Original Research

Improving Healthcare Experiences for Transgender and Intersex Populations

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ABSTRACT

Intersex is an umbrella term for individuals who are born with sex characteristics that do not typically fall into male or female categories. Individuals who are intersex make up about 1.7% of the United States population today and are identified within the lesbian, gay, bisexual, transgender, and intersex (LGBTQIA+) community. Many people who are intersex identify as transgender, which relates to the social process of gender change, as they develop into adults. In Georgia, approximately 4% of the population identify as LGBTQIA+. The purpose of this paper is to increase awareness of the perceived discrimination from healthcare providers, non-inclusive organizational practices, and lack of skilled providers that serve as barriers to healthy outcomes for transgender and intersex individuals. Culturally competent care is necessary for physicians to provide an openly safe environment for people who are LGBTQIA+ to help improve their comfort level to disclose their health information. Recommendations for physicians caring for people who are LGBTQIA+ to incorporate into their clinics include: having acceptable advertising practices, educating staff and providers, maintaining biases, and providing inclusive intake forms.

BACKGROUND

Recognizing disparities in health outcomes among individuals who identify as lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+) is important for public health practice professionals. People who are LGBTQIA+ often face discrimination within the healthcare delivery system while seeking treatment for their health. Social exclusion, stigmatization, and provider bias are some of the discriminatory behaviors that have been reported among people who are LGBQIA+ and often result in negative mental and physical health outcomes (Zeeman et al., 2019).

The terms transgender and intersex are often used interchangeably, yet they refer to different identifications on the LGBTQIA+ spectrum. Understanding the difference requires an understanding of sex and gender. The term transgender is the umbrella term to describe an individual who identifies as a different gender from the one they were assigned based on their external genitalia at birth (Powell, 2021; Thanem, 2011). Disorders of sexual development (DSD), which is also categorized as intersex, encompass a group of congenital conditions associated with atypical development of internal and external genital structures (Acién and Acién, 2020; Hughes, 2008). Intersex is the term used to describe people born with reproductive or sexual anatomy, or a chromosome pattern that can't be classified as typically male or female. These conditions can be associated with variations in genes, developmental programming, and hormones (Witchel, 2017). Although people who identify as Intersex are often included in the LGBTQIA+ umbrella, there is much diversity among this group of individuals. Many people who are intersex do identify as transgender, thereby adding to the confusion (Pinto & Moleiro, 2015).

In the U.S., approximately 0.6% people identify as Transgender, in 2019, up to 1.7% of the U.S. population was born with a DSD, indicating that approximately 5.6 million people in the U.S. were born Intersex (Archibald, 2019). Based on the most recent estimates, approximately 7.6 million people in the United States identify as both intersex and transgender, (Archibald, 2019). In Georgia, approximately 425,000 people identify as LGBTQIA+ out of a total of 10,799,566 (Conron & Goldberg, 2020; United States Census Bureau, 2022). This equates to approximately 4% of Georgians who currently identify as LGBTQIA+. As Georgia's population becomes more diverse, the need for unbiased competent healthcare professionals in the state to meet the healthcare needs for individuals who are LGBTQIA+ is warranted. The purpose of this paper is to increase awareness of the perceived discrimination from healthcare providers, non-inclusive organizational practices, and lack of skilled providers that serve as barriers to healthy outcomes for transgender and intersex individuals. Strategies on how healthcare professionals can be more inclusive in their practice will also be presented.

Cultural Competency among Healthcare Professionals

According to a survey conducted by Sharek et al. (2015), only one in three participants believed that healthcare professionals have sufficient knowledge of LGBT issues, and less than half (43%) felt respected as an LGBT person by healthcare professionals. Documented barriers to seeking care have also been reported and include: heteronormative

assumptions by healthcare providers that everyone is straight; non-inclusive organizational practices (e.g., lack of availability of educational information on LGBTQIA+ or with non-hetero examples and medical intake forms that do not contain inclusive language). Stressors such as, internalized negative social attitudes, internalized homophobia/transphobia, felt discrimination, and concealment of sexual and gender identity can lead to adverse health outcomes such as depression, anxiety, substance use disorders, suicide, and various physical health outcomes that are responsive to stress, such as asthma (Meyer, 2015). Heteronormative views and the lack of cultural competency from providers can prevent individuals who identify as LGBTQIA+ from receiving quality healthcare, resulting in poor health condition management (Brotman et al., 2002; Mercer & Jordan, 2021). Health care providers should ensure that the staff is trained to appropriately care and speak to patients who are LGBTQIA+ appropriately and ethically, further understanding that discrimination is illegal and morally unacceptable. Religious beliefs or negative feelings must be put aside (Morris, et al., 2019).

A history of negative attitudes toward homosexuality within the medical community has contributed to the present lack of comprehensive training in LGBTQIA+ specific health issues in many medical schools ("LGBTQ and Health Care: Advocating for Health Access for All," 2019). Since the 1950s, medical care for intersex people has centered around surgical interventions during infancy to make their genitalia appear more male or female without their consent (Rosenwohl-Mack et al., 2020). People who are LGBTQIA+ may be more reluctant to disclose their sexual orientation for fear of repeated negative experiences or fear that coming out would bias their care (Lee, 2017). Major organizations, including the American Psychiatric Association have formally adopted resolutions opposing healthcare practices that may cause physical and mental harm to people who are LGBTQIA+ ("Just the facts," 2008). The patient-provider relationship requires trust to ensure effective communication, and it is deemed necessary for physicians to provide an openly safe environment for people who are LGBTQIA+, to improve their comfort level in disclosing information about their health.

Culturally competent or culturally congruent care includes providing care that is sensitive, knowledgeable, and meaningful for the population presenting for health care services (Kaiafas & Kennedy, 2021). For providers to provide culturally competent care, it requires an individual to have the skillset to be aware of their own values, cultures, and biases. Recommendations have been suggested by Margolies et al. (2018) for providers to improve cultural competency within their clinics by identifying 3 common goals of LGBTQIA+ cultural competency training: to increase knowledge, to increase LGBTQIA+-affirming attitude, and to increase LGBTQIA+-affirming behavior. Moreover, caring for trans/nonbinary people is not an optional set of skills beyond the standard scope of practice, and thus healthcare providers have the responsibility to seek out further training if they feel unprepared by their training to care for trans/nonbinary people (Roosevelt et al., 2021). According to the article Observed Deficiencies in Medical Student Knowledge of Transgender and Intersex Health (2017), all medical students at Boston University were given a self-assessed survey of their knowledge and attitudes regarding subpopulations within the LGBTQIA+ population. As a result, surveyed classes reported lower knowledge about transgender health than LGB health, and every class reported significantly lower knowledge of intersex health in comparison to LGB. As more information becomes available regarding intersex and transgender populations, there is an increase in need for culturally informed physicians.

Implications for Public Health Practice

Intersex and transgender populations often share similar experiences while accessing healthcare. According to Pratt-Chapman et al. (2021), people with intersex conditions and asexual persons do not always identify as part of the LGBTQIA+ community; however, these communities are often included in cultural competency education to raise awareness of shared experiences of stigma and barriers to health care. Learning to take care of members of LGBTQIA+ community involves understanding and being open to multiple special considerations and avoiding unconscious and perceived biases (Bass & Nagy, 2021). Perception bias is when our perception is skewed by the stereotypes and assumptions, we have about other groups (Caccavale, 2021). It is recommended that the provider and staff should listen to the LGBTQIA+ patient and follow their lead, and when in doubt, ask the patient how they or their partner should be described. Once the term has been discussed, the provider should provide documentation in the patient's electronic medical record to help providers and staff remember for future visits (Tuller, 2020). Therefore, continuing education for healthcare providers that focuses on role-playing an examination with an intersex patient using specific guiding questions can be a starting point.

Recommendations suggested by Bass and Nagy (2021) to make their clinic more LGBTQIA+ friendly include: advertising practices as accepting of members of the LGBTQIA+ community; educating staff and providers to be comfortable in discussing sexual orientation, gender orientation, and sexual practices; include members of the LGBTQIA+ community as part of your staff and train your staff to refer to patients by their name and chosen descriptive pronouns; maintain an open mind and avoid judgment regarding sexual orientation and practices; include the term partner on intake forms in addition to the spouse and sexual identity; participate in LGBTQIA+ affirming referral programs such as the Health Professionals Advancing LGBTQ Equality or Gay Health; in the waiting room, provide magazines including the LGBTQIA+ community and brochures on sexually transmitted infection prevention, substance abuse, safe sex practices, and hormone therapy; Support observance of LGBTQIA Pride Day, World AIDS Day, and National Transgender Day of Remembrance; lastly, providers should train their staff and

provide continuing education on the care of the LGBTQIA+ patient.

Theoretical Framework

An additional way to support how providers can provide supportive healthcare experiences for intersex and transgender communities is to frame implications for practice around a specific theoretical framework. We reviewed several theories and selected the Minority Stress Theory (Meyer, 2015). This theory explains the intersectionality of emotional disorders and sexual minority status which can be addressed in various clinical settings. Minority stressors include external and internal conditions and events. Examples of external minority stressors are discrimination and victimization. Examples of Internal stressors are expectations of rejection and discrimination, concealment of minority identity, internalizations of negative dominant cultural attitudes, beliefs, stereotypes, and values (Hoy-Ellis, 2021). Lacombe-Duncan et al. (2022) have suggested guidelines for providers to incorporate into their practices, which include but are not limited to: For mental health providers, it is recommended to assess for factors described in the Minority Stress Model, including prior discrimination or victimization, expectations of future victimization or rejection, internalized transphobia, and resilience. Also, clinicians must therefore take extra care to conduct such conversations in a sensitive way that cannot be construed as judgmental of that person's identity. For primary care providers, materials should be intersectionality-affirming, inclusive of LGBTQ+ people of different abilities, ethnicities, sexual orientations, and gender identities. Gender affirming care is to ensure sexual identity and orientation is asked on medical forms to better assess the individual's health risks (Lapinski et al., 2018). Additional suggestions include: listening and asking the patient to help determine what pronouns the patient prefers to avoid misgendering. Misgendering occurs when a healthcare provider intentionally or unintentionally refers to a person, relates to a person, or uses language to describe a person that doesn't align with their affirmed gender (Clements, 2018). For fertility specialists, forms, either paper or electronic, should be updated to be inclusive of conception choices and pregnancy experiences of LGBTQ+ people.

At an organizational level, anti-discrimination policies that take into consideration the intersecting experiences that impact people who are intersex, and transgender can be useful to set a tone for the provision of affirming care (Lacombe-Duncan, 2022). Overall, implementing health practices listed above will possibly provide safety to patients who are LGBTQIA+ within healthcare environments resulting in better health and wellbeing for the individual.

Limitations

The commentary addresses the improvement of healthcare experiences for Transgender and Intersex populations in Georgia, therefore recommendations and implications for public health practice may not be generalizable to healthcare professionals in other states that already incorporate inclusive practices with their Transgender and Intersex patients. Furthermore, the recommendations in this paper for improving healthcare experiences for Transgender and Intersex persons may or may not apply to other gender minorities.

CONCLUSION

With Georgia's population becoming increasingly diverse, it is important for health professionals to have a clear understanding on sex and gender. Cultural competency within the healthcare profession has great potential to significantly improve health outcomes for people who are LGBTQIA+. Health professionals should advocate for continued education for themselves and their peers to mutually understand risks, recommendations, and the benefits of community allyship for patients who are LGBTQIA+.

Public health serves as a leader for recognizing disparities in marginalized and vulnerable communities, and it is at the forefront for working with our healthcare partners to reduce bias among healthcare providers and improve health outcomes in the LGBTQIA+ community. The emotional toll that federal and state policies can have on the LGBTQIA+ community impacts access to reproductive health and affirming healthcare which contributes to disparities in health outcomes for this population. Public Health organizations must affirm their commitment to addressing disparities in reproductive health access and bias by providers so that people are treated fairly and ethically.
Health and healthcare outcomes for people who are LGBTQIA+ is most effective when health professionals are equipped with appropriate cultural competency training and accompanying knowledge about specific mental and physical issues that affect the LGBTQIA+ community (Pratt-Chapman & Potter, 2021). As the language of gender expression and sexual identity continues to evolve, there is a need to provide strategies for inclusivity for all gender minority communities.

References

Acién, P., & Acién, M. (2020). Disorders of Sex Development: Classification, Review, and Impact on Fertility. Journal of clinical medicine, 9(11), 3555. https://doi.org/10.3390/jcm9113555

Archibald, J. C. Transgender and intersex sports rights. (2019). Virginia Journal of Social Policy & the Law, Vol. 26, Issue 3, pp. 246-276

Bass, B., & Nagy, H. (2021). Cultural competence in the care of lgbtq patients. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK563176/

Caccavale, J. (2021). Perception Bias: What is it and how can it affect recruitment?. https://www.beapplied.com/post/perception-bias-what-is-it-and-how-can-it-affect-recruitment.

Conron, J. K., & Goldberg, K. S. (2020). Lgbtq people in the u.s. not protected by state non-discrimination statutes. UCLA: Williams Institute-School of Law. https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-ND-Protections-Update-Apr-2020.pdf

Clements, K. C. (2018). What does it mean to misgender someone?. https://www.healthline.com/health/transgender/misgendering

Hoy-Ellis C.P. (2023). Minority Stress and Mental Health: A Review of the Literature. J Homosex. Apr 16;70(5):806-830. doi: 10.1080/00918369.2021.2004794. Epub 2021 Nov 23. PMID: 34812698.

Hughes, I. A. (2008). Disorders of sex development: a new definition and classification. Best Pract Res Clin Endocrinol Metab. 22(1):119-34. doi: 10.1016/j.beem.2007.11.001. PMID: 18279784.

Just the Facts Coalition. (2008). Just the facts about sexual orientation and youth: A primer for principals, educators, and school personnel. Washington, DC: American Psychological Association. https://www.apa.org/pi/lgbt/resources/just-the-facts.pdf

Kaiafas, K. N. & Kennedy, T. (2021). Lesbian, gay, bisexual, transgender, queer cultural competency training to improve the quality of care: an evidence-based practice project. https://doi.org/10.1016/j.jen.2020.12.007

Lacombe-Duncan, A., Andalibi, N., Lee, R., & Weinstein-Levey, E. (2022). Minority stress theory applied to conception, pregnancy, and pregnancy loss: A qualitative study examining LGBTQ+ people's experiences. PLoS One, 17(7) doi:https://doi.org/10.1371/journal.pone.0271945

Lapinski J., Covas, T., Perkins, J.M., Russell, K., Adkins, D., Coffigny, M.C., & Hull, S. (2018). Best Practices in Transgender Health: A Clinician's Guide. Prim Care. 45(4):687-703.

Lee, A., & Kanji, Z. (2017).Queering the health care system: Experiences of the lesbian, gay, bisexual, transgender community. https://files.cdha.ca/profession/journal/2259.pdf

(2019). LGBTQ and Health Care: Advocating for Health Access for All. Tulane University: School of Public Health and Tropical Medicine. https://publichealth.tulane.edu/blog/advocating-for-lgbtq-health-access/

Margolies, L., Joo, R., & McDavid, J. (2018). Best practices in creating and delivering lgbtq cultural competency training for health and social service agencies. National LGBT Cancer Network.

Mercer, K. & Jordan, D. (2021). Barriers to the acquisition of quality care for intersex populations. Jiann-Ping Hsu College Of Public Health: Eagles Talking About Public Health. Georgia Southern University. https://jphcoph.georgiasouthern.edu/opr/etaph/

Meyer, I.H. (2015). Resilience in the Study of Minority Stress and Health of Sexual and Gender Minorities. Psychology of sexual orientation and gender diversity, 2, 209-213.

Pinto, N., & Moleiro, C. (2015). Gender trajectories: transsexual people coming to terms with their gender identities. Prof. Psychol. Res. Pract. 46, 12–20. doi: 10.1037/a0036487

Pratt-Chapman, M. L., & Potter, J. (2021). Caring for Sexual and Gender Minority Patients: What Factors Explain Self-Reported Competence Among Healthcare Professional Students? Journal of Oncology Navigation & Survivorship. 12(12), 439–460.

Roosevelt, L K., Pietzmeier, S., & Reed, R. (2021). Clinically and culturally competent care for transgender and nonbinary people, The Journal of Perinatal & Neonatal Nursing: Volume 35 - Issue 2 - p 142-149 doi: 10.1097/JPN.0000000000000560

Rosenwohl-Mack, A., Tamar-Mattis, S., Baratz, A. B., Dalke, K. B., Ittelson, A., Zieselman, K., & Flatt, J. D. (2020). A national study on the physical and mental health of intersex adults in the U.S. PLoS One.15(10):e0240088. doi: 10.1371/journal.pone.0240088. PMID: 33035248; PMCID: PMC7546494.

Sharek, D., McCann, E., Sheerin, F., Glacken, M., & Higgins, A. (2015). Older LGBT people's experiences and concerns with healthcare professionals and services in Ireland. Int J Older People Nurs. 10:230–40.

Thanem, T. (2011). Embodying transgender in studies of gender, work and organization. Handbook of gender, work and organization, 191-204.

Tuller D. For lgbtq patients, high-quality care in a welcoming environment. (2020). Health Aff (Millwood). 39(5):736-739.

Witchel, S. F. (2017). Disorders of sex development. Best Pract Res Clin Obstet Gynaecol. 48:90-102. Epub. PMID: 29503125; PMCID: PMC5866176. doi: 10.1016/j.bpobgyn.2017.11.005.

United States Census Bureau. (2019). Characteristics of Same-Sex Couple Households: 2005 to Present. https://www.census.gov/data/tables/time-series/demo/same-sex-couples/ssc-house-characteristics.html

United States Census Bureau. (2022). Quickfacts: Georgia. https://www.census.gov/quickfacts/GA

Zeeman, L., Sherriff, N., Browne, K., McGlynn, N., Mirandola, M., Gios, L., Davis, R., Sanchez-Lambert, J., Aujean, S., Pinto,N., Farinella, F., Donisi, V., Niedźwiedzka-Stadnik, M., Rosińska, M., Pierson, & A., Amaddeo, F. (2019). Health4LGBTI Network, A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities, European Journal of Public Health, Volume 29, Issue 5 Pages 974–980, https://doi.org/10.1093/eurpub/cky226