
  - Which drugs do you currently use? How often?
- Do you ever have sex while drunk or high?
  - Have you ever done something sexually while high or drunk that you regretted or didn't really want to?

Patient interview – Safety and violence

- How are things going at home, school or work?
- Do you feel safe when you are at home?
- Do you feel safe in your neighborhood and school/work?
- Has anyone ever picked on you? Can you tell me about it? Was this because you are LGBTQ?
- Who can you turn to for advice, support or protection?

Patient education

- Smoking cessation
- Alcohol and drug use, harm reduction
- Safer sex
- Proper nutrition and exercise
- Local resources
- Hormone replacement therapy – medication administration, risks, side effects

Tips for working with transgender patients

- Avoid unnecessary questions. Keep the focus on care rather than indulging in questions out of curiosity.
  - It is inappropriate to ask about genital status if it is unrelated to their care.
  - "Is my question necessary for their care or am I asking it for my own curiosity?"
  - "What do I need to know? How can I ask for the information I need to know in a sensitive way?"
  - Sometimes information about biological sex and/or hormone levels is important for assessing risk and/or drug interactions. But in many health care situations, gender identity is irrelevant.

Tips for working with transgender patients

- Never disclose a person's transgender status to anyone who does not explicitly need the information for care.
  - Do not gossip or joke about transgender people
  - Only discuss a patient's transgender identity with those who need to know for providing appropriate and sensitive care.
  - If disclosure is relevant to care, use discretion and inform the patient whenever possible.

  Congruence between verbal and nonverbal communication is critical!

What to avoid

- Avoid using "transgender" as a diagnostic term
  - It does not imply a medical or psychological condition.
- Avoid using "transgender" as a noun
  - A person is not "a transgender"; they may be a transgender person
- Avoid using "transsexual" as a noun
  - A person is not "a transsexual"; they may be a transsexual person.
- Avoid using "trans" as a noun
  - A person is not "a trans"; they may be a trans person
- Avoid using "transgendered"
  - It is not an affliction. We didn't "decide" to be transgender.

What to avoid

- Avoid asking "What is your real name and/or gender"
  - Suggests that they are deceptive, fooling, pretending, posing, and masquerading
- Avoid using "sex change" or "pre/post op" – instead use "transition" or "gender affirmation"
  - Inaccurately suggests that one must have surgery to change sex
- Avoid saying "when you were a girl/boy"
  - Use: "before you transitioned" or "when you were living as a girl."
  - Use other frames of reference: "last year", "when you were in middle school"

Unhelpful questions or comments

- "When did you decide to be a man/woman?"
- "You look so real. I never would have known."
- "Have you had/do you want THE surgery?"
- "What is your real name?"
- "You are so attractive, why would you want to…?"
- "Can I see what you looked like before?"
- "When did you know you wanted to change?"
- "You aren't a real man/woman."

Offensive words

- She-male
- He-she
- Trannie or tranny
- "Real" woman or "real" man
- Referring to someone as "it"
- Referring to non-transgender people as "normal"

Greetings and salutations

A new client comes to your health center presenting for care. You are unsure what pronoun to use (ex. "he" or "she"). Which of the following is the LEAST preferred strategy to use with your patient in this situation?
  - Politely ask them what pronoun they prefer
  - Avoid using a pronoun at all
  - Use "it" as a neutral pronoun
  - Use "they" as a neutral pronoun

Patient scenario

- Your review the appointments for the day. Your first patient of the day is listed as:
  - Patient's name: Jessica Banks
  - Demographics: 18, Caucasian, female
  - Reason for appointment: suspected UTI, chief complaint: burning with urinations and increased frequency

Patient scenario - *Continued*

- You noticed that your new patient just arrived and have checked-in with the front desk. Another staff member brings the client into an exam room since you were speaking with a parent on the phone. Upon walking into the exam room, the patient appears extremely masculine and has a light scruffy beard.
  - How do you greet your patient?
  - How do you address them?
  - How do you manage the possible discrepancy with the medical record and the patient's gender identity and gender expression?
  - If a handoff report is necessary – what do you communicate?

Patient scenario

- Would you treat this patient scenario any differently?
  - Patient's name: Ashley Banks
  - Demographics: 36, Caucasian, female
  - Reason for appointment: suspected UTI
  - Patient appears as a masculine athletic female with short hair.

Websites for further education

- Advancing effective communication, cultural competence, and patient-and family-centered care: A roadmap for hospitals. Joint Commission. http://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf
- Center for Disease Control and Prevention: www.cdc.gov/lgbthealth
- Center of Excellence for Transgender Health, University of California, San Francisco: transhealth.ucsf.edu
- Gay and Lesbian Medical Association: www.glma.org
- Fenway Health Institute: www.lgbthealtheducation.org
- Injustice at every turn: A report of the national transgender discrimination survey. National Center for Transgender Equality. www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf
- National Gay and Lesbian Task Force: thetaskforce.org
- WPATH – World Professional Association for Transgender Health: www.wpath.org
- New York City Health and Hospitals –To Treat Me, You Have to Know Who I Am. www.youtube.com/watch?v=NUhvJgxgAac

References

- Brennan, A. M. W., Barnsteiner, J., Siantz, M. L. D. L., Cotter, V. T., & Everett, J. (2012). Lesbian, gay, bisexual, transgendered, or intersexed content for nursing curricula. *Journal of Professional Nursing*, 28(2), 96-104.
- Center of Excellence for Transgender Health, University of California, San Francisco. http://transhealth.ucsf.edu
- Eliason, M. J., Dibble, S., & DeJoseph, J. (2010). Nursing's silence on lesbian, gay, bisexual, and transgender issues: The need for emancipatory efforts. *Advances in Nursing Science*, 33(3), 206-218.
- Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*, 38(3), 230-236.
- Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. National Center for Transgender Equality.
  - www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf
- Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., & Crepaz, N. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS and Behavior*, 12(1), 1-17.
- Jacobson, J. (2013). Helping Transgender Children and Teens. *American Journal Of Nursing*, 113(10), 18-20. doi: 10.1097/01.NAJ.0000435340.48589.8a
- Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient-and family-centered care: A roadmap for hospitals*. Joint Commission.
  - http://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf

References

- Killerman, S. (2013). The Social Justice Advocate's Handbook: A Guide to Gender. Austin, TX: Impetus Books.
  - The Genderbread Person v2.0: itspronouncedmetrosexual.com/2012/03/the-genderbread-person-v2-0/
- Lim, F. A., & Berstein, I. (2012). Promoting awareness of LGBT issues in aging in a baccalaureate nursing program. *Nursing Education Perspectives, 33*(3), 170-175. doi:10.5480/1536-5026-33.3.170
- Lim, F. A., Brown, D. V.,Jr, & Jones, H. (2013). Lesbian, gay, bisexual, and transgender health: Fundamentals for nursing education. *The Journal of Nursing Education, 52*(4), 198-203. doi:10.3928/01484834-20130311-02; 10.3928/01484834-20130311-02
- Mayer, G. (2013) *Providing cross-gender hormone therapy for transgender patients*. The National LGBT Health Education Center. Retrieved from: www.lgbthealtheducation.org
- New York City Health and Hospitals. (2011). To Treat Me, You Have to Know Who I Am. Retrieved from: https://www.youtube.com/watch?v=NUhvJgxgAac
- Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2009). Lifetime risk factors for HIV/STI infections among male-to-female transgender persons. *Journal of acquired immune deficiency syndromes (1999), 52*(3), 417.
- Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., ... & Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender–related content in undergraduate medical education. *JAMA: The Journal of the American Medical Association, 306*(9), 971-977.

References

- Rondahl, G. (2009). Students inadequate knowledge about lesbian, gay, bisexual and transgender persons. *International Journal of Nursing Education Scholarship*, 6, 1-17.
- Rosser, B. S., Oakes, J. M., Bockting, W. O., & Miner, M. (2007). Capturing the social demographics of hidden sexual minorities: An Internet study of the transgender population in the United States. *Sexuality Research & Social Policy*, 4(2), 50-64.
- Snowdon, S. (2010). The medical school curriculum and LGBT health concerns. *Virtual Mentor, 12*(8), 638.
- Snowdon, S. (2013) Recommendations for enhancing the climate for LGBT students and employees in health professional schools: *A GLMA White Paper*. Washington, DC: GLMA
- U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. (2010). Healthy people 2020. Retrieved from: http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25

Questions?

"Knowing is not enough; we must apply. Willing is not enough; we must do."
—*Goethe*

[Student Name]
[email address]