Talking points

People who identify as transgender are frequently subjected to stigma and discrimination, limiting their access to healthcare.

Stigma and discrimination often lead to postponement of treatment.

Health professionals who have anti-transgender attitudes pose a significant threat to healthcare access.

There is a disparity in transgender-focused educational materials available to health professionals.

Transgender people are under-represented in up-to-date evidence-based practice.

How discrimination affects access to healthcare for transgender people

Lesbian, gay, bisexual and transgender (LGBT) people are a vulnerable and often ostracised section of society, due to discriminatory attitudes among many individuals and groups in society. How-ever, it can be argued that people who identify as transgender experience these problems most acutely because acceptance of them lags behind that of those who are lesbian, gay or bisexual. This article discusses a literature review exploring barriers to and facilitation of access to healthcare for people who identify as transgender. The themes presented describe the transgender healthcare experience from the perspective of both transgender people and health professionals. The review identified that discrimination and healthcare education and attitudes can result in postponement of care, disparity of research, inadequate education and training opportunities, and uncomfortable or problematic interactions, which accumulate to negatively affect the overall health of this patient group.

Citation


Box 1. Transgender terms

Trans: an umbrella term describing people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth (Box 1).

LGBT: Lesbian, gay, bisexual and transgender.

Transgender: A term used to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth.

Cross dresser: A person who chooses to dress in the clothing of the opposite gender.

Non-binary: A term used to describe people whose gender identity does not fit within the traditional binary of male or female.

Genderqueer: A term used to describe people who do not identify with the gender they were assigned at birth.
Discussion

It is difficult to make realistic estimates of the size of the global transgender population – formal studies on incidence and prevalence have not been conducted. The challenge associated with collating transgender demographics is thought to be exacerbated by high levels of transphobia (fear or hatred of transgenderism or transsexuality), epidemiology of gender dysphoria, societal stigma and discrimination (Winter, 2009). Even if such studies were conducted, therefore, cultural differences and attitudes would make it difficult to guarantee accurate results. As a result, estimates vary widely; in the UK the population is thought to be between 65,000 and 300,000 (DH, 2008). It is important to find accurate measures of the transgender population in order to ascertain the level and nature of discrimination, inequality and social exclusion faced by the transgender community (DH, 2008).

Methodology
A systematic literature search was performed using CINAHL Plus and MEDLINE databases because of their specific health focus. Initial search terms 'transgender' [AND] 'health' [AND] 'access' [AND] 'experience' returned 32 results published between 2000 and 2016. To ensure that the review focused on current ideas and concepts the search dates were updated to between 2006 to 2016, producing 29 results. Twelve articles were reviewed and deemed unsuitable; abstracts of the remaining 17 were analysed for key concepts, which included different aspects of transgender experiences when accessing healthcare, and seven articles were chosen for detailed analysis.

Discrimination
Discrimination is defined as treating a person or a particular group differently, or worse, than others; it is thought to negatively affect the quality of health for vulnerable groups. Health inequalities are said to occur partly as a result of discrimination within society – it affects decisions about whether to prevent or treat conditions within vulnerable groups, thus determining their risk of illness, health and well-being (World Health Organization, 2015). Although 'gender reassignment' is one of nine characteristics afforded protected status in the UK by the Equality Act 2010 (Box 2), transgender healthcare staff and patients continue to experience discrimination, abuse and bullying (Somerville, 2015). This review found that discrimination is manifested in health professionals' behaviours and in institutional cultures, consequently creating barriers when transgender people try to access healthcare.

Box 2. The Equality Act 2010
The following characteristics are protected under the act:
- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

One transgender patient suggested 'you just have to repeat yourself, telling them and telling them what you want'.

Literature on transgender discrimination
Poteat et al (2013) asked transgender individuals to identify their experiences of discrimination in the healthcare environment. Participants reported that doctors refused to provide care or treatment and that they believed they were treated this way after disclosing they were transgender. Anticipation of discrimination led some to limit their contact with healthcare providers to avoid exposure to yet more discriminatory behaviours.

Similarly, a survey of 2,092 LGB respondents (Guasp (2013)) revealed concerns about future care needs; 31% of all participants and 35% of those aged over 50 expected that they would be treated worse than heterosexual people by staff if they were a resident in a care home. It is reasonable to assume members of the transgender community have similar concerns.

Cruz (2014) further suggests that discrimination is a major cause of why transgender people postpone seeking healthcare; 28% of the 2,025 participants in this US study, all of whom identified as transgender, postponed seeking curative care when unwell because they felt discriminated against. McBride and Hansson (2010) suggested that even one negative experience with a specific healthcare provider is likely to cause transgender people to feel unable to use that service or facility again, thus increasing the likelihood of postponing care. Clearly, delaying seeking care will contribute to health disparities; raising awareness of this negative impact on the health of the transgender community could reduce the likelihood of postponement and in turn lead to a reduction in health inequalities.

McBride and Hansson (2010) described how transphobic behaviours manifest in actions such as the repetitive use of inappropriate gender pronouns. Cruz (2014) argued that using inappropriate pronouns and language to address transgender people were among the reasons for postponement.

One participant in Poteat et al’s study (2013) described a healthcare interaction where one professional used male pronouns and the other used female pronouns; neither had asked their patient. Chapman et al (2012) suggested the fact that health professionals had little awareness of how to engage respectfully with LGBT families often led to them inadvertently ‘outing’ an individual’s sexual orientation or preferred identified gender. For example, two respondents overheard a conversation where they were referred to as the ‘same-sex couple’. These experiences highlight how what may seem innocuous comments or remarks from health professionals can undermine respect for patients’ right to privacy in all aspects of care, a principle that is fundamental to nursing practice (Nursing and Midwifery Council, 2015).

Roller et al (2015) investigated the issues of healthcare access for transgender people, identifying that many had to find ‘loopholes’ within the system. For example, some suggested that their doctors diagnosed them with a hormonal imbalance instead of prescribing hormone treatments for being transgender. While this practice was documented in the US, Somerville (2015) highlighted similar practice in the UK, whereby 10% of health professionals had witnessed colleagues expressing the opinion that people could be cured of sexual orientation and preference.

This highlights the need for health professionals to become more familiar with the care of transgender health and transgender medicine. Lack of clinical guidance and protocols means that transgender needs are not considered, which has a negative impact on the quality of care provided. Without a sound evidence base, care may not be safe and effective, as health professionals are forced to fit transgender patients into the current healthcare structure and norms, rather than enabled to offer truly patient-centred care delivered in line with individual needs.
Participants in Roller’s (2015) study suggested they often resorted to joining online support groups, and contacting health professionals directly to see if they had experience of working with transgender patients before presenting as patients. McBride (2011) suggested that although accurate information is readily available online, enabling transgender people to access resources quickly and easily, there is a danger that they may access unregulated or inaccurate information, further perpetuating potential mental and physical health issues (McBride, 2011).

Ahmad et al (2013) suggest it is the responsibility of health professionals to refer transgender patients to gender services (in collaboration with each patient) if they present with a history of gender discomfort. This is crucial as patients need to be properly assessed for co-existing conditions, mental or physical health issues, or risk and vulnerability factors that need to be taken into account. If transgender people are left to self-refer and contact health professionals directly they may not access the most appropriate services for their needs.

Bauer et al (2009) argue that a lack of policies to accommodate transgender identities is often apparent in medical documentation such as referral forms and prescriptions. One transgender participant recalled an incident in which a doctor had written a prescription using the person’s preferred name, but the pharmacist used the participant’s birth name on the prescription information.

More than 83% of UK healthcare staff surveyed had not seen any posters or literature targeting the LGB and specifically transgender community. However, those who reported seeing such information in the workplace were more likely to have received training on LGBT health needs (Somervell, 2015). The manifestation of stigma and discrimination in bureaucratic formats adds to transgender people’s feelings of exclusion from health institutions, which in turn influences their comfort with and ability to access and use healthcare environments. This emphasises the importance of addressing LGBT issues by modifying forms and signs, to ensure they are inclusive (McBride, 2011).

Education on trans health
Transgender people’s physical and emotional health and experiences are virtually absent from educational material for health professionals (DH, 2008). This was reflected in findings from Poteat et al (2013) whose small sample included interviews from 12 health professionals, including medical physicians, endocrinologists and nurse practitioners. Eleven participants had received no training prior to working with their first transgender patient and felt unprepared. Somerville (2015) replicated these findings, revealing that a quarter of patient-facing healthcare staff interviewed reported never receiving equality and diversity training; 72% of participants said they had never had any formal training on the health needs of the LGBT community.

Grant et al (2011) agreed that many health professionals are inadequately trained to provide competent person-centred care for transgender patients. In some cases, it is apparent that transgender people feel it is largely their responsibility to educate their health professional (Poteat et al, 2013; Chapman et al, 2012; Bauer et al, 2009). Chapman et al’s (2002) participants said this made them feel empowered; they found it positive that they were the experts about their own health, and these positive feelings were reinforced when health professionals were willing to cede some power by allowing their patients to direct healthcare consultations, and showing respect for the individual’s wants and needs.

However, Poteat et al (2013) and Bauer et al (2009) saw education as an arduous task. One transgender patient reported feeling that it was often a ‘battle of wills’ with healthcare providers, while another suggested you just have to repeat yourself, telling them and telling them [health professionals] what you want’. Poteat et al (2013) provided a poignant example in which a doctor recalled a particular session with her patient: “She [the patient] had written down terms of feminisation and concepts, many of which I did not recognise; she had read too much on the internet, all of the session was spent trying to work around the myths she had brought to me.” This highlights the disparity in educational material available to health professionals and arguably presents them with a dilemma as they have a professional responsibility to work with robust evidence-based material to fully ensure the care they provide is safe and effective (NMC, 2015).

An alternative view is that transgender patients may feel they are being chastised for providing what they believe is important information about their health and wellbeing, and interpret health professionals’ actions as an attempt to defend their authority because they instantly dismiss the information. This is consistent with the negative exchange between health professionals and transgender patients described by both Bauer et al (2009) and Poteat et al (2013), highlighting how health professionals’ attitudes may consciously or subconsciously manifest in discriminating and stigmatising behaviours.

Attitude versus education
Chapman et al (2011) suggested that although education has some positive effects on health professionals’ ability to care for LGBT individuals, their attitudes towards this community are far more important. Their study used validated scales to ascertain nursing and medical

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**Box 3. Improving services for transgender patients**

**Recommendations for clinical practice**

- Use the right pronouns: ask for patient preference, and be discreet and consistent in the language used
- Be mindful that a one-size-fits-all policy, in which every patient is treated the same does not represent patient-centred practice
- Feel justified to challenge negative attitudes to advocate for transgender patients
- Think about your workplace: can gender inclusivity be improved in signage, documentation and awareness? If so, help make the changes

**Recommendations for change**

- Reflect on transgender issues that may affect your practice and access training to further develop your skills and awareness

- A bespoke training package for health professionals is needed, focusing on gender dysphoria and identifying areas of good practice, including referral services for transgender people, and their rights
- Gender awareness should become a mandatory component of equality and diversity training within pre-registration nurse education

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**Quick Fact**

28% Number of transgender people who postponed care due to discrimination
students’ understanding about homosexuality, attitudinal beliefs towards lesbians and gay men, and gay-affirmative practices (GAP). There was a weak but positive correlation between knowledge about GAP and LGBT issues. GAP scores were more strongly associated with attitudes: the more negative attitudes a participant held towards LGBT people, the more this reduced the likelihood of GAP.

The fact that Chapman et al’s (2011) study focused specifically on sexual orientation – which does not necessarily encompass transgender issues – may limit the transferability of these results to a transgender population (Polit and Beck, 2014). However, Carabez et al (2015) also found evidence of negative attitudes among nurses in the San Francisco Bay area; 30% of respondents claimed they were uncomfortable with the prospect of caring for a transgender patient, with discomfort appearing to relate to interpersonal stigma.

The NMC (2015) requires all nurses to “act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care”. It could, therefore, be argued that discriminatory behaviours run deeper than merely not understanding trans-gender health. The concept of ‘transgender’ may disrupt integral cultural, ethical and religious bindings that health professionals possess away from their occupation.

While the remaining 70% of nurses in Carabez et al’s (2015) study reported feeling comfortable in providing care for a transgender patient, the narratives of the study highlighted that these participants had witnessed other nurses “sniggering and laughing behind transgender patients’ backs”. This could indicate that, while most claimed to have a positive attitude towards these patients, they were not providing culturally competent or sensitive care.

The Equality Act 2010 would define this as ‘direct discrimination’. It could therefore be suggested that positive attitudes towards transgender individuals may not always result in compassionate practices. This has further implications for the nature of nurse education, which should include elements of self-awareness, empathy and compassion to ensure that culturally sensitive care is truly achieved.

Conclusion

The recurrent themes presented in this review describe the healthcare experience from the perspective of transgender people and health professionals. While these findings cannot be generalised to all transgender people, situations or cultures, they present new information about barriers to healthcare access for this marginalised and understudied population. The salient themes within the review included ‘discrimination’ and ‘healthcare education and attitudes’, in which postponement of care, disparity of research, inadequate education and training opportunities, and uncomfortable or problematic interactions, compound to affect the overall health of this group.

Health professionals who have anti-transgender attitudes pose a significant threat to healthcare access for this group, because their views lead them to provide inadequate care or to refuse care altogether. In addition, transgender patients who experience negative attitudes from health professionals are themselves likely to develop or confirm their negative attitudes about access to healthcare. The vicious circle of attitudes is further complicated by pervasive anti-transgender attitudes in society overall, which already discourages transgender individuals from recognising that they have equal rights and opportunities. Attitudes of healthcare providers can and should be addressed from within the health professions.

For transgender people, bureaucratic norms and actions often present as discriminatory barriers affecting their comfort and access to these healthcare services. All nurses can play a vital role in improving transgender patients’ experiences (Box 3): frontline nurses and clinical managers are also well placed to promote a transgender-inclusive environment in healthcare. This can include modifying policies, procedures, forms and signage, and the language