

“THE IMPACT OF STIGMA AND DISCRIMINATION ON HEALTH CARE ACCESS IN THE TRANSGENDER POPULATION”

Abstract.

The Lesbian, Gay, Bisexual and Transgender (LGBT) community is a vulnerable and ostracised section of society due to unacceptance of their very existence amongst many communities. This review will consider individuals who identify as transgender and present new information about barriers to and facilitation of access to health care for this often marginalised and understudied population. The recurrent themes presented describe the health care experience from the perspective of both the Transgender Individual (TI) and Health Care Practitioner (HCP). The poignant 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, accumulate to impact the overall health of this group.

5 Key Points.

- This marginalised group frequently subjected to stigma and discrimination limiting their access to health care provision
- Stigma and discrimination often lead to postponement of treatment
- HCPs who have anti-transgender attitudes pose a significant threat to health care access
- There is a disparity in transgender focussed educational materials available to HCPs
- TIs are under-represented in up to date evidence based practice.

Introduction

The Lesbian, Gay, Bisexual and Transgender (LGBT) community is a vulnerable and ostracised section of society due to unacceptance of their very existence amongst many communities (Department of Health [DH], 2008). This review will chiefly

consider individuals who identify as transgender, but with an understanding that their experiences are also affected by the discrimination felt by the LGB community. The term 'transgender' is used when an individual's sexual identity or gender expression differs from their physical gender at birth (gender dysphoria) (Winter, 2009). Transgender is an umbrella term which encompasses a range of gender-variant forms including transsexuals, cross dressers and genderqueer persons (Lombardi, 2001).

The World Professional Association for Transgender Health (WPATH) (2012) has established internationally accepted 'standards of care' for the conduct required to successfully treat and care for gender identity and gender dysphoria. Whilst the standards of care are based upon international evidence the origins of its work are centred within the United States (US) geography and culture, currently there are no equivalent guidance available within the United Kingdom (UK).

Furthermore there are huge inconsistencies, both nationally and internationally, in population estimates in the UK it is anticipated the transgender population ranges from 65,000 to 300,000 (DH, 2008). The challenge of collating transgender demographics is thought to be compounded with high levels of transphobia (fear or hatred of transgenderism or transsexuality), epidemiology of gender dysphoria, societal stigma and discrimination (Winter, 2009). 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).

A systematic literature search was performed utilising both the CINAHL Plus and MEDLINE databases because of their specific health focus. Articles within these databases have been peer reviewed, thus ensuring the credibility of the articles analysed.

Transgender individuals (TIs) have long endured high levels of prejudice, burdened by social and economic marginalisation due to negative attitudes with regards to the way they identify or express their felt gender. The Equality Act (2010) recognises gender reassignment as a protected characteristic and states that it is unlawful to discriminate against a TI, however a report conducted by the National Gay Lesbian Task Force (2011) (cited in Grant et al 2011) showed that TIs experience a high

proportion of discrimination in every major area of life in comparison to their heterosexual counterparts, including accommodation, occupation, health and health care, education, family life and the law (Grant, Mottet & Tanis, 2011). The difficulties faced by the transgender community result in inequalities in career opportunities, income, standards of living, access to social services, physical and mental health and overall wellbeing (Grant, Mottet & Tanis, 2011).

Health outcomes for this population currently depict high rates of sexually transmitted diseases, depression, substance abuse, self-harm and suicide (WPATH, 2012). The complex medical needs of TIs are exacerbated by the additional barriers and obstacles faced when accessing primary, emergency and transition-related care (NHS England, 2015; WPATH, 2012). In a survey conducted by the Equalities Review (2010), more than half felt they suffered discrimination because of their transgender status in that healthcare input was refused altogether by healthcare professionals (HCPs) or that their treatment was adversely affected (DH, 2011; DH, 2008). This creates an impression that HCPs need to be more informed about transgender health needs in order for competent and effective care to be delivered (NHS England, 2015).

Discrimination and Access to Healthcare

Discrimination is defined as treating a person or a particular group differently, or worse, than others; and is thought to impact quality of health for vulnerable groups (Equality Act, 2010). Health inequalities are said to occur partly because of discriminations within society, because this impacts upon the decision to prevent or treat conditions within vulnerable groups thus determining the risk of illness, health and wellbeing (WHO, 2015). Discrimination was a prominent theme within all of the papers reviewed, it is evident that discrimination is manifested in health care professionals' behaviours, and institutional cultures, which consequently creates barriers for TIs when accessing healthcare.

Cruz (2014) suggests that discrimination is a major cause of postponement in healthcare for the transgender population. Half of the participants eligible for the study (2,025), all of whom identified as transgender, postponed seeking curative care when unwell because they felt discriminated against or could not afford it. The figure of postponement for this select group is 30% higher than national average

estimates (Cunningham & Felland, 2008). Results from participant responses in this study should be, however, treated with caution. The dependent variable was to discover the reason for postponement of curative care. Participants were only given two options to identify why care was postponed and these included affordability or discrimination. Arguably the nature of the options given was leading and whilst participants were able to choose 'not applicable', these responses (2,407) were excluded from the study. The validity of the results are therefore questionable as participants may attribute their experiences of postponement incorrectly due to the limited choices available, and furthermore the responses to those who chose 'not applicable' are not represented (Polit & Beck, 2014). The negative impact postponement has upon health outcome is evident from one TI in which they reflected on their experience as they were unable to claim for gender reassignment on their insurance, they did not act on an abnormal smear, hoping it would develop into cancer. Seven years later they received a hysterectomy due to a spread of abnormal cells. (Roller et al 2015). With this example in mind, it could be argued that postponement of care is a contributing factor to transgender health disparities. Raising awareness about the negative impact postponement of care can have upon the health of the transgender community could serve to reduce the likelihood of postponement and lead to a reduction in health inequalities.

Transgender participants were asked to identify their experiences of stigma in the healthcare environment. Some individuals explained how they were outright declined care by a doctor on more than one occasion, whereas others described being 'passed on' to other healthcare providers. TIs felt they were treated this way once it had been disclosed they were transgender. (Poteat et al 2013). It could be argued that the movement from one healthcare provider to another explains a reason for postponement. Having to find another HCP after being denied or redirected to other professionals could take some time. As a consequence without prompt and timely healthcare it could potentially perpetuate disease, physical and psychological illness. It is also apparent that TIs experience difficulties in accessing transgender competent health care resorting to joining online and face-to-face support groups, and contacting HCPs directly to see if they had worked with TIs before (Roller et al 2015). This gives some insight into how the transgender population cope with the discrimination when attempting to access healthcare.

Roller et al (2015) aimed to delve deeper into understanding the issues of healthcare access for TIs, identifying that many had to find 'loopholes' within the system. For example, some TIs suggested that their doctors diagnosed them with a hormonal imbalance instead of having hormone treatments for being transgender. This highlights the need for HCPs to become more familiar with the care of transgender health and transgender medicine. Whilst in this case care was not postponed, clear lack of clinical guidance and protocols meant that transgender needs were not considered, having implications on the quality of care provided. Without a sound evidence base, care may not be safe and effective as healthcare staff are forced to fit transgender patients into the current healthcare structure and norms, as opposed to transgender care being truly patient centred, where healthcare is delivered in line with their individual needs. It is evident that there is a disparity of research as TIs highlight difficulties in finding accurate information about their transgender health (Bauer et al 2009). It could therefore be argued that a disparity of research means there is an absence of robust evidence to help understand transgender issues.

It is apparent that TIs are not only under-represented in up to date evidence based practice (Bauer et al 2009), but also they are significantly under-represented in healthcare protocols and policies, such as on paperwork and signage, as these often reproduced traditional social relationship patterns (Chapman et al 2012). An example being one same sex couple identified a consent form given to them for their child's surgical procedure that only provided the choice between ticking mother or father, which they felt was not applicable to them. This adds to their feelings of exclusion from health institutions which in turn influences their comfort and ability to access and utilise healthcare environments. The manifestation of stigma and discrimination in bureaucratic formats within a healthcare context serves to highlight the importance of addressing these issues by instigating the modification of forms and signs, with the aim for them to be more inclusive of the LGBT population.

Health Care Professional Education and Attitudes

It is apparent that TIs' physical and emotional health and experiences are virtually absent from educational material (DoH 2008). This was reflected in findings from Poteat et al (2013) who interviewed 12 healthcare professionals, including medical physicians, endocrinologists and nurse practitioners, of whom 11 indicated no

training was undergone prior to working with a transgender patient, and as a result suggested they felt unprepared when treating their first TI. Similarly Carabez et al (2015) identified that 80% of respondents (268 nurses) in the San Francisco Bay area, identified that they did not attend any LGBT training at all. Around 26 of the participants voluntarily suggested, once the interview had finished, that they would benefit from more training because of their self-identified lack of understanding and awareness of transgender related health.

Grant et al (2011) agree that there are many HCP not adequately trained to provide competent person centred for Tis. In some cases it is apparent that Tis feel it is largely their responsibility to educate their HCP (Chapman et al 2012; Poteat et al, 2013; Bauer et al 2009). Chapman et al (2102) describe how this made TIs feel empowered and found it positive that they were the experts about their own health, the positive experiences were helped when the medical provider was willing to renounce some power in health encounter and allowing the patient to direct this, being respectful to the individual's wants and needs. However Poteat et al (2013) and Bauer et al (2009) viewed HCP education as an arduous task. One transgender patient discussed how they felt it was often a 'battle of wills' between them and the provider, with another suggesting that 'you just have to repeat yourself, telling them and telling them (HCPs) what you want'. Poteat et al (2013) provide a poignant example whereby a doctor recalled a particular session with her patient: "she had (the patient) 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 the HCP and arguably presents the HCP with a dilemma as they have a professional responsibility to work with robust evidence-based material to fully ensure that care is safe and effective. (Nursing and Midwifery Council, 2015). An alternative view is that the patient may feel they are being chastised for providing what they believe to be important information about their health and wellbeing and interpret the HCP's actions as an attempt to defend their authority because they instantly dismiss the information. This is consistent with the negative exchange between the HCP and TI as described by both Bauer et al (2009) and Poteat et al (2013). This therefore highlights how HCP attitudes may consciously or subconsciously manifest in discriminating and stigmatising behaviours.

Chapman et al (2011) suggests that though education has some positive effects on a HCP's ability to care for LGBT individuals, far more important is the HCP's attitudes towards this community. Validated scales were utilised in order to ascertain nursing and medical students' understanding about homosexuality, attitudinal beliefs towards lesbians and gay men, and gay affirmative practices (GAP). Chapman et al (2011) found a weak but positive correlation between knowledge about GAP and LGBT issues. GAP scores were more strongly associated with attitudes, in that the more negative attitudes there were towards LGBT, the more this reduced the likelihood of GAP. A limitation, however, could be that these tests focus specifically upon sexual orientation which does not necessarily encompass transgender issues, thus impacting the transferability of these results to a transgender population (Polit & Beck, 2014). However Carabez et al (2015) also found evidence of negative attitudes amongst nurses in the San Francisco Bay area, whereby 30% of the respondents claimed they were uncomfortable with the prospect of caring for a TI, with discomfort appearing to relate to interpersonal stigma. It could therefore be argued that discriminatory behaviours run deeper than merely not understanding transgender health. The concept of 'transgender' may disrupt integral cultural, ethical and religious bindings that HCPs possess away from their occupation. The remaining 70% of the nurses in Cabarez et al's (2015) study identified they felt comfortable in providing care for a transgender patient, however the narratives of the study actually highlighted that these participants discussed how they had witnessed other nurses 'sniggering and laughing behind transgender patients' backs'. This could indicate that whilst the majority stated that they had a positive attitude towards the TIs, they were not providing culturally competent or sensitive care. It could therefore be suggested that positive attitudes towards transgender individuals may not always result in compassionate practices; however the self-assurance exhibited by the majority of the nurses in opposition to their culturally insensitive practice indicates a misinterpretation in their perception of their own self-awareness. Therefore this has further implications for the nature of training offered, which should include elements of self-awareness, empathy and compassion to ensure that culturally sensitive care is truly achieved.

Conclusion and Recommendations

The recurrent themes presented in this review describe the health care experience from the perspective of both the TI and HCP. While these findings are not generalisable to all transgender people, situations or cultures, they do present new information about barriers and facilitators to health care access for this marginalised and under-studied population. The poignant 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, accumulate to impact the overall health of this group. What follows are recommendations for how the field of health, namely nurses, could respond to these findings.

The issue of healthcare postponement and difficulties when navigating the system was identified as a predicting factor in TIs' health inequalities. Public health nurses and organisations are a useful means of promoting awareness about the dangers of postponing healthcare. This should also include information about support available to dissuade individuals from taking action which could negatively impact their health. It is possible that this could be done in an online capacity as well as using posters and leaflets in and around community groups. Using online support forums should be harnessed by knowledgeable HCPs and evidence based guidance such as the standards of care (WPATH, 2012) to provide correct and appropriate health information as the internet is a well-utilised and effective communication platform within the transgender community (Roller et al 2015). These interventions should also provide information about local resources for TIs who need healthcare as well as introducing TIs to supportive and knowledgeable health care providers to eliminate the 'passing on' of transgender patients amongst HCPs.

The lack of literature available demonstrates research itself is absent in key areas of transgender health, which negatively influences education and training opportunities. It is clear HCPs must improve their knowledge of transgender health care and transgender medicine. The expanding role of nurses means that nurse researchers are in a position to incorporate TIs and their issues to conduct research on a broad range of health related topics. Furthermore, population-based research surveys need

to be conducted within the UK in order to provide much-needed data about transgender individuals within this culture.

HCPs who have anti-transgender attitudes pose a significant threat to health care access, because their attitudes lead them to provide inadequate health care or refuse care altogether. In addition, transgender patients who experience negative attitudes from HCPs are themselves likely to develop or confirm negative attitudes about health care accessibility. The vicious circle of influential attitudes is further complicated by a pervasive anti-transgender society in general, which already discourages transgender individuals from believing they have equal rights and opportunities. Attitudes of health care providers can and should be addressed from within the health care profession amongst doctors, nurses and students. This could be accomplished through training schemes and advocacy education that support transgender patients' rights, and through the inclusion of educational programmes so that HCPs can develop an awareness of self-perception and how this affects a marginalised population, how to empower individuals, and give patient centred care.

Health care services are conducted in an environment with multifaceted interactions between many aspects including technology, policies, procedures, and resources; and for TIs bureaucratic norms and actions often pose as discriminatory barriers affecting their comfort and access to these systems. Nurses have an instrumental role in the influencing of transgender patients' experiences in healthcare. Furthermore, front line nurses and clinical managers are well situated to guide transgender inclusive environment within the healthcare context such as modifying policy, procedures, forms and signage, and modifying the language norms within the clinical setting therefore making the service more inclusive for both the transgender and diverse LGB population.

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