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"Even Five Years Ago this Would Have Been Impossible:" Health Care Providers' Perspectives on Trans* Health Care

Richard S. Henry

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“Even Five Years Ago this Would Have Been Impossible:”

Health Care Providers’ Perspectives on Trans* Health Care

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
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Abstract

Trans* studies and issues have recently increased in coverage by the media and popular press. With recent changes in the DSM-5 (APA, 2000; APA 2013) and insurance law (HHS, 2014), trans* healthcare has been under increasing scrutiny. While a small number of studies (Bradford, Reisener, Honnold, & Xavier, 2013; Grant et al., 2011; Rounds, McGrath, & Walsh, 2013; Tanner et al., 2014) have documented discrimination and lack of cultural competencies from the perspective of trans* patients, little research exists that examines the training, support, and decision-making processes of medical professionals who treat trans* patients (Snelgrove et al., 2012, p. 2). The goal of this research study is to explore the training and cultural competencies of healthcare professionals in treating trans* patients by surveying and interviewing healthcare professionals about their experiences of trainings, familiarity with practices/protocols, and attitudes toward treating trans* patients. A survey of 35 health care professionals and nine interviews were conducted. These health care professionals, while generally accepting of trans* individuals, still had some reservations about working with trans* patients and suggested that there were many barriers and challenges to providing trans* health care. A majority of health care professionals had little or no familiarity with treatment protocols or diagnoses for trans* patients, and very few had received any type of training (formal or informal) before or after starting working in the health care about trans* patients. While there are many areas in which there perceived challenges and barriers to care, several participants did observe that there has been a shift in health care recently that is moving towards being more inclusive and responsive to trans* patients.

Introduction

Going to the doctors, while merely a hassle for some people, can be an ordeal for others. For trans*¹ individuals, going to doctors carries the possibility of micro-aggressions² and micro-inequalities³, and outright discrimination and denial of services. While there are some accounts of what it is like to seek the services of health care professionals (hereafter HCPs) from the perspective of trans* patients (Bradford, Reisener, Honnold, & Xavier, 2013; Feinberg, 2001; Grant et al., 2011; Rounds, McGrath, & Walsh, 2013; Tanner et al., 2014), there is very little attention to or investigation about trans* health care from the perspective of HCPs (Snelgrove et al., 2012).

There is a relationship between the level of training and education of HCPs and their ability to provide culturally competent care to patients (Clark, 2005). HCPs need to be concerned about this because inadequate education or training may cause the level of care of trans* patients

¹ Trans* is used as shorthand to acknowledge the range of identities that may begin with the prefix trans or fall under a category that does. One such category is transgender, which operates as both a gender identity and an umbrella term. It is often understood as anyone who does not identify with the socially expected gender associated with the sex they were assigned at birth. Gender identity is one's own internal sense of gender, be it as a woman, man, or something else. Some identities that might fall under the trans* umbrella include: transgender, transsexual, male-to-female (MTF, M2F), female-to-male (FTM, F2M), bigender (two/both genders), agender (without gender), genderqueer, gender non-conforming, two spirit (a Native American term), berdache (a European term for Native Americans), hijra (an Indian term), and androgenous. It is important to note that not all individuals who identify with these terms consider themselves trans*. Drag and other performers, as well as intersex individuals, are also sometimes lumped under the transgender umbrella, but again may not identify as such.

² "Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership" (Sue, 2010).

³ Micro-inequalities are "small events which are often ephemeral and hard-to-prove, events which are covert, often unintentional, frequently unrecognized by the perpetrator. Micro-inequities occur wherever people are perceived to be 'different...' These mechanisms of prejudice against persons of difference are usually small in nature, but not trivial in effect. They are especially powerful taken together" (Rowe, 1990).

to suffer. While a small number of studies (Bradford, Reisener, Honnold, & Xavier, 2013; Grant et al., 2011; Rounds, McGrath, & Walsh, 2013; Tanner et al., 2014) have documented discrimination and lack of cultural competencies of health care professions from the perspective of trans* patients, the training, support, and decision-making processes of HCPs who treat trans* patients is largely unexplored (Snelgrove et al., 2012, p. 2). There are also suggested/recommended protocols and best practices for trans* health care, but how these protocols are enacted or ignored by physicians is unknown, and therefore important to study.

My purpose in this thesis is to explore the training, interest and comfort levels, and roles of HCPs in dealing with trans* patients. In order to do so, I surveyed HCPs about their level of interest and comfort in treating trans* patients, as well as their familiarity with treatment protocols and how helpful they find them. I also interviewed HCPs about how they became involved in trans* health care, their experiences providing trans* health care, and sources or references they have found about trans* health care and whether those sources have been helpful.

Below I first provide some background on how the needs of trans* individuals differ from those of LGB individuals and how historically some HCPs, such as psychologists/psychiatrists, surgeons, and endocrinologists, have been seen as gatekeepers to transition care⁴. I then briefly examine the trans* health care experience and activist critiques by examining the system in which this health care is taking place. Specifically, I look at the experiences of HCPs: their training, cultural competency, and the protocols and regulations within which they work. For the purposes of this study I've chosen to focus on medical professionals—primarily nurses, primary care physicians, and specialists like endocrinologists—rather than mental health

⁴ Health care providers regulate access to hormones and surgeries, which are the medical means of transitioning.

professionals, although both participate in trans* health care. In my discussion of theory I utilize Foucault to argue that governmentality, bio-citizens, bio-power, and biopedagogies provide a useful theoretical framework for understanding the experiences of HCPs within the system of health care. Finally, I describe the methods I used to conduct the study.

Background

Trans* studies and issues have recently increased in coverage by the media and popular press. With recent changes in the DSM-5⁵ and insurance law⁶, trans* health care has been under increasing scrutiny. Trans* patients may be a small minority; however, their exact number has been a matter of much debate. This has been in part due to the difference in language by which trans* gets defined and categorized (Greatheart, 2013). A study by Gates (2011) estimated that .03% of the population identified as transgender. However, according to the DSM-5: “For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%” (APA, 2013). Sex differences also vary by age group and by country (APA, 2013). It is acknowledged, however, that these are likely underestimates, as not all trans* individuals seek medical intervention (APA, 2013), and prevalence rates used in earlier editions of the DSM (DSM-IV-TR) date back to the 1960s, when fewer people were seeking surgery or were being diagnosed (Conway, 2002; Greatheart, 2013). Additionally, in countries where treatment is more accessible and acceptable, prevalence rates are also higher (Greatheart, 2013; Seil, 2004). Overall, since not all trans* individuals seek surgeries, hormone treatments, or are diagnosed with gender dysphoria (formerly gender identity disorder, or GID), which would bring them to

⁵ In the DSM-5, gender identity disorder (GID) was removed and replaced with gender dysphoria. Gender dysphoria is housed in its own separate category, unlike gender identity disorder in previous versions of the DSM. (APA, 2000; APA 2013).

⁶ The U.S. Department of Health & Human Services Departmental Appeals Board overturned a longstanding Medicare National Coverage Determination that “transsexual surgery” would not be covered by Medicare. However, while this decision removed the federal blanket exclusion, individual Medicare contractors now make decisions in relation to transition related care (HHS, 2014).

the attention of health care gatekeepers, there is no easy way to track and ascertain the size of this growing community (Greatheart, 2013).

Literature Review

Diversity is defined as “the combination of certain dimensions of difference (patient’s biology, gender, age, culture, and education) that interact and can result in dissimilar needs and preferences” (Celik, Abma, Widdershoven, van Wijmen, & Klinge, 2008, p. 65). In health care, these differences can create “disparities and disadvantages in access, diagnosis, and treatment between patient populations” (Celik, Abma, Widdershoven, van Wijmen, & Klinge, 2008, p. 65). These inequalities can negatively impact patients’ health, even when HCPs do not acknowledge these differences as significant. Not only do differences matter, but they can have “clinical implications” (Celik, Abma, Widdershoven, van Wijmen, & Klinge, 2008, p. 65). Eve Sedgwick argues, “People are different from each other” (1990, p. 22). Even people who share all or most of our positionalities may still seem different from us and others (Sedgwick, 2005). If doctors are not trained to deal with diversity, it makes it challenging to form a relationship with patients. Nevertheless, trans* patients are often excluded from diversity trainings (Clark, 2005, p. 323, 326; Rounds, McGrath, & Walsh, 2013, p. 100; Snelgrove et al., 2012, p. 1-3, 5), ignoring the voices of trans* patients and the barriers they face.

There are many barriers to providing and receiving trans* health care. Some of these barriers are faced by the patients, others by the HCPs, and some are faced by both groups. For patients these barriers include socio-cultural and socio-economic factors, provider insensitivity, and discrimination. Together, trans* patients and their health care providers may experience issues with insurance, trouble communicating, and difficulty establishing a trusting relationship. For HCPs themselves, institutional controls, education, training, policy, and bias may be barriers

to caring for trans* patients. The range and scope of these barriers can make accessing and providing health care services daunting. Each set of barriers is discussed further below.

Patients

Trans* patients face many barriers to receiving adequate health care. These barriers include social stigmatization, economic marginalization, provider discrimination, and institutional/structural barriers (Clark, 2005, p. 323-324; Roberts & Fantz, 2014, p. 983). Insensitivity of HCPs is commonly cited as a reason why trans* patients do not access services (Lombardi, 2001, p. 870; Clark, 2005, p. 323; Maguen, Shipper, & Harris, 2005, p. 481). Trans* patients who have previously experienced discriminatory or uncomfortable treatment are less likely or willing to seek treatment again, and they may take longer to establish trust with a provider (Clark, 2005, p. 325).

The needs of LGB individuals in accessing health care are often different than trans* individuals, yet they are often lumped together in research. On the Gay and Lesbian Medical Association website under patient resources they offer top ten issues to discuss with your health care provider for gay men, bisexuals, lesbians, and transgender persons. While issues of safe sex/sexual health/STDs, alcohol/tobacco/substance use, cancer risk, depression and anxiety, and fitness were common to all four lists, trans* persons also addressed issues of access to health care, health history, hormones, and injectable silicone (Allison, 2012; Poteat 2012; Winn, 2012a; Winn, 2012b). These differences suggest that while there may be some commonalities and overlap in concerns, some critical differences may be overlooked. Often, “[t]ransgender issues are buried within the data collected regarding the lesbian, gay, and bisexual (LGB) population” (Clark, 2005, p. 321). Trans* and sexual identities often get conflated, despite significant differences among them (Dilley, 2004, p. 113). In 1999 the American Public Health Association

(APHA) created policies to increase awareness for the need of trans* specific research (Clark, 2005, p. 322; Lombardi, 2001, p. 869). Clark (2005) argues, “In doing so, the association brought significant attention to the unique health care needs of the transgender population, as well as stressing that transgender men and women must not be blindly categorized into LGB issues” (p. 322). Differentiating between the needs of trans* and LGB patients is not unilaterally accepted; while the Department of Health and Human Services (HHS) specifically names sexual orientation “as an indicator for disparities in health or health care services” (Clark, 2005, p. 324), it fails to acknowledge trans* patients, as it focuses on sexuality while ignoring gender identity and expression⁷. Ignoring differences among LGBTQ identified individuals provides an incomplete perspective and is potentially dangerous as trans* patients are considered to be most at risk for getting poor quality health care from providers (Rounds, McGrath, & Walsh, 2013, p. 106).

Historically, mental and medical health professionals have been seen as gatekeepers of transition (discussed further below). This has led to extremely uneven power dynamics between providers and patients (Chyten-Brennan, 2014, p. 274). Some trans* patients have chosen to avoid medical and mental health care altogether for this reason (Chyten-Brennan, 2014, p. 274). Other trans* patients have felt the need to adopt the narrative of “having been born one gender trapped in the body of the other in order to satisfy providers and to secure the necessary approval for transition” (Chyten-Brennan, 2014, p. 274). The notion that doctors, especially psychiatrists and psychologists, act as “gatekeepers,” allowing or denying access to medical treatment, has helped to construct the script that trans* people feel they must follow in order to be taken

⁷ The Department of Health and Human Services has proposed a provision entitled *Nondiscrimination in Health Programs and Activities* to section 1557 of the Affordable Care Act to prohibit discrimination in health care settings based on sex, which is to include gender identity or gender expression (HHS, 2015; TLC, 2015; Young, 2015).

seriously (Prosser, 1998, p. 101). Since these medical professionals control access to treatment, trans* people may feel forced, compelled, or coerced into telling their story in alignment with this script. Deviations from this script have even created a hierarchy in diagnosed trans* identities. Dean Spade argues:

What sense does it make to label some people as true transsexuals, and others as secondary, or confused, or imitation? Whom does such an attitude serve? I can think of no one but the gatekeepers, those who would seize the power of life and death by demanding that transsexuals satisfy an arbitrary standard (Spade, 2003, p. 20).

Spade shows how powerfully ingrained the medical narrative script or narrative has become as a legitimizing authority, and how restricting it is to individuals whose experiences may not align with it. In order to have access to the hormones and surgery many people feel they need, one has to explain and describe their experiences in a manner that allows the medical professional to check all the appropriate boxes on their checklist:

Dominant narratives of transgender experience are reinforced by the DSM criteria for GID, but these exclude other gender variant individuals for whom transitioning treatment may be beneficial. An ethical implication extending from this is the possibility that patients feel compelled to provide disingenuous histories of their transgender identity in order to ensure treatment, should their actual experiences not align with GID criteria. (Snelgrove et al., 2012, p. 2)

If HCPs are the gatekeepers to transition and sensitive, competent care then it is important for them to be aware of how dominant narratives create barriers for trans* patients.

Discrimination is a big problem for trans* patients. In the National Transgender Discrimination survey⁸, 19% of participants reported being refused care altogether (Grant et al., 2011, p. 6). The same survey found that 50% of respondents reported needing to teach their providers about trans* health care (Grant et al., 2011, p. 6). Another 28% of respondents postpone seeking medical care due to discrimination (Grant et al., 2011, p. 6). A further 28% reported being harassed while seeking treatment and 2% were victims of violence (Grant et al., 2011, p. 72). In a more recent study of female-to-male transgender individuals “Overall, 41.8 percent of FTM participants reported verbal harassment, physical assault, or denial of equal treatment in a doctor’s office or hospital” (Shires & Jaffee, 2015, p. 134). Commenting on this study, Dr. Laura Erickson-Schroth, a psychiatrist and editor of the book *Trans Bodies, Trans Selves*, suggested that the study may be an underestimate, “because the sample was skewed towards young, white, college-educated people with jobs and private health insurance... If 42 percent of that group is reporting discrimination, the number may be even higher for others” (Seaman, 2015). This experience of discrimination, harassment, and outright violence can be a huge barrier to accessing the health care services one needs.

Interactions between HCPs and trans* patients may also create barriers between the patient and their health care provider. For example, trans* patients “may experience invasive or inappropriate questions regarding sexual practices or genitalia, leading transgender persons to be suspicious of providers and health care institutions” (Cobos & Jones, 2009, p. 341). Additionally, if a patient does not trust their doctor, they are less inclined to disclose their identity to a provider, which may result in a misdiagnosis or important health related issues being overlooked.

⁸ A new national transgender survey is currently underway to get updated information about the transgender community.

This may be especially true for, “[t]ransgender persons who are in conflict with their sexual anatomy... including sexual practices or parts of the body that are biologically identified with sex or gender” (Cobos & Jones, 2009, p. 341). There are well known cases and personal stories of trans* individuals being refused treatments by doctors, hospitals, and paramedics because of being trans* (Feinberg, 2001). “As a result, many of us fear contact with health professionals” (Feinberg, 2001).

Such issues are compounded by the fact that trans* patients often need multiple providers, ones involved with the gender transition and others for regular, routine, and maintenance care (Lombardi, 2001, p. 870). This suggests there may be differences in receiving general health care and transition-related care. However, it is difficult to discuss one without the other because general health will influence decisions about transition-related care, and transition-related care may influence general health. For the purposes of this paper, the focus is on overall health care, not transition-specific care.

It can be incredibly difficult for trans* patients to find a doctor. Heterosexual gender normative patients can be reasonably assured they can pick any doctor from a list and be provided care, whereas trans* and other sexuality and gender minority patients often have to do further research to ensure the provider is culturally competent (Rounds, McGrath, & Walsh, 2013, p. 105). Sometimes trans* patients have to travel considerable distance in order to access sensitive care (Cruz, 2014, p. 72). This can be a huge burden logistically and financially. Gorton & Grubb summarize many of the barriers trans* patients face stating:

Many of us have delayed or avoided health care and health maintenance screenings because of negative interactions with the health care system. We have been denied care because our providers refused to see us or because our insurance company would not pay.

We have waited disproportionately longer. We have been asked to fill out forms with boxes that do not describe us. We have been called names or pronouns that are accidentally or deliberately incorrect. We have heard biased and harassing comments from clinicians and staff. We have had unnecessary or prolonged physical exams. We have been denied access to safe and appropriate bathrooms. We have been assigned to inappropriate hospital rooms. And the list goes on. (Gorton & Grubb, 2014, p. 215)

All of these barriers can make it incredibly difficult for trans* patients to seek treatment and find culturally competent and compassionate care.

Navigating Health Care Systems: Patients and Providers

Some barriers are experienced both by the trans* patient and the HCPs. Insurance is frequently cited as one of these barriers. Providers often face difficulties in getting authorization to treat a patient depending on how the insurance company lists the gender of the patient (Gorton & Grubb, 2014, p. 219). Trans* patients must choose which designation is most appropriate for them, often forcing patients to choose which necessary medical treatments will get covered (Gorton & Grubb, 2014, p. 219). At the time of this writing, only ten states (California, Colorado, Connecticut, Illinois, Massachusetts, Nevada, New York, Oregon, Vermont, and Washington) and Washington D.C. prohibit transgender exclusions in insurance (Transgender Law Center, n.d.).

Apart from issues of insurance, there are two primary models for trans* transition-related health care. Those are the informed consent model and the World Professional Association for Transgender Health (WPATH) Standards of Care (SoC). The informed consent model “means that the individual possesses the cognitive ability to make an informed and independent decision about their health care and are choosing to do so without coercion” (ICATH, n.d.). Many clinics

are starting to follow the informed consent model, including Planned Parenthood⁹, the Howard Brown Health Center¹⁰, the Mazzoni Center¹¹, Fenway Health¹², and the Tom Waddell Health Center¹³. However, informed consent clinics are not available everywhere, which for some is a barrier for being able to begin medical transition. The informed consent model also varies in practice; however, the basic premise remains the same which is that patients should guide their own health care experiences. But some clinics that claim to be informed consent have their own set of criteria you must meet to be eligible to begin medical transition. These requirements, for some, can be a barrier to care.

The other model is developed by WPATH. WPATH was formerly known as the Harry Benjamin International Gender Dysphoria Association after Harry Benjamin, who was one of the first physicians to work with individuals with gender dysphoria, whom he termed “transsexuals.” WPATH is currently on their seventh edition of the SoC, which came out in 2012 (WPATH, 2015b). The first edition was published in 1979 (WPATH, 2015b). The others were published in 1980, 1981, 1990, 1998, and 2001 respectively (WPATH, 2015b). According to WPATH, the SoC “articulate a professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders, and help professionals understand the

⁹ There are at least twenty-six several Planned Parenthood locations that offer hormone replacement therapy using the informed consent model (Urquhart, 2016).

¹⁰ The Howard Brown Health Center is located in Chicago, IL and is a large LGBT health organization. Among the services they offer is transgender healthcare, including primary care, hormone replacement therapy, and other preventative services.

¹¹ The Mazzoni is a LGBT community health center in Philadelphia, PA. They offer training and resources for providers, support groups, pediatric and adolescent services, and clinical care (including hormone therapy).

¹² Fenway Health is a LGBT community health center in Boston, MA. They provide medical, mental, and support services for transgender patients.

¹³ The Tom Waddell Health Center is in San Francisco and is one of the primary health clinics in the SF Health Network, a complete public care system. This location has a transgender clinic for providing hormone replacement therapy.

parameters within which they may offer assistance to those with these conditions” (WPATH, 2015a). This model has been highly criticized for the strictness of its requirements, and for potentially putting patients in unsafe positions during the real-life experience test. The real-life experience test requires individuals to socially transition, or live as their preferred gender for a length of time (usually two years), before they can start hormones. However, because many trans* individuals cannot pass without hormones it was asserted that they were at greater risk for violence during this period. For many these stringent requirements become unnecessary barriers. Contrasted to the informed consent model, under the SoC there are strict criteria and processes that the patient must go through before being able to access medical transition. With informed consent, the patient only needs to be deemed cognitively able to make the decision and that they are doing so without coercion. In both models the decision ultimately rests with the HCP, which gives HCPs a lot of power for trans* health care.

Along with the two models for transition health care, there are two primary medical diagnostic schema by which a trans* person might be diagnosed. Right now a diagnosis is often the first step in a medical transition and is often, although not always, required to have insurance cover any aspect of medical transition. The first diagnostic schema is the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) which came out in 2013. The DSM is published by the American Psychiatric Association and is used as the standard classification of mental disorders. The DSM-5 is the seventh revision. The first edition of the DSM was published in 1952; however, transsexualism was not added until the 3rd edition (APA, 1980). The name and criteria of the diagnosis has shifted several times. The first major name change was from Transsexualism in the DSM-III-R to Gender Identity Disorder in the DSM-IV (APA, 1987; APA, 1994). The second name shift was from Gender Identity

Disorder in the DSM-IV-TR to Gender Dysphoria in the DSM-5 (APA, 2000; APA, 2013). In addition to name changes, the diagnostic criteria shifted from the DSM-III to DSM-III-R, from the DSM-III-R to the DSM-IV, and again from the DSM-IV-TR to the DSM-5 (APA, 1980; APA, 1987; APA, 1994; APA, 2000; APA, 2013). While early editions of the DSM provided little more than diagnoses, DSM-5 provides “diagnostic criteria”, “specifiers”, “diagnostic features”, “associated features supporting diagnosis”, “prevalence”, “development and course”, “risk and prognostic factors”, “culture-related diagnostic issues”, “diagnostic markers”, “functional consequences of gender dysphoria”, “differential diagnosis”, and “comorbidity” information (APA, 2013).

The second model is through the World Health Organization’s International Classification of Diseases (ICD), currently in the 10th version which was released in 1994, although the United States is only set to adopt it this year (WHO, 2015b). The 11th revision is expected out in 2018 (WHO, 2015b). The ICD-10 is “the standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups” (WHO, 2015b). Not only is the ICD-10 a diagnostic tool, but it is used by:

physicians, nurses, other providers, researchers, health information managers and coders, health information technology workers, policy-makers, insurers and patient organizations to classify diseases and other health problems recorded on many types of health and vital records, including death certificates and health records. (WHO, 2015b)

In this way it is also a statistics and data management strategy. In the ICD-10 section F64 is gender identity disorders, under which diagnosis F64.0 is Transsexualism (WHO, 2015a). The entire diagnosis reads:

A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex. (WHO, 2015a)

Some advocates have suggested if the ICD-10 criteria were revised and updated it might allow for gender dysphoria to be removed from the DSM (Lev, 2005, 59). Essentially, trans* patients must receive this diagnosis in order to legitimize their treatment, but at the same time many insurance plans still have trans* exclusions so having this diagnosis will prevent insurance from covering the cost of treatment. This catch-22 can prevent HCPs from being able to treat their patients and prevent trans* patients from receiving care.

Regarding these two models, the American Psychological Association in their *Report of the APA Task Force on Gender Identity and Gender Variance* recommended both the need to “Establish a task force to examine both the science and politics of the GID diagnosis and ask this group to monitor and, if possible, participate in the revision of the DSM” and “Evaluate critically the criteria outlined in the WPATH Standards of Care” (APA, 2009, p. 69). This suggests that the existing diagnoses and protocols for treatment may not be adequate or complementary. Additionally, trans* advocates have called for the removal of any trans* diagnosis from the DSM, because it equates gender identity with a mental disorder and pathologizes it. Since mental illness carries a tremendous stigma, being diagnosed with gender dysphoria is further stigmatizing and marginalizing of an already vulnerable population. However, if individuals reject this diagnosis and label, then it is much harder to medically transition. For HCPs, these diagnoses do not cover the wide range of trans* experiences and identities, thus putting them in a position where they may not have adequate information.

Providers

Not only do trans* patients encounter challenges in accessing treatment, HCPs often encounter barriers to providing care. Major areas of concern include “accessing resources, medical knowledge deficits, ethics of transition-related medical care, diagnosing vs. pathologising trans identity, and health system determinants” (Snelgrove et al., 2012, p. 4). Sometimes it can be as small as forgetting “the importance of acknowledging how the client’s name is pronounced, if they prefer to be addressed in a more formal manner... or what pronoun they prefer” (Clark, 2005, p. 326). By using the wrong pronoun and/or neglecting to ask for a preferred pronoun(s), trans* patients may feel invisible or invalidated and reluctant to open up or disclose necessary information to the provider. If the patient is reluctant to disclose information to their provider, this may lower the standard of care the HCP is able to provide because they may not get the information they need to help the patient. Additionally, HCPs may feel inadequately prepared to serve trans* patients due to a lack of training, education, or experience. So, while there are multiple potential knowledge sources that providers could potentially rely and draw upon, such sources may be lacking or HCPs may be unaware of them. This is related to the concept of “erasure” which is the systematic denial and invalidation of identities, bodies, and experiences (Snelgrove et al., 2012, p. 2). In a health care setting erasure may occur as a result of the lack of services for trans* patients and a lack of resources for providers (Snelgrove et al., 2012, p. 2).

Providers must also be aware of their own biases, attitudes, and values about gender identity in order to work effectively with patients whose identities might be contrary to their own values and beliefs (Clark, 2005, p. 326). “It is estimated that levels of bias and misinformation are high among health care professionals” (Maguen, Shipper, & Harris, 2005, p. 481). Failing to

address their own values and beliefs may result in stereotypical or discriminatory treatment of a trans* patient. As one example illustrates:

At the end of an hour-long in-service for healthcare providers I conducted a few years ago, a physician bluntly dismissed the necessity of the training stating the clinic absolutely did not have any transgender patients. Considering the efficacy of hormones and GRS [gender reassignment surgery] for some individuals, I asked how clinic personnel would even know if a client was transgender. Some professionals and non-professionals alike seem to think they have the ability to visually identify every trans person, which is simply not the case. Levels of bias and misinformation are high among health care professionals and specialized training to work with a transgender population is far less frequent. (Greatheart, 2013, p. 18-19)

This can be a challenge in part due to the lack of training and education received about trans* health, as it is not a part of medical school curricula (Cruz, 2014, p. 72). If health care providers are not trained about trans* health, they may encounter barriers they did not even know existed. This lack of education and training results in, “[p]hysicians... not knowing the available resources or care strategies appropriate for the trans patient population” (Snelgrove et al., 2012, p. 4).

Cultural competency is related to education and training of health care providers and is a significant barrier to trans* health care. In any profession, cultural competency is “a way of being sensitive to the differences in culture of constituents and acting in a way that is respectful of the values and traditions of the client while performing those activities or procedures necessary for the client’s well-being” (de Chesnay, Wharton, & Pamp, 2005, p. 31). Cultural competency is thought to have four dimensions: caring, cultural sensitivity, cultural knowledge,

and cultural skills (de Chesnay, Wharton, & Pamp, 2005, p. 32). Values of nursing include “health care for all, cultural competence, and commitment to education” which are thought to be critical to trans* health care (Clark, 2005, p. 321).

Within cultural competency trainings, trans* would be only a small part. Yet research suggests that though “we have been repeatedly oriented to respect diversity of ethnicity, religion, and disabilities, issues surrounding sexual orientation and gender identity are overlooked when considering cultural awareness” (Clark, 2005, p. 326). In practical terms, cultural competency may help a provider to determine if the questions they are asking are relevant to treating their trans* patient or simply something they are curious about or want to know (Polly & Nichole, 2011, p. 62). These intrusive questions asked by HCPs can lead to trans* patients feeling discomfort and shame, which might cause these patients to be less likely to seek medical treatment in the future. At all levels, “Inadequate cultural competence and restrictive policies—whether official or not—were seen to contribute to systematic discrimination and transphobia that manifest as barriers to care” (Snelgrove et al., 2012, p. 8).

Trans* patients are also a diverse group with different preferences for terminology, with some individuals using terms that others may find offensive (Cobos & Jones, 2009, p. 342). This can be confusing for providers who may not be familiar with the terminology, which may result in unintentional offense (Cobos & Jones, 2009, p. 342). Also, many intake and medical forms do not reflect the diversity of sex, gender, or relationship statuses that might be relevant to trans* and other patients (Rounds, McGrath, & Walsh, 2013, p. 106). This means HCPs may be getting inaccurate information, which may impede their ability to provide culturally competent and sensitive care. If health care providers are not aware of the barriers faced by patients it may

further impede their ability to provide sensitive, culturally competent care or to establish trust with their patients.

Referring patients to other HCPs is another barrier. It can be challenging to identify “trans-friendly” providers, particularly if they work in different clinics or networks (Snelgrove et al., 2012, p. 4). HCPs making referrals for patients must figure out not only the specialist availability, but for trans* patients the sensitivity of the specialist (Snelgrove et al., 2012, p. 4). It can sometimes take multiple referrals to find a specialist willing to treat trans* patients. This can add additional work for HCPs, but it can also lead to them establishing relationship with other providers.

Not only can referring patients to other providers be difficult, but being able to get necessary procedures, screenings, or therapies covered by insurance can be especially challenging for HCPs if there is “sex-specific eligibility criteria” (Snelgrove et al., 2012, p. 8). For example, pap smears for trans men and prostate exams for trans women may or may not be covered based on the sex listed on insurance. The inability to access procedures, screenings, and exams could impede the ability of HCPs to provide appropriate care.

Inadequate knowledge, education, training, networks, and cultural competency of HCPs are significant barriers to trans* health care. HCPs receive little or no education in curriculum or the workplace about the specific health needs of trans* patients (Clark, 2005, p. 323, 326; Rounds, McGrath, & Walsh, 2013, p. 100; Snelgrove et al., 2012, p. 1-3, 5). As such, they are ill-prepared to offer comprehensive or sensitive care (Clark, 2005, p. 323). However, Feinberg argues education, alone, is not sufficient:

Education is important. But attitudinal change is not the same as institutional change. If education is not tied to transforming systems of health care delivery, then it's as effective

as putting out a forest fire with teacups full of water. Sensitivity and diversity training has to be linked to a commitment to institutional change and mechanisms for compliance.

(Feinberg, 2001)

According to Feinberg, both the individual (provider) and institutional (protocols/treatment guidelines/recommendations, insurance, best practices, administrative, etc.) levels are important to be able to provide culturally competent trans* health care. Feinberg is suggesting unless what is being learned in sensitivity and diversity trainings is being converted into practice with some way of holding the individuals and institutions accountable, such trainings are a wasted effort. For example, providers should not just be told that asking what pronouns a patient uses is important, but they should have some system for getting that information (either on an intake form or by asking), and there should be a feedback system to track how attentive they are to this information. In order “to provide much-needed services to this population, researchers, educators, and health care professionals of all types need concrete, comprehensible information about transgender individuals” (Lombardi, 2001, p. 869). Additionally, if HCPs are not receiving training or education on working with trans* patients, this suggests they also are not being taught the protocols and best practices. So even HCPs who may be willing to work with trans* patients may simply not know how.

Theoretical Framework

Michel Foucault's notions of governmentality, biopower, biocitizenship, biopedagogies, and the panopticon provide one way of understanding the patient/health care provider dynamics and the system in which these relationships operate. These concepts rest on the overarching notion of power. Power, according to Foucault, "produces; it produces reality; it produces domains of objects and rituals of truth" (1979, p. 194). Foucault further explains that power is not a structure or institution (Foucault, 1990, p. 93). But what is power? In *The History of Sexuality Volume 1* Foucault defines power as discursive and dispersed, as well as pervasive and inescapable (Foucault, 1990). Foucault argues that power is everywhere, because it comes from everywhere (Foucault, 1990, p. 93). "Power must be understood as... the strategies... whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies" (Foucault, 1990, p. 92-93). In other words, power is both strategy and possibility (Foucault, 1990). The law, sovereignty of state, and domination he notes, however, are sometimes only terminal forms power takes (Foucault, 1990, p. 92). It is these forms of power that give rise to governmentality.

Governmentality relates to how governing occurs, and adopts a broader meaning of government that is not necessarily directly linked to a nation-state. Dean (1999) argues governmentality is a field of study, one which focuses on "the government of human conduct in all contexts" (p. 3). In other words, governmentality is the process of how the management of behaviors occurs. Governmentality "distinguish[s] the particular mentalities, arts and regimes of government and administration" (Dean, 1999, p. 2). To relate this to health care, health care is a

heavily regulated system. Government and laws play an integral role in how the health care system operates. One example of this would be insurance law, and more specifically what can or cannot legally be excluded from coverage. To understand how this occurs I seek to explicate the governing practices contained within these systems of human conduct. Specifically, asking questions about challenges HCPs face may identify micro-expressions of the larger structural and systematic barriers or controls.

The management of populations is another aspect of governmentality. “One of the greatest innovations in the techniques of power in the eighteenth century was the emergence of ‘population’ as an economic and political problem” (Foucault, 1990, p. 25). While the power over life and death had long been a privilege of sovereign power, the notion of populations and population management subverted this (Foucault, 1990, p. 135). Instead, “The old power of death that symbolized sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life” (Foucault, 1990, p. 139-140). With the management of life and populations came the need to control and influence it. “Hence there was an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations, marking the beginning of an era of ‘bio-power’” (Foucault, 1990, p. 140). Biopolitics and biopower became the means through which this is done.

Biopolitics is the regulatory control of populations and biopower is the power over bodies, in this case, the bodies of trans* patients. “Biopolitics denotes a specific modern form of exercising power” (Lemke, Casper, & Moore, 2011, p. 33). This power is the power over populations. The concept of biopower has three dimensions, the first of which is “a form of truth discourse about living beings and an array of authorities considered competent to speak that truth” (Rabinow & Rose, 2006, p. 203-204). The second is “strategies for intervention upon

collective existence in the name of life and health” (Rabinow & Rose, 2006, p. 203-204). The third is “modes of subjectification, in which individuals can be brought to work on themselves... in the name of individual or collective life or health” (Rabinow & Rose, 2006, p. 203-204). In other words, biopower operates with authorities who provide truth, strategies for intervention, and the subjectification and (self)regulation of individuals in relation to those truths. In the context of health care, HCPs are viewed as one set of authorities, often as authorities of diagnosis, treatment protocols, and insurance. For trans* health care, they may be the only recognized authorities in the system of governmentality as the voices of trans* patients may be negated though, ironically, trans* patients may serve as sources for the constructed truth discourse then authoritatively managed by HCPs. Thus, as the first dimension of biopower is to be able to create and competently speak about the discursive truths of a population, this relates to the notion of cultural competency of HCPs. Are HCPs adequately trained to speak authoritatively about trans* health care? To assess this I will ask questions about their experience, education, and level of familiarity with the models of health care previously discussed.

Biopower also necessitates strategies of interventions. The systems of control, management, and regulation are enacted through interventions known as biopedagogies (Foucault, 1990, p. 139). Biopedagogies are “disciplinary and regulatory strategies that enable the governing of bodies in the name of health and life” (Wright, 2009, p. 14). Biopedagogies dictate what one should or should not do and what one’s constraints and obligations are (Foucault, 1979, p. 11). In this way, “the body is also directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it” (Foucault, 1979, p. 25). These systems of control are also systems of order. “They also acted as factors of segregation and social hierarchization, exerting their influence on the respective forces of both these

movements, guaranteeing relations of domination and effects of hegemony” (Foucault, 1990, p. 141).

In relation to health, these policies and regulations dictate who good, healthy citizens are. For example, “Biopedagogies place individuals under constant surveillance and towards increased self-monitoring by elevating their knowledge around diseases/conditions, as well as learning how to be healthy” (Iriart, Franco, Merhy, 2011, p. 9). Biocitizens enact these biopedagogies. “Individuals are offered a number of ways to understand and change their behaviors, as well as encouraged to take action to educate other members of their families and communities to have healthy lives” (Iriart, Franco, Merhy, 2011, p. 9). Thus a biocitizen is engaged in trying to live healthier lives, as dictated through the biopedagogies, and encourage those close to them to do the same. In this way, biopedagogies “inform and persuade people on how they should understand their bodies and how to live their lives” (Iriart, Franco, Merhy, 2011, p. 9). In relation to trans* health care the protocols and diagnoses that health care providers rely on include The World Professional Association for Transgender Health (WPATH) Standards of Care (SoC), the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), and the World Health Organization’s International Classification of Diseases 10 (ICD-10). To gauge how HCPs relate to and understand these documents, I will ask questions about how familiar they are with them and how helpful they find them. These biopedagogies are prescriptive, both for the HCPs and their trans* patients.

Biocitizens are expected to internalize the biopedagogies for their own betterment. According to Dorothy Roberts, “all Americans are increasingly expected to become biocitizens who assume full responsibility for their own welfare” (2011, p. 310). To relate this to health care provider and patient relationships, patients are expected to conform to medical regulations and

interventions prescribed by their health care providers. However, if the biopedagogies or dominant medical narratives about trans* individuals are not sensitive to the daily lived experiences and narratives created by trans* individuals, patient care may suffer or individuals may not get their needs met. This begs the question where HCPs attain their knowledge about the needs of trans* patients. Because Foucault assumes a model of diffuse power through narrative discourses, if power comes from everywhere it follows that trans* patients' discourses about their lived experiences exist in negotiation with the biopedagogies. Therefore, how trans* patient discourses inform the understandings of HCPs will also be addressed in the study.

Another concept Foucault talks about that may be helpful in understanding this project is that of the Panopticon. The panopticon is the ideal prison. It is established in such a way that it renders each inmate permanently visible and continuously able to be surveilled (Foucault, 1979, p. 201). Knowing this, the inmate will internalize that surveillance and will act as though they are being watched, whether or not the actual act of surveillance is taking place (Foucault, 1979, p. 201). This system “assures the automatic functioning of power” and “the perfection of power should tend to render its actual exercise unnecessary” (Foucault, 1979, p. 201). The panopticon, as a system of power and control, is not limited to prisons. Foucault argues that, “The Panopticon... must be understood as a generalizable model of functioning; a way of defining power relations in terms of the everyday life of men” (Foucault, 1979, p. 205). This system can be used, according to Foucault, for prisons, hospitals, schools, and employment (1979). The panopticon is:

polyvalent in its applications... It is a type of location of bodies in space, of distribution of individuals in relation to one another, of hierarchical organization, of disposition of centres and channels of power, of definition of the instruments and modes of intervention

of power, which can be implemented in hospitals, workshops, schools, prisons. Whenever one is dealing with a multiplicity of individuals on whom a task or a particular form of behaviour must be imposed, the panoptic schema may be used. (Foucault, 1979, p. 205)

This system not only accounts for the prisoners, patients, school children, or laborers who internalize the surveillance under this system of power, but has “an apparatus for supervising its own mechanisms” (Foucault, 1979, p. 204). Everyone involved with or employed by the system is also under surveillance, able to be judged and observed (Foucault, 1979, p. 204). In this way the doctors, nurses, teachers, and guards are all inexplicably bound up in the system, watching and being watched, as they implement the biopedagogies. In other words, doctors try to get patients to comply with medical treatments and biopedagogies, but are in turn operating within a system of controls.

In relation to trans* health care, the WPATH SoC, the DSM-5, and ICD-10 operate as regulatory discourses and biopedagogies. The HCPs’ relationship to their patient, while not directly observable, is still subject to control and surveillance in the form of laws, insurance, medical ethics, etc. These regulatory documents require HCPs to look for certain criteria and standards to be met in order for patients to be eligible for treatment. By asking how familiar and how helpful HCPs find these documents, as well as more generally about their experiences implementing the biopedagogies, it may be possible to explore whether HCPs experience these notions of surveillance and control.

Michel Foucault’s notions of governmentality, biopower, biocitizenship, biopedagogies, and the panopticon provide a way of understanding the roles and relationships of the health care provider and the system in which these professionals operate. Through survey and interview questions about treatment protocols/treatment guidelines/recommendations and HCPs

experiences in providing trans* health care it may be possible to see how these theories operate in the lived experiences of HCPs. These theories may also provide useful lenses through which to view and analyze the HCPs' answers. The next section discusses how the surveys and interviews will be conducted and the data analyzed.

Methods

This project used interviews and surveys to assess the interest and comfort level of HCPs in treating trans* patients, how familiar they are with current protocols/treatment guidelines/recommendations, how helpful they find those protocols/treatment guidelines/recommendations, their roles in providing trans* health care, and their experiences with providing trans* health care. This is done in attempts to answer the question: how do HCPs experience trans* health care? I utilized feminist methodologies in undertaking this project. Feminist methodology tries to bring women's, marginalized, and underrepresented voices into the research process, makes visible the assumptions and politics driving the research, critiques the power relations within research, and strives to create social change (Golombisky, 2010; Hesse-Biber, 2008). This project seeks to understand the disparities and challenges of trans* health care through the lens of the provider. In order to address and potentially transform the system of healthcare, the needs of patients and the experiences and challenges for both patients and HCPs must be identified. Specifically, I used Qualtrics to survey HCPs about how interested HCPs were in treating trans* patients, how comfortable they are in treating trans* patients, how familiar they are with treatment protocols/treatment guidelines/ recommendations, and how helpful they found such treatment protocols/treatment guidelines/ recommendations. Then, I invited those survey respondents who reported experience working with trans* patients to participate in an electronic interview. After discussing both of these methodologies, below, I describe how I analyzed the interview and open-ended survey question data.

Survey

I first obtained institutional review board permission for this study (a copy of IRB approval can be found in Appendix A). Using Qualtrics, a web-based survey invitation was distributed by email to a purposive sample of HCPs. The survey sample consisted of members of health care listservs, organizations for HCPs, trans* health care advocacy groups, and professional societies for HCPs. These included an academic medical center in Florida, a community health center in Florida, and a regional hospital in Oregon. Listservs were primarily regional, community health provider lists or private practices that served specific populations. To access these individuals I utilized gatekeepers, who are HCPs or who work in organizations or networks with HCPs with whom I have had prior interaction. Some gatekeepers distributed the survey link directly to the organizations/listservs for which they are members. The remaining gatekeepers provided contact information and/or introductions to allow me to send the survey link to the members of their organization/listserv via email. Using this snowball sampling procedure I eventually received 38 completed surveys.

The first page of the online survey was the consent form. Participants had to click accept in order to indicate consent and access the survey. The surveys collected demographic information, including information about gender, race/ethnicity, location of training and practice, years of experience, specific profession, and if they have experience working with trans* patients. They were also asked to describe the type of experience they had with trans* patients, and to provide their own definition of trans*. A likert scale was included used to measure how interested HCPs were in treating trans* patients, how comfortable they are in treating trans* patients, how familiar they are with treatment protocols/treatment guidelines/recommendations, and how helpful they found such treatment protocols/treatment guidelines/recommendations or

biopedagogies. Their education on trans* issues was extensively discussed, including experience with trainings on trans* issues or protocols before and after working with trans* patients. An extensive system of skip-patterns were designed to eliminate unnecessary questions for respondents. Thus, if respondents reported not being familiar with a particular protocol, they were not asked further questions regarding that protocol. The attitudes of HCPs about trans* individuals were measured by a few questions adapted from the Attitudes Toward Transgender Individuals (ATTI) Scale (Walch et al., 2012). Optional open-ended response fields were given at the end for participants to give voice to any comments, concerns, opinions, etc., in line with feminist methodologies. The survey was available online for 10.5 weeks and accessible via a URL sent to participants. Participants were sent an initial invitation and usually one reminder¹⁴. Approximately 12 gatekeepers and listservs were solicited for this project. Survey data was then imported into SPSS to run frequency and cross tabulation analysis. Open-ended responses were coded using primarily structural and data driven thematic and theoretical coding. Structural coding is “question-based” in which “similarly coded segments are... collected together for more detailed coding and analysis” (Saldana, 2009, p. 66-67). The frequencies of codes across open ended responses was also calculated. The complete survey can be found in Appendix B.

Interviews

Survey participants who reported experience working with trans* patients were asked if they were willing to also participate in a semi-structured e-interview about those experiences. Those respondents who reported experience working with trans* patients were shown an additional question where they could volunteer to be interviewed about those experiences.

¹⁴ Snowball participants sometimes had an unknown number of exchanges with the gatekeepers. The number of reminders for interview participants was also typically higher, as multiple interactions occurred.

Participants had the option of communicating via email or phone, and eight respondents chose to conduct the interview by email. The nine individuals who agreed to participate were, prior to the interview, sent a short description and purpose of the interview, copies of the IRB-approved informed consent forms and an explanation of the informed consent process, including my intention to maintain anonymity via the assignment or selection of pseudonyms for the overall project. Phone interviews were recorded with permission of the participant, and all recordings were destroyed as soon as the transcription was completed. All email interview transcripts were downloaded and then removed from the server and stripped of any identifying information including email addresses.

I utilized an e-interview method, including both phone and email, to query how respondents had become interested or involved in trans* health care, what challenges they may have faced, and what sources of information they use as part of their work. The goal of this was to gain further understanding of these participants' experiences. Interviews allow for a depth and opportunity for clarification not possible with surveys or other methods. Additionally, it enhanced understanding of the survey data. Using a semi-structured interview format also allowed the participants the opportunity to actively participate in shaping the research process by focusing on the aspects of the questions and topic most salient to them. This had the potential to yield data or a line of inquiry that may have gone undiscovered in a survey alone. Based on the responses to these questions, further follow-up questions were asked to prompt for greater detail or reflection. The written email exchanges and phone transcriptions were then coded using structural, and data driven thematic and theoretical coding.

The questions for the interview were reflective of Foucault's notions of governmentality and biopedagogies. See appendix C for the interview guide. The aim with the interview was to

understand the system of health care for trans* patients, and how HCPs experience and navigate that system. Each interview comprised of demographic questions (because the survey was not linked to the interview in any way), a set of questions about the HCPs' personal experiences, and another set of questions about the health care system. Some questions were related to the resources, or biopedagogies, that the HCPs are aware of, how they engage with and utilize them, and how these biopedagogies may have changed over time. In relation to governmentality, the participants were asked about the system of trans* health care, challenges they've encountered, the impact of setting, policy, and context on their experience of trans* health care, and their professional role.

E-interviewing was chosen because this allows for the possibility of reaching a wider range of HCPs. By using e-interviewing, I increased access to participants and potential participants (James & Busher, 2009, p. 48). Additionally, the participants responded at their convenience (James & Busher, 2009, p. 47). This is especially important for HCPs as their work schedules vary and may not follow the traditional work week. For these reasons, e-interviewing was the best method for this project.

Work using e-interviewing methods is not inherently feminist. What makes this project feminist is the concern with the experiences of the trans* community, which is an oppressed, stigmatized, and marginalized group (Hesse-Biber, 2014, p. 189). While there are studies and articles documenting experiences from the trans* patients' perspective, there is very little work asking HCPs about their experiences working with trans* patients. By including HCPs' voices, it might be possible to answer questions that might not be answerable from the patient perspective and illuminate other challenges and experiences HCPs have in relation to treating, interacting with, and serving trans* patients (Hesse-Biber, 2008, p. 337). Questions about obstacles or

barriers to providing trans* care, training and education about being sensitive and aware of issues that might be unique to trans* patients, and best practices can best be answered by interviewing HCPs. Additionally, each participant was given the option of reading the transcript of their interviews to clarify or add to and to see a draft of the final thesis. This process allows participants to play an active role in the research process.

Interview and Open-Ended Response Data Analysis

Content analysis is “the systematic study of texts and other cultural products or nonliving data forms” (Leavy, 2007, p. 227). Content analysis assumes, “we can learn about social life, such as norms, values, socialization, or social stratification, by looking at the texts we produce... Furthermore, cultural artifacts do not simply reflect social norms and values; texts are central to how norms and values come to be shaped” (Leavy, 2007, p. 229). Zhang and Wildemuth (2009) propose eight steps for content analysis. They are “prepare the data”, “define the unit of analysis”, “develop categories and a coding scheme”, “test your coding scheme on a sample of text”, “code all the text”, “asses your coding consistency”, “draw conclusions from the coded data”, and “report your methods and findings” (Zhang & Wildemuth, 2009, p. 310-312). Preparing the data simply means transforming it into a usable text or transcript, usually written (Zhang & Wildemuth, 2009, p. 310). In this case, the interviews were transcribed and open-ended responses from the surveys were downloaded. Defining the unit of analysis refers “to the basic unit of text to be classified during content analysis” (Zhang & Wildemuth, 2009, p. 310). This can be words, sentences, paragraphs, or even whole documents used to convey an idea. Developing categories and a coding scheme can be done inductively or deductively from the data, previous studies, or theory (Zhang & Wildemuth, 2009, p. 311). For this data I used structural, thematic, and theoretical coding, and I focused on both manifest (phrases) and latent

(implicit meanings) content in the documents. For the theoretical coding I drew upon Foucault's concepts of governmentality, biopedagogies, and the panopticon. The next step is testing your coding scheme, which allows you to check the clarity and consistency of the coding scheme (Zhang & Wildemuth, 2009, p. 311). This is done through axial coding in which the dominant elements are determined, redundant codes are removed, and the most representative codes remain (Boeije, 2010, p. 109). In finalizing my data analysis I identified major themes that were structurally similar to the survey, in addition to those that were unique. Within these themes I attempted to determine whether the experiences of the interview subjects, who also participated in the survey, largely supported the trends of the survey or contradicted it.

Results

In order to try and understand the experience and perspective of HCPs about trans* health care, the results of the survey and interviews are presented conjointly by theme. I first provide demographics of the participants with an explanation of the importance of geography and place for trans* health care. Then through the narratives of the interview participants we see how doctors start out or are first exposed to trans* patients. This is followed by a discussion of how HCPs define trans* from both the interview and survey. After that I look at the attitudes of HCPs towards trans* individuals, how comfortable they are about treating them, and how relevant HCPs feel various aspects of the trans* identity are to doing their job. Next I explore some of the experienced and perceived challenges that HCPs encounter in providing trans* health care; from working with other providers, to insurance, to names and pronouns, and to assigned sex. This is followed by an examination of the training HCPs receive and their familiarity of protocols and a look at the resources they use. Finally, I use one interview narrative, supported by others, to try to show the lived experiences and daily realities of this highly complex system.

Survey and Interview Demographics

Using purposive snowball sampling, 38 participants completed the survey. Three surveys were excluded from final analysis because they were mental health specialists, which left a total of 35 participants. Participants were asked to select all gender identities (28 females, 3 males, 1 male trans*/transgender, 1 trans*/transgender, 1 female genderqueer/genderfluid/gender-nonconforming, and 1 genderqueer/genderfluid/gender-nonconforming). Participants were also asked to select all race/ethnicities that applied. Survey participants were overwhelmingly white

(33 participants), with 1 Asian and white and 1 Hispanic/Latino participant also. Participants were born between 1950 and 1992, for an age range of approximately 23-65. The 16 states where they received their medical training are listed in Table 1:

Table 1: Survey Respondents' Reports of the States Where They Received Medical Training

State Trained In:	Number of Participants
Oregon	7 (20%)
Florida	6 (17.14%)
California	5 (14.29%)
Massachusetts, Indiana, New York, Washington	2 (5.71%) each
Colorado, Connecticut, Idaho, Illinois, Minnesota, Missouri, Pennsylvania, Utah, Wisconsin	1 (2.86%) each

Most participants received their training in Oregon, Florida, or California, although 16 states are represented. Table 2 lists the states where they currently practice:

Table 2: States Currently Practicing in

State Practicing In:	Number of Participants
Oregon	16 (45.71%)
Florida	10 (28.57%)
California	3 (8.57%)
Idaho	2 (5.71%)
Massachusetts	2 (5.71%)
New York	1 (2.86%)
Utah	1 (2.86%)

The vast majority of the survey respondents practice in either Oregon or Florida. As noted earlier, this occurred as a result of accessing specific health care facilities in both states and regional provider networks. The professions of the participants are listed in Table 3:

Table 3: Participants' Professions

Profession	Number of Participants
Nursing	17 (48.57%)
Other ¹⁵	13 (37.14%)
Primary Care/General Practitioner/Family Doctor	4 (11.43%)
Gynecologist, OB/GYN	1 (2.86%)

Nearly half of the participants were nurses, and if we include under the category of nursing nurse practitioners who self-identified as other, over half of the participants are engaged in some form of nursing. Part of the reason there may be so many nurse respondents is because nurses outnumber physicians (Pope, Snyder, & Mood, 1995). Also, several of the initial contacts were made with nurses, which may have allowed them greater access to other nursing professionals.

Table 4 shows the years of experience for the participants:

Table 4: Years of Experience

Years of Experience	Number of Participants (%)
1-5	8 (22.9)
6-10	9 (25.7)
11-15	4 (11.4)
16-20	4 (11.4)
21-25	1 (2.9)
26-30	1 (2.9)
31+	8 (22.9)

Almost half of the participants had less than ten years of experience, while approximately 23% had more than 30 years of experience, leading to a bimodal distribution. Of the 35 subjects who took part in the survey, 27 (77.1%) said they had experience working with trans* patients. Those

¹⁵ Other included: physical therapy, chiropractor, primary care/endo nurse practitioner, pediatric gastroenterology (3), occupational therapist, nurse practitioner, medical assistant/X-Ray tech, patient advocacy (2), advanced registered nurse practitioner, and pharmacy. While some of these are nurse practitioners, they self-identified as other, rather than with the nursing category.

with experience with trans* patients worked with the following approximate number of trans* patients:

Table 5: Approximate Number of Trans* Patients with Whom They Have Worked

Approximate Number of Trans* Patients	Number of Participants (%)
1-2	4 (14.8%)
3-4	6 (22.2%)
5-6	2 (7.4%)
7-8	2 (7.4%)
9-10	2 (7.4%)
11-15	1 (3.7%)
16-20	0 (0%)
21+	10 (37%)

It is significant that over a third of the participants reported working with over 20 trans* patients throughout their careers. Nevertheless, a third of the respondents also reported working with fewer than five trans* patients also, again leading to a bifurcated distribution. Of the 27 participants with trans* experience, nine¹⁶ completed an additional interview.

Interviews were completed electronically either by email or phone. Eight participants chose to complete the interview by email. Not including the two incomplete interviews, the fewest number of email exchanged was three (some participants asked for both sets of questions up front) and the greatest number of emails exchanged was 14. Most participants exchanged between four and six messages. For those who completed the interviews five identified as female, two as male, one as male*¹⁷, and one as a trans man. All identified primarily as white/Caucasian, with some including Italian American, Swedish, German, French-Canadian, British, Irish, European, and/or American Indian heritage. The range of the ages of the participants was 38 years, with a mean age of 42.9 years. There is a 34 year range in experience,

¹⁶ Two of the interviews are partially complete and ongoing.

¹⁷ One participant's dominant identity is male, although in some contexts and depending on the circumstances will identify with/claim other gender identities.

with a median of 15 years and a mean of 16.9 years. All but one of the participants worked in large urban settings, with this individual reporting that they worked in a small rural city. The proportion of nurses interviewed was similar to the proportion of nurses surveyed; however, while the other occupational categories are represented in the interviews, it was not in the same proportions as the number surveyed. Each interview participant is identified below by a gender neutral pseudonym¹⁸. Participants were assigned gender neutral pseudonyms because gender is often assumed or inferred based on names. For trans* patients, being referred to by their chosen name and appropriate pronouns can be a huge challenge. Choosing gender neutral names decenters gender. The interview participants, their pseudonyms and demographics are listed in Table 6.

A Note on Geography

Where one lives impacts what services one has access to. Eight out of the nine people interviewed all worked in a large urban environment. Emory has patients “who drive 5-6 hours to come to see me because they are unable to find anyone in the towns they live in who will provide care.” Emory made the observation, “Some areas (generally urban/academic) are much more aware and open to needs of trans people.” Jaylin agreed:

Trans healthcare is improving nationwide but it is still generally something that is easier, better, and advancing only in large metropolitan areas. In my clinic, we actually have an incredibly easy time serving this population as opposed to a more rural clinic or community. I think telemedicine and other digital solutions that allow doctors to quickly discuss best practices, specific cases, and treatment plans will really help to make trans

¹⁸ Gender neutral pseudonyms were picked from a list of names retrieved from <http://www.randalolson.com/2014/12/06/top-25-most-gender-neutral-names-in-the-u-s/>

care possible everywhere. Additionally, there is a huge amount of work still needed to break social and political stigma against the trans community so that more people will be willing to seek out information about providing for trans people.

HCPs who work in urban environments may have greater access to information and trainings about trans* health care and issues, networking opportunities with other “trans* friendly” providers, and a variety of treatment options that might not otherwise be readily available elsewhere. Also, as telemedicine and technology improves, these will help HCPs provide a greater range of services to harder to reach populations.

Table 6: Interview Participants Demographics

Pseudonym	Demographics
Riley	A white 65 year old female RN with 45 years of experience of experience working in a small rural city.
Hayden	A white 46 year old Italian-American male with 18 years of experience working as a pediatric/adolescent young adult doctor who works in a large urban setting.
Casey	A white 66 year old male gynecologist with 35 years of experience working in a large urban city.
Peyton	A white 28 year old female with 5 years of experience working as an occupational therapist who works in a large urban setting.
Shay	A white 34 year old female with 15 years of total experience currently working in operative care nursing in a large urban city.
Devyn	A white/Italian, French-Canadian, American Indian 41 year old female with 17 years of experience who currently works as a surgical nurse in a large urban environment.
Emory	A 44 year old white trans man with about 6 years of experience currently working as primary care in a large urban city.
Jaylin	A 28 year old white male with only one year of experience in health care as a patient advocate, but over ten years working with the trans* community, in a large urban area.
Kerry	A 34 year old white female with 10 years of experience working as a nurse practitioner in a large urban environment.

Starting Out, and What Does Trans* Mean?

HCPs come into contact with trans* individuals in a myriad of ways. While trans* patients may have unique health care needs and desires related to transition, such as hormone

replacement therapy and gender reassignment surgery, they also have other health care needs and can enter the health care system through a variety of means. This was the experience of most of the interview participants, whose first experiences with trans* patients were often brief and not related to transition. For instance, Riley is a white 65 year old female RN with 45 years of experience working in a small rural city, but not a significant amount of experience working with trans* patients: “I have limited experience in caring for these types of patients and I can say I have only dealt with maybe 10-12 in my career.” When she did work with trans* patients, she considered her experience to be incidental, simply a part of the routine performance of the job.

On the other end of the spectrum, Hayden is a white 46 year old Italian-American male with 18 years of experience working as a pediatric/adolescent young adult doctor who works in a large urban setting. Part of Hayden’s adolescent medicine fellowship was:

Caring for homeless youth and a significant percentage of these homeless youth were transgender. As part of their care was to work with them finding their needs to help with them coming to terms of transgenderism and helping take positive steps towards transitioning.

Hayden’s fellowship with an already vulnerable population, homeless adolescents, led to working with an even more vulnerable population, homeless trans* youth. This involvement with trans* individuals has been an important part of his medical career.

First exposure was also relatively innocuous, from the perspective of the HCPs. Casey is white 66 year old male gynecologist with 35 years of experience working in a large urban city. Casey had a moment early on as a resident in which he first encountered a trans* patient. Casey recounted:

Well one of the first times I was ever really aware of what was happening was when I was a resident in the early 80s. I was in a weight loss clinic and had this patient that was there and he had a beard as thick as my thick beard and masculine and took his shirt off and had two big scars on his chest. And I said ‘what was that?’ and he said ‘I had my breasts removed. I was a female.’ And I thought ‘well ok’, it didn’t bother me.

Casey made it to his residency having no prior exposure to trans* patients or transition, and only then gained that experience through direct contact with a trans* patient. This was just the first of several trans* patients Casey worked with throughout his career. At one point he was a director of women’s health and assistant medical director of a student health center and also working as faculty at a medical school. At the time they had “a whole team for transgendering and I was the gyn person for that.” Casey adds:

I’ve been doing this for 35 years and I’ve seen this my entire career. It’s not anything really new. The... getting people to pay more attention to it, being... sympathetic, empathic for the people that are... transgender is... what’s new. It’s always been there.

It’s been there since the beginning of time. This is nothing new.

For Casey, trans* patients may not be new, but how the health care system is treating them is. Part of this, as Casey believes, is coming from an increased attention and awareness of the needs of trans* patients.

Defining Trans*. When talking about trans* health care, one of the questions that needs to be asked is how trans* is being defined. The ICD-10 diagnosis F64 of transsexualism is, the “desire to live and be accepted as a member of the opposite sex” (ICD-10, 2015). This desire is often accompanied by a discomfort with one’s body and the hope to “make one’s body as congruent as possible with one’s preferred sex” (ICD-10, 2015). The DSM-IV-TR diagnosis of

gender identity disorder emphasis “cross-gender identification,” meaning the desire to be the other sex and a discomfort with one’s assigned sex or gender role (APA, 2000). The DSM-5 diagnosis of gender dysphoria is, “A marked incongruence between one’s experienced/expressed gender and assigned gender” (APA, 2013). These clinical diagnoses and definitions bear many similarities to the definitions provided by the HCPs in this study, which suggest that these medicalized notions of what it means to be trans* are informing or influencing the discourse about what it means to be trans* among these HCPs. However, given the limitations and critiques of these diagnoses, we need to understand the implications of this dominant binary, biomedical discourse and how it impacts how trans* patients are being perceived, treated, and the relationship they have with HCPs.

Among the HCPs responses ranged simply from not knowing at all (1) to one simply stating “human” to another answering “it is an umbrella term” or that the definition should be based upon the individual(s) who chose to claim that identity (3) to the vast majority who place an emphasis on biological sex and genetics (29). The most common themes among the responses were references to binary male/female, birth assignment, physical sex or genetics, and an incongruence/opposite/transition/difference. Some examples of this include: “A person who identifies with the opposite gender of biological anatomy,” “People who feel their physical gender does not align with their identified gender,” “Someone who does not identify with the gender assigned them at birth, by doctors or by chromosomes,” “someone who does not define their gender per genetics,” and “people who self identify as belonging to a sex other than what they were born with, what their primary genitalia, sex organs are, or are/will have a sex change.” All of these responses rely on a medicalized understanding of the body and biology as sexed and gendered.

HCPs work in a highly regulated and regimented environment. In this environment, the medical model is the dominant framework through which any issue or body is made sense. The notion of a medical model comes from Foucault's (1979) *Discipline and Punish* in which it is the schemata "of cure and normalization" (p. 248). The objective of this medical model is to produce "passive individuals or 'docile bodies' who are expected to adjust to their impairments and comply with the prescribed regimen of rehabilitative treatment administered by medical professionals who occupy a privileged position of authority vis-à-vis patients or clients" (Berger, 2013, p. 26). This may help to explain why HCPs overwhelmingly understand transgender in terms of a rejection of sex assigned at birth, genetics, biological sex, and physical characteristics. Having a definition of trans* that relies on the medical model understanding of sex and gender as biological reinforces existing dimorphic and binary understandings of sex and reproduces existing doctor-patient power structures, as the doctor has the power to judge "normal" and by extension "abnormal" expressions of sex and gender.

Medical understanding holds that certain characteristics denote male and others denote female, and those are the default starting points. Dean Spade, founder of Sylvia Rivera Law Project and transgender activist, wrote a piece entitled "About Purportedly Gendered Body Parts" in which he argues for a more gender neutral language to talk about bodies. He proposes, "Rather than saying things like 'male body parts,' 'female bodies' or 'male bodies' we can say the thing we are probably trying to say more directly, such as 'bodies with penises,' 'bodies with uteruses,' 'people with ovaries' and skip the assumption that those body parts correlate with a gender" (Spade, 2011.). Shifts in language like this are more inclusive of trans* individuals.

Attitudes, Comfort, and Relevance

The attitudes of HCPs about trans* individuals were measured by asking participants to answer questions on a five point scale from strongly disagree (1) to strongly agree (5). The statements included: “Trans* individuals should be accepted completely into our society,” “I would feel comfortable working closely with a trans* individual,” “I would feel comfortable if I learned that my best friend was a trans* individual,” and “There should be restrictions on being trans*” revealed mostly positive attitudes with 65.7%, 54.3%, 57.1%, and 17.1% (question was reverse-coded) strongly agreeing and means of 4.49, 4.31, 4.31, and 1.49 (question was reverse-coded) respectively. For these statements, there was a relatively high level of acceptance demonstrated.

There were two statements, however, in which a different pattern emerged. While the mean of “Being trans* is a sin” was 1.29, with 80% percent reporting they strongly disagree with that statement, three participants (8.6%) selected “neutral” as to whether or not being trans* was a sin. This response is intriguing, because it implies that social desirability bias may have played a role in some of the responses on the survey. It is possible that developing an implicit bias measure might control for social desirability in ways that this self-report measure does not. The statement, “Romantic partners of trans* individuals should seek psychological treatment,” was the only one with a mean towards the middle (2.46) and was the only question with a mode of 3. This suggests some possible ambivalence or confusion towards the question, as some may be interpreting therapy as a positive (getting support for a stigmatized relationship) and others may view this as a negative (having an “inappropriate” or stigmatized relationship). Generally, however, this sub-scale shows support and acceptance of trans* individuals by the respondents.

In an interview, Riley stated:

I am convinced that caring for trans patients is a mind set on the part of the health care provider and an open mind and education goes a really long way to making a trans patient's healthcare experience a positive one.

Because Riley believes the attitudes of the providers can affect trans* patient experiences, she goes on to say, "I think the real answer here is education and assistance in breaking down the barriers in healthcare providers' mind sets regarding trans patients." The implication of Riley's remarks are that, to her, negative attitudes of HCPs can be a barrier to care, but education may help eliminate that barrier. Ultimately, Riley thinks, "People just need to get beyond the stigma and their own preconceived ideas of what these patients are like."

Some of the other nursing participants also mentioned the attitudes and treatment of trans* patients. Shay, a white 34 year old female with 15 years of total experience currently working in operative care nursing in a large urban city, stated, "The protocols, guidelines, and standards I use when treating trans* patients is the same as I use for all patients. I believe that all people should be treated with kindness and respect." Like Shay, Devyn, a white/Italian, French-Canadian, American Indian 41 year old female with 17 years of experience who currently works as a surgical nurse in a large urban environment, said, "I treat every patient the same. They get the best I have to give, and the highest level of respect while they entrust themselves to my care." Such rhetoric was echoed by other respondents who are not nurses. Casey observed, "The physicians, the training, the knowledge, is changing to be more accepting. And I've felt that if you go to med school to take care of people you should be like that from day one anyway." While Casey is suggesting that there has been a shift within medicine and health care to be more accepting of trans* patients, he relies upon the same understanding of how acceptance is achieved—through educational practices.

In addition to understanding HCPs attitudes towards trans* patients, it is important to also understand their interest and comfort in working with them. On the survey, thirty of the participants (85.7%) said they had at least some interest in working with trans* patients in relation to general health care needs (not specific to transition), while 20 participants (57.1%) indicated at least some interest in working with trans* patients in relation to transition health care. Only 3 (8.6%) participants indicated any discomfort in working with trans* patients in general, while 12 (34.2%) indicated little comfort or no comfort in working with trans* patients related to transition. It is possible that those responses came from specialties, locals, and domains not generally involved in transition related care. In one of the interviews, Riley found:

I unlike others in the clinic had no issues working with these patients and just treated them as I would any other patient. Most of the other staff had an issue even interviewing the trans patient and would hand them off as I had no problem. I worked for a urology group and they did not perform the surgeries that are often times associated with these patients. They were not difficult to deal with at all, in fact they were most often delightful individuals.

Riley's experience here is telling; when HCPs are comfortable working with trans* patients, other HCPs may defer to them for such care, avoiding their own interactions. This can also be seen in the special care team that Casey was on mentioned earlier, a group of dedicated HCPs who were specially appointed to be in charge of all trans* health care. It is also evidenced in the fact that Emory had patients traveling several hours for their care, because there was nobody closer who was willing to treat them. Thus, support for trans* patients may be shallow within facilities, and limited to some—but not all—of the HCPs who work there.

Related to the interest and comfort of HCPs is how relevant a patient's trans* identity and transition status is to their job. Respondents differentiated between these two issues in terms of their applicability. Twenty-nine participants (82.8%) indicated that knowing a trans* patient's identity was at least somewhat relevant to their job. However, only 27 (77.1%) said that knowing a trans* patient's transition status was at least somewhat relevant to their job.

In several interviews a patient's medical history, transition status, and biology also came up. For Shay:

Adequate history of treatments, procedures, and medications is the most helpful in working with trans* patients, the same as it is with all patients. An accurate medical history of trans* and non-trans* patients guides us in making decisions about course of treatment, positioning guidelines, and other things needed to keep patients safe. For example, a male transitioning to a female probably still needs prostate exams. A female transitioning to a male may still need pap-smears or other gynecological work-up.

Accurate and complete medical history can help in deciding the best plan of care.

If a HCP does not have a complete and accurate picture of what is going on in a patient's body, it much more difficult for them to know how to treat them and to do so safely. Casey seemed to agree stating that:

We don't change screenings and anything dependent on gender, you know. There is all still the same recommendations. Ok? If, if, if you started as female, you know, we need to worry about breasts, you know, even when you have mastectomies there is still some breast tissue around. Uh, if you still have female, uh, genital urinary parts, you know, we screen it, test, and treat and look for all the same things. Same thing with men. You know, if they still have a prostate, you know, you screen for prostate cancer when they

get older. You don't change. You don't change the STD screenings or any of that stuff.

All still applies.

In other words, one's biological assignment at birth and the steps one has or has not taken medically to transition matter. Additionally, Casey added, "if you are initially female and you are transgendering to male as long as you have uterus, cervix, vagina, and vulva, you still have to have all the same things that someone that has not gone through the transgender." How relevant the information is may vary by profession and situation, however, it is a part of a trans* patient's medical history that HCPs feel is important to know.

The HCPs, as they speak about these issues, appear to be having difficulty with language and using the correct terminology, differentiating between body and identity, and distinguishing between sex and gender. Whether HCPs distinguish between sex and gender, or find such a distinction necessary or helpful, may help to explain some of the inconsistencies. Also, as argued earlier, medical understanding has male and female defaults, which may help account for why they revert to those explanations when discussing the need for certain screenings. However, the language and terminology that HCPs use is not without consequence and should be a part of cultural competency trainings on trans* health care. While a provider may have the medical knowledge and competency to treat a trans* patient, having the social and cultural knowledge will allow them to provide the best possible care and experience to their patient. While practitioners are not advocates, part of cultural competency includes being familiar with and knowing how to speak to trans* patients. For example, "to transgender" is not a verb. Also, "transgenderism" is not common parlance among the trans* community. Using phrases like "a male transitioning to female" or "a female transitioning to male" misidentifies the individual by assuming that they were once male or female. While this last item may be more controversial,

herein lies some of the tension between the medical model/biology and gender identity, and who has the power to determine one's label.

Challenges

The 27 participants who had experience working with trans* patients were asked about how much of a challenge different aspects of providing care presented. The eight participants who did not have experience working with trans* patients were asked how much of a challenge they thought it would be. Responses were ranked on a four point scale from not at all (1) to a great deal (4). Table 7 shows those everyone who experienced or expected some degree of challenge or difficulty to the statements about challenges:

Table 7: Response to Challenges

How challenging has been/do you imagine the following would be?	Number of respondents with experience (%) reporting experiencing challenges	Number of respondents without experience (%) presuming challenges
Establishing trust or rapport with trans* patients	17 (63.0)	6 (75.0)
Referring trans* patients to other providers	14 (51.9)	5 (62.5)
Networking with other providers	16 (59.3)	4 (50.0)
Finding support from other providers	18 (66.7)	5 (62.5)
Knowing how to ask about and using the right name and pronouns	16 (59.3)	7 (87.5)
Discussing health care issues related to trans* patients assigned sex	14 (51.9)	7 (87.5)
Getting insurance coverage (general health care needs)	18 (66.7)	5 (62.5)
Getting insurance coverage (transition health care)	15 (55.6)	8 (100)

Working With Other Providers. There was a small difference between the groups when it came to other providers. Participants without experience working with trans* patients seem to feel that “networking with other providers” and “finding support from other providers” would be

less challenging than those who had experience, but “referring my trans* patients to other providers” would be more challenging. The discrepancy between experience and expectation for referring patients is small. This was supported by an interview, in which Hayden’s stated that one aspect that made providing trans* health care more challenging was, “Working with the medical community to provide respectful and value based health care when working with external medical partners. Such as when I have to refer to subspecialist or the ER.” What factors are at play that may account for this difficulty, however, require further investigation.

Names and Pronouns. When asked about “knowing how to ask about and using the right name and pronouns for my trans* patients,” this appeared to be perceived as a significant challenge for both groups. For participants with trans* 16 (59.3%) participants said that they would have at least a little challenge in learning to use the right name and pronouns for their patients. Seven (87.5%) of the participants without trans* experience also indicated they thought that there would be at least a little challenge in being able to ask about and use the correct name and pronouns for a trans* patient. With over half of HCPs with trans* experience and well over half without trans* experience reporting that names and pronouns usage is a challenge, figuring out why this poses such a barrier and creating strategies and interventions for HCPs could help reduce or eliminate this obstacle.

Assigned Sex. The issue of “discussing healthcare issues related to my trans* patients’ assigned sex” also appeared to pose a challenge or anticipated challenge for HCPs. Fourteen (51.9%) of HCPs with experience with trans* patients said they had some issue in discussing health care issues related to the trans* patient’s assigned sex. For participants without trans* experience, seven (87.5%) thought it would be challenging. Since trans* patients may still require screenings and preventative care that is related to their assigned birth sex, this could have

a number of negative ramifications, including trans* patients not getting the screenings and preventative care that they need.

Insurance. Insurance coverage is another aspect of care that HCPs were asked about, both in terms of general health care needs and specific to transition health care. Jaylin, a 28 year old white male with only one year of experience in health care as a patient advocate, but over ten years working with the trans* community in a large urban area, claims:

Insurance is one of the biggest challenges in providing care to trans patients. Every year many insurance plans take significant steps towards improving coverage for trans care, and this year the federal government helped by banning blanket exclusions for trans medical care. Even so, trans patients can reasonably expect to need to fight with their insurance on a regular basis. Even plans that have pretty good coverage for trans care can be problematic, largely because there is not a system-wide understanding of the plan or even of what transgender means. It's common for patients to call their insurer with a reasonable question regarding what is covered for gender affirmation care, and to be met with hostility, blank looks, and total lack of education. Often patients are told there is no coverage simply because the insurance representative doesn't know about what their plan actually offers. Additionally, there are plenty of plans that only have the bare minimum required to not be in violation of the federal mandate, and many plans have specific exclusions for trans care, since the federal mandate only bans blanket exclusions, not particular exclusions for specific procedures and medications.

On the survey, HCPs with experience with trans* patients were slightly more likely to think “getting insurance coverage of general healthcare needs” was challenging than those without experience. In regards to for “getting insurance coverage for transition healthcare” there seemed

to be less agreement. For participants with trans* experience, the mean was 2.56 with bifurcated modes of 1 and 4, with ten participants answering “not at all” and another ten answering “a great deal.” This split is particularly striking, and the factors behind it require further investigation. All of the participants without trans* experience indicated a belief that there would be at least a little trouble getting coverage for transition related care.

In several of the other interviews, insurance was also brought up. Hayden stated the biggest challenge is “insurance and that these patients can’t afford to receive the care that they need.” Hayden did add, “I have been more succedssful [*sic*] in having patients use their health insurance to get the blood work and medications necessary. Even 5 years ago this was impossible.” Kerry, a 34 year old white female with 10 years of experience working as a nurse practitioner in a large urban environment, explained, “One of our providers and our program director spend many hours writing letters, making requests, making phone calls, making appeals, etc.” suggesting that getting approval for coverage can be a very time consuming and lengthy process for HCPs. Devyn found, “In my particular field, I find that there isn't great insurance coverage (from what some patients have said).” One survey respondent remarked, “Medicare coding for transgender individuals has been very challenging.” The difference between private plans, Medicare, and other forms of coverage also add to the complexity. Casey said:

I haven’t really been involved with billing for services for hormones replacement. With that uh we were just starting it at Z when I left and I don’t know if there is any issues with the insurance companies approving them paying for that. So that is probably an issue, just my gut feeling because the insurance companies who are the evil empire, you know, they want your money but they don’t want to pay it back. Their job is not to

provide health care, their job is to collect premiums and deny health care. And you can quote me.

There is a perceived adversarial relationship, not only between patients and their insurance companies, but HCPs and insurance companies as well. Emory, a 44 year old white trans man with about 6 years of experience currently working as primary care in a large urban city, stated, “Most of what I do in general is not covered by insurance. People come to see me who are willing and able to invest in their health outside the insurance model.” Since so much is not covered by insurance and dealing with insurance can be so complicated and time consuming, some providers opt not to accept insurance at all. Insurance and being able to afford to access health care is one piece of the trans* health care puzzle.

Training and Protocols

When asked about their familiarity with protocols/treatment guidelines/recommendations specific to their profession, 65.7% of respondents had little or no familiarity with the recommendations about how to treat trans* patients for their profession. Furthermore, 29 (82.9%) had received no formal training related to working with trans* patients before starting working in health care. Twenty-eight (80%) did not receive any type of informal training or education about working with trans* patients before starting to work in health care, either. After beginning their careers in health care 22 (62.9%) still have not received formal training or education about working with trans* patients. As one survey respondent stated:

I worked briefly in a clinic that provided hormone therapy for individuals wishing to make the “change” I felt very un-educated when it came to the special handling, protocols or needs of trans patients during this time. The only special protocol I followed [sic] was a common courtesy and strict HIPPA standards protocol.

Even this individual who was working directly with trans* patients and providing transition related care did not feel adequately trained to work with the patients at this site. In response, 15 (42.9%) survey respondents reported seeking out other forms of informal education or training in regards to working with trans* patients after starting to work in their health care profession. Yet this is often seen as the responsibility of the individual HCP, rather than the site or the profession. In one interview, Riley suggested that having, “CEU¹⁹ education for nurses who may work with trans patients in their practice” would be helpful for working with trans* patients.

Participants who had received training, either formal or informal and before or after starting to work in health care, were asked where they had received that training and how helpful they had found the training to be. Six participants said that they had at least some formal training and seven participants reported at least some informal training prior to starting working. Their responses about where they received that training and how helpful they found it are in Table 8:

Table 8: Training Prior to Starting Working

Formal Training Prior to Starting Working ²⁰		
	Number of Participants who reported receiving training N=6	Percentage who found the training at least somewhat helpful
Medical Professionals: within your specialization or profession	6	100%
Medical Professionals: not in your specialization or profession	6	50%
Medical Associations	4	75%

¹⁹ CEU is an acronym for continuing education units. These are a common requirement for nursing and other HCPs.

²⁰ There were some reports of other trainings for formal and informal trainings both before and after starting working, but participants did not specify who gave them or where they were received and so it was excluded from final analysis.

Table 8 (Continued)

	Number of Participants who reported receiving training N=6	Percentage who found the training at least somewhat helpful
Non-Medical Academic Scholars	4	50%
Advocacy Groups	5	100%
Trans* Individuals	6	100%
Informal Training Prior to Starting Working		
	Number of Participants who reported receiving training N=7	Percentage who found the training at least somewhat helpful
Medical Professionals: within your specialization or profession	5	60%
Medical Professionals: not in your specialization or profession	5	60%
Medical Associations	4	25%
Non-Medical Academic Scholars	6	50%
Advocacy Groups	6	66.7%
Trans* Individuals	7	85.7%

Thirteen participants said that they had at least some formal training and 22 participants said that they had sought out at least some informal training after starting working. Table 9 lists their responses about where they received that training and how helpful they found it to be:

Table 9: Training After Starting Working

Formal Training After Starting to Work		
	Number of Participants who reported receiving training N=13	Percentage who found at least somewhat helpful
Medical Professionals: within your specialization or profession	12	91.7%
Medical Professionals: not in your specialization or profession	9	88.9%
Medical Associations	7	71.4%
Non-Medical Academic Scholars	7	71.4%
Advocacy Groups	8	87.5%
Trans* Individuals	10	100%
Informal Training After Starting to Work		
	Number of Participants who reported receiving training N=22	Percentage who found at least somewhat helpful
Medical Professionals: within your specialization or profession	19	100%
Medical Professionals: not in your specialization or profession	16	93.8%
Medical Associations	10	40.0%
Non-Medical Academic Scholars	13	69.2%
Advocacy Groups	11	81.8%
Trans* Individuals	19	94.7%

Regardless of when training takes places, trans* individuals and medical professionals within their own specialization or profession are the two groups that consistently were rated as being very helpful sources of training. Kerry echoed this in answering the question “What have been the most helpful ways you’ve learned about trans* healthcare?” by saying, “From the patients

themselves and amongst other professionals.” Similarly, Peyton, a white 28 year old female with 5 years of experience working as an occupational therapist who works in a large urban setting, remarked:

The best education I have received about this topic is right from the patient’s themselves.

I am fortunate that I had patients who were open enough to discuss some of the particulars with me, and working with them on a daily basis helps build that rapport and trust that they are able to work with me and help teach me along the way.

Being in a situation that allowed Peyton to build a relationship with the patients and learn about how they wanted to be treated was very instructive. Peyton added, “I think hearing about people’s experience in healthcare related situations right from the trans community is helpful so I know exactly what approach to use.” These participants found their interactions with trans* patients to be learning experiences, but the extent to which such interactions are interpreted as such by other HCPs is not clear, nor is the extent to which trans* patients are comfortable educating their HCPs during the course of their treatment.

All of this training and education has been geared toward medical knowledge. Devyn remarked, “It would be nice to have some education on the population of trans patients, some of the challenges they face, and other issues outside the surgical scope of care. It would be nice to get a broader picture.” Along with the clinical understanding, having social and cultural knowledge about trans* patients is something that at least some providers want, and may help them to provide more culturally competent care.

Protocols. The diagnoses and protocols most discussed for trans* patients in the United States are from the DSM-5 (recently updated from the DSM-IV-TR), ICD-10 (in transition from ICD-9), and WPATH. However, HCPs were not very familiar with these protocols, overall.

Table 10 shows the percentage of respondents who reported being “not at all familiar” with each protocol:

Table 10: Familiarity with Protocols and Diagnoses

	Percent who report “Not at all familiar”
WPATH	62.9
ICD-9	71.4
ICD-10	68.6
DSM-IV-TR	60
DSM-5	65.7

Across the board, nurses were less likely than other HCPs to be familiar with the protocols and diagnoses.

Those who had indicated at least some familiarity with these diagnoses and protocols were asked how much training they had received about it, how helpful the training was, how helpful the diagnosis/protocol is, and how applicable they find it to their patients. The percent who reported “somewhat” or “very” is reported in Table 11:

Table 11: Protocol and Diagnosis Training and Helpfulness

	WPATH	ICD-9	ICD-10	DSM-IV-TR	DSM-5
Participants (%) who reported receiving training on the diagnoses and protocols	61.5%	30.0%	54.5%	50.0%	33.3%
Of those who received training, percent who reported the <u>training</u> to be “somewhat” or “very” helpful	87.5	66.7	83.3	57.1	75.0
Of those who received training, percent who found the <u>protocols</u> to be “somewhat” or “very” helpful	100	66.7	83.3	57.1	100

Table 11 (Continued)

	WPATH	ICD-9	ICD-10	DSM-IV-TR	DSM-5
Of those who received training, percent who found the <u>protocols</u> to be “somewhat” or “very” applicable for trans* patients	100	66.7	83.3	42.9	75.0
Of those who reported familiarity, percent who found the <u>protocols</u> to be “somewhat” or “very” helpful	92.3	30.0	54.5	57.1	58.3
Of those who reported familiarity, percent who found the <u>protocols</u> to be “somewhat” or “very” applicable for trans* patients	92.3	30.0	54.5	42.9	41.7

This suggests that even those who are familiar with the diagnoses and protocols have not received very much training about them. There are also differences among the protocols and diagnoses. While WPATH seems to be generally accepted as applicable to trans* patients, the newer ICD diagnosis is considered to be vast improvement over the previous version, but the newer DSM diagnosis is only considered to be more helpful and applicable by those who had been trained about it, suggesting a shift in the biopedagogies, practices, and approaches to trans* health care.

While HCPs don’t seem to be very familiar with or trained about WPATH, ICD-9, ICD-10, DSM-IV-TR, or DSM-5, they do have other sources to which they refer. Such sources included: Recommendations from the American College of OBGYNs, Up To Date, other proficient practitioners, clinical experience, Kaiser Permanente’s “A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual, and Transgendered Population, 2nd edition,” other professional health care journals (unspecified), bio-identical hormone prescribing

A4M²¹, NHS England Gender Dysphoria Protocol, Vancouver Coastal, and UCSF. One survey respondent stated, “Professional Health care journals have had more information and guidelines for assessment and help for Trans, Gay, Lesbian patients in general in the last few years.”

Hayden said, “I use the Endocrinology guidelines as they incorporate WHO standards as well as stanrdards [*sic*] for preventive health care. They work well in organizing the care for the patients as well as the providers. It really has been useful incorporating transitioning into age appropriate preventative care.” This suggests that there is a wide variety of resources that providers consult when treating trans* patients.

Along with these other sources that they do use, there are other resources that they would find helpful. Peyton stated, “Journal articles, lectures or conferences during state or national organization conferences (i.e. American Journal of Occupational Therapy, the annual American Occupational Therapy Association conference, the Pennsylvania Occupational Therapy Association Conference) or even just webinars for continued education.” Having information that is relevant to their specific profession and specialty, is accessible, and is ongoing, seem to be of most importance.

Individual Patients: Gratitude, Mistrust, and “No Hope”

There is no singular path to transition, and even what it means to be trans* is not always the same to each patient. For Emory, “I approach each patient individually. Not all trans patients have the same goals or other indicators of health so it is not possible to group them based solely on gender identity in terms of how I approach the healthcare I provide.” An individual’s treatment needs to be tailored to that individual to ensure that they are receiving the best possible care that they can. Additionally, Jaylin is noticing a shift in how individuals are choosing to

²¹ The American Academy of Anti-Aging Medicine

identify and how medical care can be affirming. I include here a large segment of Jaylin's interview, to ground my analysis in Jaylin's understanding of the interplay between changing culture, identities constructs, and the work of HCPs. According to Jaylin:

I'm seeing is younger folks identifying in a much less binary way. Many of the young people that I speak to identify as gender queer, non-binary, or are unwilling to box themselves in by a gender identity at all. Medical considerations for this population are extremely important, especially since the research up to this point has only been in support of full medical transition from one binary gender to the opposite binary gender. There are excellent strategies for providing gender affirming medical care to gender non-conforming patients, and making sure that these best practices are written up right alongside best practices for binary identifying transgender people is vital.

By integrating strategies that respect and affirm the different ways in which people choose to identify and express that identity, HCPs can ensure they are providing their trans* patients with appropriate care.

As a patient advocate, Jaylin works with patients in a variety of ways, and as such is witness to a wide range of reactions. Jaylin works with patients who have scheduled clinical primary care or behavior health appointments or who participate in the weekly walk-in clinic. Anybody can utilize their services, so Jaylin sometimes sees patients from other states and sometimes even internationally. This again speaks to the issue of geography and access, as patients from other states and countries are availing themselves of the clinic's services. Despite the potential cultural differences between such geographically diverse patients, in general Jaylin finds that there are three main types of patients/reactions. Jaylin explains:

My general experience of working with trans patients is that they are a) incredibly grateful and somewhat hesitant to believe they can actually get care once they get to our clinic; b) they are mistrustful of health care for multiple reasons including past negative experiences/harassment, lack of education of providers, and the need to advocate for their own care in almost all clinical settings; c) they are seeking excellent care for a health and wellness concern that is not very different than someone seeking to manage any other part of their primary care, but trans people are treated as though they are asking for outrageous accommodation and services, and so are often jaded and further traumatized by a medical system that is actually quite able to meet their needs, if it made trans education a priority.

Jaylin was not the only one to comment about patient's mistrust. Kerry also stated, "Often they [trans* patients] are fearful as they have been so mistreated by most public services." These archetypes of trans* patients' reactions, although not mutually exclusive, demonstrate the impact the health care system and HCPs can have. Trans* patients can become jaded or mistrustful of HCPs or very grateful based on their previous interactions with the health care system.

Not only do trans* patients have reactions to trans* health care, when asked if anything stood out about trans* health care, Jaylin responded:

I'm always moved and saddened when a patient comes in and is shocked, moved, and amazed that they will be able to pursue their transition. Many people believe that there is "no hope" for them, and that gender affirmation is not possible. Sometimes this is due to lack of education, but just as often the feeling comes from a place of self-loathing or repeated denial at the hands of doctors. To be able to help someone learn about their option and get connected to services is very rewarding.

HCPs have a unique, but extremely limited vantage point from which they view the patients' experiences. Jaylin is moved and saddened by patients' experiences, as well as derives pleasure from being able to set them up with services. There is a relationship, however brief and fleeting, between patients and HCPs. However, those relationships often get judged by the very short 15-20 minute appointments in which patients and HCPs get to interact, which may miss the bigger picture and context in which these interactions are taking place. In the context of a doctor's appointment, a HCP may be talking about optimal blood work ranges, thinking about insurance, running through protocols, and reflecting on similar patients. The patient may be thinking about how the HCP used the wrong pronoun, or how the name in their chart is still not updated, or what identity marker their insurance is under, their hopes and apprehensions for medical transitioning, and how much this is all going to cost. It is through all of this that trans* health care gets filtered.

Conclusion

Trans* health care is a multifaceted topic, as it encompasses both general care and transition related care. Trans* patients and HCPs face barriers and obstacles to getting and providing health care. Through understanding the experiences of HCPs, we may be better able to understand trans* health care and find ways to overcome some of the obstacles and barriers HCPs encounter. HCPs come into contact with trans* patients in a variety of ways, often simply as a function of their routine duties and job. For the most part the HCPs surveyed held positive attitudes towards trans* individuals, although there was some ambivalence as to whether partners of trans* individuals should seek psychological treatment. This may have been more an interpretation of being in a stigmatized relationship than a disgust reaction towards the relationship. Attitudes towards and comfort and interest in treating, however, can be separate issues. Of the 35 participants, most were both interested and comfortable working with trans* patients, although more so in relation to general health care than transition related care. This is likely because of the profession or setting in which the participants practiced, and the limited exposure that many had to transition related care. My respondents also thought trans* health care posed some challenges for them, most notably knowing how to ask about and using the right name and pronouns for trans* patients, discussing healthcare issues related to trans* patients' assigned sex, and managing insurance. They also reported very little training or education, formal or informal, about trans* health care. However, consistently the best education they received was from trans* individuals themselves and medical professionals within their own specialization or profession.

While the medical model is the dominant framework through which HCPs make sense of trans* health care, there is not a singular dominant discourse. This is evidenced through the lack of familiarity of protocols, standardized training and education, and the numerous sources used (including several international sources). While none of the diagnoses or protocols was familiar to a majority of the respondents, the DSM-IV-TR appeared to be most recognizable to 40%, and over 60% of the respondents reported receiving some training on WPATH. Interesting, the ICD-9 which is now outdated but was essential to the appropriate coding for health care and insurance, had both the fewest number of reported trainings (30%) and the most respondents (at 71.4%) who were not at all familiar with it. While there is a very low familiarity with these protocols and diagnoses, many providers had other resources that they relied on. This relates back to Foucault's notion of biopedagogies, as these protocols and diagnoses are meant to dictate trans* health. How these biopedagogies get understood and interpreted relates to the medicalization of trans* identities: how trans* gets defined, how it is approached, and how trans* gets managed through a medicalized lens, often of mental illness, hormones, and surgery. While additional trainings may come in handy, as very few providers sought out additional trainings about trans* health care, these trainings would need to balance keeping up with advances in medicine with the ever evolving and changing social realities of the trans* community, which may not be reflected in the medicalized lens.

There has been increasing awareness of trans* issues across multiple domains socially, culturally, and legally, and in particular in health care. Among other things, this increased awareness has stemmed from and led to the diagnostic changes in the DSM-IV-TR to DSM-5, to the changes in insurance law, and to debates about what age children should be allowed to decide and pursue social and medical transition. This study is significant as it helps to highlight the need

for further research across several domains within healthcare, especially in regards to education and training, challenges, and attitudes. Specifically, future research should look at the general attitudes of HCPs of different professions towards trans* patients, the education and training being received about trans* patients and how effective it is, ways of helping providers know how to ask and use the right name and pronouns for trans* patients, and discussing healthcare issues related to trans* patients' assigned sex. By using a mixed methods approach, this study was able to provide convergent and corroborative narratives of the survey data. This study is also contributing to a very small, but growing, body of literature about trans* health care.

The need for more information and research is enormous. As one survey respondent put it:

The barriers to high quality and appropriate care for trans patients are enormous. In addition to societal stigma, cultural barriers, financial barriers, and internalized transphobia, patients face a discipline that is still emerging and where standards o [sic] care are constantly in flux. Intersecting identities and the interaction of physical and mental health conditions with gender transition further complicate care. Right now everything is needed: more, and more robust research; more funding; more outreach o [sic] touch trans communities of color and other marginalized trans groups; trainings for professionals in all areas of health care... the list goes on.

Together HCPs and trans* patients face barriers to giving and receiving appropriate health care. HCPs who are culturally competent to the many barriers trans* patients face can work to limit the number of barriers that they create and impose by learning and using the right names and pronouns and being aware of biased attitudes and prejudices toward their trans* patients.

However, armed with insufficient training and knowledge and faced with other challenges, it can be difficult to provide these services.

There are several limitations to this study. The first is the sample size is small; as such the results are not generalizable. Part of the reason the sample size is small is due to the difficulty of “researching up,” especially when asking about a vulnerable, marginalized, or stigmatized population. “Researching up” is when you are researching someone who occupies a position of greater power, authority, or influence than yourself. Elite interviews is a common example of this. For, “It is assumed that people in positions of authority or power might have different perspectives, thus it is important to understand their viewpoints to more fully understand the social world” (Kezar, 2003, p. 398). However, there are potential problems to researching elite populations, such as: limited time, access, and a smaller population of potential participants (Duke, 2002; Harris et al., 2008; Kezar, 2003). Additionally, because of the limited timeframe in which this study took place, several major holidays fell during the research study. The timing of studies can impact participation (Duke, 2002, p. 49). Finally, there was not a lot of diversity among participants. While snowball samples are not designed to generate a diverse sample, there is a need for a more diverse sample to include further points of comparative analysis in future research, including by profession, geographic location (especially urban vs rural), and type of practice.

How HCPs experience trans* health care is influenced by numerous factors. For some HCPs, they perceive the patients’ trans* identity as more or less salient to the health care being provided. HCPs in different professions, clinical, and geographic settings have varied access to support and resources which might impact their experience with trans* health care. While much of the emphasis has been on the barriers to care, the challenges, and the negative aspects of

trans* health care, participants were also quick to point out how much health care has been changing. Changes from the ICD-9 to ICD-10 and from the DSM-IV-TR to DSM-5 both speak to the changing discourse about trans*. In regards to getting bloodwork and certain medications covered by insurance, Hayden stated that, “Even 5 years ago this was impossible.” With the increasing attention and awareness being given to trans* health care, there is plenty of opportunity to improve the HCP experience and reduce barriers to trans* health care.

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Appendix A:

IRB Approval



RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX (813) 974-7091

11/6/2015

Richard Henry
Women's & Gender Studies
4202 East Fowler Ave
Tampa, FL 33620

RE: **Expedited Approval for Initial Review**
IRB#: Pro00021181
Title: Healthcare Professionals' Perspectives on Trans* Healthcare

Study Approval Period: 11/5/2015 to 11/5/2016

Dear Mr. Henry:

On 11/5/2015, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
[IRB Protocol.docx](#)

Consent/Assent Document(s):
[Online Adult IC.docx](#)

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

- (6) Collection of data from voice, video, digital, or image recordings made for research purposes.
- (7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history,

focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

A handwritten signature in black ink that reads "John A. Schinka, Ph.D." The signature is written in a cursive, flowing style.

John Schinka, Ph.D., Chairperson
USF Institutional Review Board

Appendix B:

Survey

I am (select all that apply)

☐ Male

☐ Female

☐ Trans*/Transgender

☐ Genderqueer/Genderfluid/Gender-Nonconforming

☐ Prefer not to answer

☐ Other, please specify

I am (select all that apply)

☐ American Indian/Alaska Native -- *Print name of enrolled or principal tribe(s) for example, Mayan, Navajo, Tlingit, and so on.*

☐ Asian -- *Print origin(s), for example, Indian, Chinese, Pakistani, Trinidadian, and so on.*

☐ Hispanic or Latino -- *Print origin(s), for example, Cuban, Mexican, Puerto Rican, Argentinean, Colombian, and so on.*

☐ Native Hawaiian/Other Pacific Islander -- *Print origin(s), for example, Guamanian or Chamorro, Fijian, Samoan, Tongan, and so on.*

☐ Middle Eastern/North African/Arab -- *Print origin(s), for example, Egyptian, Lebanese, Moroccan, and so on.*

☐ White -- *Print origin(s), for example, German, Irish, French, British, and so on.*

☐ Other ethnicity, race or origin -- *Print origin(s).*

You were born in (year)

State you received your medical training in

State you are currently practicing in

Your specific profession/specialty

- ☐ Primary Care/General Practitioner/Family Doctor ☐ Gynecologists, OB/GYN
- ☐ Nursing (e.g. CNA, LPN, RN, NP) ☐ Other, please specify
- ☐ Endocrinologist

Years of experience in your profession

- ☐ 1-5 ☐ 21-25
- ☐ 6-10 ☐ 26-30
- ☐ 11-15 ☐ 31+
- ☐ 16-20

This survey is about healthcare professionals' perspectives on trans* healthcare. How do you define trans*?

Do you have experience working with trans* patients?

- ☐ Yes ☐ Unsure/I don't know
- ☐ No

With approximately how many trans* patients have you worked?

- ☐ 1-2 ☐ 9-10
- ☐ 3-4 ☐ 11-15
- ☐ 5-6 ☐ 16-20
- ☐ 7-8 ☐ 21+

Does your work site provide transition-related healthcare?

(Transition is often defined as the process individuals undergo to begin living and presenting as the gender they identify as. This process sometimes includes a component of medical transition. Some of the most common examples of medical transition include hormones and surgery.)

- ☐ Yes ☐ No
- ☐ Unsure

What treatment model does your site follow?

- ☐ WPATH Standards of Care ☐ Other, please explain
- ☐ Informed Consent ☐ Unsure

Before you started working in healthcare did you have any **formal** (i.e. part of the official curriculum) training or education related to working with trans* patients?

- ☐ Yes
 ☐ Some
 ☐ No

How helpful did you find each of these sources of formal (i.e. part of the official curriculum) training or education related to working with trans* patients?

	Not At All	Somewhat	Very	Did Not Receive
Medical Professionals within your specialization or profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Professionals not in your specialization or profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Associations, please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-Medical Academic Scholars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Advocacy Groups, please specify (type and/or organization) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trans* Individuals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Before you started working in healthcare did you have any **informal** training or education related to working with trans* patients that came from opt-in, co-curricular (complimentary to, but not a part of official curriculum), or extracurricular activities during your education or training?

- ☐ Yes
 ☐ Some
 ☐ No

How helpful did you find each of these sources of informal training or education related to working with trans* patients?

	Not At All	Somewhat	Very	Did Not Receive
Medical Professionals within your specialization or profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Professionals not in your specialization or profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Associations, please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-Medical Academic Scholars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Advocacy Groups, please specify (type and/or organization) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trans* Individuals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

After you started working in healthcare did you have any **formal** training or education related to working with trans* patients that came from your job or work experience?

- ☐ Yes
 ☐ Some
 ☐ No

How helpful did you find each of these sources of formal training or education related to working with trans* patients that you received from your job or work experience?

	Not At All	Somewhat	Very	Did Not Receive
Medical Professionals within your specialization or profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Professionals not in your specialization or profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Associations, please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-Medical Academic Scholars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Advocacy Groups, please specify (type and/or organization) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trans* Individuals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

After you started working in healthcare have you sought out any other forms of **informal** medical training or education related to working with trans* patients?

- ☐ Yes
 ☐ Some
 ☐ No

How helpful did you find each of these sources of those other forms of informal medical training or education related to working with trans* patients?

	Not At All	Somewhat	Very	Did Not Receive
Medical Professionals within your specialization or profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Professionals not in your specialization or profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Associations, please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-Medical Academic Scholars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Advocacy Groups, please specify (type and/or organization) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trans* Individuals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are there other, perhaps non-medical, resources that you use or refer to in relation to trans* healthcare?

☐ Yes, please describe

☐ No

Please rate your level of agreement with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Trans* individuals should be accepted completely into our society	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Romantic partners of trans* individuals should seek psychological treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being trans* is a sin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel comfortable working closely with a trans* individual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There should be restrictions on being trans*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel comfortable if I learned that my best friend was a trans* individual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How would you rate each of the following, as they related to your specific profession?

	None	Little	Some	Substantial
Your interest in working with trans* patients in relation to transition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your interest in working with trans* patients in general (not specific to transition)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your comfort in working with trans* patients in relation to transition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your comfort in working with trans* patients in general (not specific to transition)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your familiarity with protocols/treatment guidelines/recommendations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How relevant to your own specific specialty/profession is knowing the following?

	Not At All	Not Really	Somewhat	A Great Deal
Your patient's trans* identity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your patient's transition status	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How challenging has each of these issues been to you in providing trans* healthcare?

	Not At All	A Little	Some	A Great Deal
Getting insurance coverage of general healthcare needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting insurance coverage for transition healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referring my trans* patients to other providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Networking with other providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Finding support from other providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowing how to ask about and using the right name and pronouns for my trans* patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discussing healthcare issues related to my trans* patients' assigned sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Establishing trust or rapport with my trans* patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How challenging do you think each of these issues would be in providing trans* healthcare?

	Not At All	A Little	Some	A Great Deal
Getting insurance coverage of general healthcare needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting insurance coverage for transition healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referring trans* patients to other providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Networking with other providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Finding support from other providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowing how to ask about and using the right name and pronouns for trans* patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discussing healthcare issues related to trans* patients' assigned sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Establishing trust or rapport with trans* patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What protocols/treatment guidelines/recommendations are you familiar with related to trans* health?

	Not at all familiar	Somewhat	Very
The World Professional Association for Transgender Health Standards of Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Diagnostic and Statistical Manual of Mental Disorders IV-TR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Diagnostic and Statistical Manual of Mental Disorders 5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The International Classification of Diseases 9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The International Classification of Diseases 10	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions about The World Professional Association for Transgender Health Standards of Care

	Not at all	Somewhat	Very
How helpful do you find it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How applicable do you find it for your patients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much training did you receive about it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How helpful was the training?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions about The Diagnostic and Statistical Manual of Mental Disorders IV-TR related to trans* health

	Not at all	Somewhat	Very
How helpful do you find it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How applicable do you find it for your patients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much training did you receive about it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How helpful was the training?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions about The Diagnostic and Statistical Manual of Mental Disorders 5 related to trans* health

	Not at all	Somewhat	Very
How helpful do you find it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How applicable do you find it for your patients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much training did you receive about it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How helpful was the training?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions about The International Classification of Diseases 9 related to trans* health

	Not at all	Somewhat	Very
How helpful do you find it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How applicable do you find it for your patients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much training did you receive about it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How helpful was the training?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions about The International Classification of Diseases 10 related to trans* health

	Not at all	Somewhat	Very
How helpful do you find it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How applicable do you find for your patients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much training did you receive about it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How helpful was the training?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are there any other protocols/treatment recommendations/guidelines you reference when treating trans* patients? If so, please describe them.

Please share with us any other comments or information you feel we need to know about trans* healthcare.

Appendix C:

Interview Guide

Demographics:

How do you identify your gender?

How do you identify your race/ethnicity?

How old are you?

How many years of experience do you have working in healthcare field?

How many years of experience do you have working with trans* patients?

What is your specific profession and/or specialty?

What setting do you currently work or practice in (e.g. a hospital or community health center)?

What is the population density of the location of your workplace or practice [e.g. large urban (with a population 50,000+), midsize urban area (with a population between 2,500 to 49,999 people), or small rural city (with a population less than 2,500)] (USDA, 2013)?

Set 1: Experiences

1. How do you define trans*?
2. Please tell me how you become involved in trans* healthcare.
3. What experiences have you had working with trans* patients?
 - a. Is there a specific moment that stands out to you as being particularly significant to you becoming involved with trans* healthcare?
4. What are some of the biggest challenges you've encountered in providing care to trans* patients?
5. What aspects of your work (e.g. the location)—or healthcare in general—have made providing trans* healthcare more challenging?
6. In your experience, how has the discourse/thinking about trans* patients changed among healthcare professionals in your area of specialization?
7. What have been the most helpful ways you've learned about trans* healthcare?

Set 2: System of Care

1. What do you think is the current quality of healthcare for trans* patients in general?
2. What protocols/guidelines/standards do you use when you're treating trans* patients? Please tell me how you chose them and how well they work for you.
3. What are some examples of the ways in which policy has impacted your ability to treat your trans* patients?
4. How do you ensure your work/your trans* patients' healthcare needs are covered by insurance?

5. What sort of medical resources relevant to your profession/specialization would be most helpful for working with trans* patients?
6. What other non-medical resources do you use or would you like to use in working with trans* patients?
7. How do you communicate with your patients the protocols/guidelines/standards and other resources you use in guiding your recommendations about treatment?
8. How have your trans* patients personal experiences informed how you approach trans* healthcare?