

**Trans\* Health Disparities, Health Care Utilization, and the Gender Dichotomy**

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## **Chapter I – Introduction**

"Biology loves variation. Society hates it."

-Milton, Diamond

On March 23<sup>rd</sup>, 2010, President Barack Obama signed a revolutionary piece of legislature, the Patient Protection and Affordable Health Care Act (ACA), in an attempt to modernize an overwhelmed and insufficient insurance system. The ACA's goal was to increase access to affordable insurance. Additionally, the ACA banned Health Insurance Marketplaces and the plans sold in them from discriminating on the basis of sexual orientation and gender identity. The bill also prohibited discrimination by many health care providers, such as doctors, hospitals, and clinics, by offering a new standard for patient protections, referred to as the Patient's Bill of Rights. The Patient's Bill of Rights put an end to a number of unfair insurance practices; for example, making it unlawful for a plan that receives federal financial assistance to deny coverage for a prostate screening for a trans\* woman or a pelvic exam for a trans\* man if these services are otherwise covered (Blumenthal, 2014). Despite the bill's efforts, the trans\* community - a broad term used for people whose gender identity or gender expression differs from their assigned sex at birth - still experiences discrimination in obtaining insurance enrollment, coverage, and adequate health care services for their special needs.

This community faces a wide variety of disparities and severe barriers of access in every aspect of the healthcare industry. This can most blatantly be seen in the lack of access to adequate primary care, inability to acquire insurance coverage for surgical expenses related to transitioning, and stigma and discrimination perpetuated by uninformed healthcare

professionals and outdated paperwork conventions. Clinical management associated with primary care of trans\* patients is complicated by a lack of adequate knowledge about and exposure to the trans\* community, their beliefs and behaviors, and the specific challenges they face. In addition, treatments raise ethical considerations which can be unfamiliar or challenging for physicians. The high cost of gender therapies, including hormones and sexual-reassignment surgeries, utilized for transitioning are still not covered by the ACA. Furthermore, trans\* identified people often avoid healthcare infrastructures altogether out of fear of facing discrimination. Many trans\* people have negative experiences with their health care providers; they fall through the cracks, stuck in a seemingly endless grey area in a black-and-white health care system.

My thesis attempts to better understand why these healthcare disparities exist, despite the Affordable Health Care Act's stated goal to provide more inclusive coverage to historically disenfranchised populations. In order to provide the proper historical context for the current situation, I did an extensive literature review which delved into the development of the trans\* community and its reception by the medical field in the last few decades. To reach a more complete understanding, I incorporated psychological, medical, sociological, and anthropological sources into my research. Upon establishing the historical timeline, I turned to the more personal consequences of the ACA's failure to create an egalitarian and safe setting for all patients. My primary concern was with patients' comfort, or lack thereof, in communicating with their primary health care providers and disclosing information surrounding their identities. Another colossal hurdle for trans\* patients continues to be the spotty insurance coverage that places important transitional procedures, like surgical reassignment and hormonal therapy, in jeopardy. Upon concluding my literature review, I

realized there was a startling lack of representation from the trans\* community itself. In my own research, I sought to give a voice to the trans\* population by going to them directly and doing one-on-one interviews to discuss their healthcare experiences in order to gain an insider's perspective on the choices that trans\* people make in regard to their healthcare options. These interviews focused around specific themes central to the trans\* community such as coming out, transitioning, mental health, and medical side effects due to hormone therapies, specifically cancer.

Based upon my literature review and subsequent interviews, I argue that the fundamental reason healthcare disparities continue to exist in the trans\* communities of America is because of the way Western society conceptualizes gender. The gender binary is a deeply engrained societal construct. For many, it is regarded as a natural truism and therefore trans\* people are delegitimized as a means of correcting the cognitive dissonance their identity engenders. Rather than challenge their own ideas about the range of gender identities, many people prefer to say that trans\* people are at best confused and at worst attention-seeking anti-establishmentarians, which completely fails to acknowledge the legitimacy of their identities. Public institutions, including healthcare, law, and education are modernizing, however the binary still exists within their foundations and therefore leads to many confusing gray areas. One such example is the health intake form which only provides two options for gender: male and female. What are trans\* and gender nonconforming patients supposed to choose? If their entire state of being is not even acknowledged on the form, how can they trust the system to treat them effectively and equally?

After identifying the root of the problem, the next steps to moving forward include implementing strategies and institutional transformations in order to reduce and ultimately

eliminate inequalities and inequities in the medical field. Most importantly, the medical preparation and education of future healthcare employees needs to be restructured and updated to provide comprehensive coverage of trans\* issues specifically, not a generalized 20-minute LGBT sensitivity lecture. After ensuring that doctors are adequately aware of trans\* medical needs, the structured intake forms need to be redesigned to allow for more inclusive options. This will not only provide a more complete picture of the patient but give the doctor all relevant information which will lead to a more informed and thorough treatment plan.

## Chapter II – Background

### *Gender Discourse Terminology*

Currently, dominant Western Society only recognizes “two strictly defined genders: male and female” (Beckholt, 2013). One’s gender experience starts right at birth when the doctor assigns a sex based on the appearance of genitalia. While most people identify with the gender that they were assigned to, many individuals are excluded by this stringent gender dichotomy.

The distinction between the terms “sex” and “gender” are not always understood well by our society, and these terms are “sometimes used interchangeably which blurs the health issues at hand” (Mcwayne et al., 2010). Sex is biological; it is generally labeled at birth, based on the appearance of outward genitalia and the assumption that this matches the correct chromosomal pairing, either XX for a girl or XY for a boy<sup>1</sup>. People are generally labeled as female or male. Gender, unlike sex is not biologically based, but rather is socially constructed. “It is what we become through our being, personality development, culture, and environment. Gender is who a person becomes through their socialization process and development” (Mcwayne et al., 2010).

It is essential to acknowledge how each of us experiences and relates to our own personal identity. The ways one views being male, female, both, neither, or anything in

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<sup>1</sup>Sex has typically been regarded as a rigid dichotomy, male or female, however scientists are beginning to acknowledge that this is inaccurate. In Anne Fausto-Sterling’s intensive review of decades of medical research, she noted that anywhere from 1 in 1500 to 1 in 100 babies are born intersex with either ambiguous genitalia, chromosomal anomalies, hormonal insensitivities, etc.  
<http://www.isna.org/faq/frequency>

between is a very individualistic and personal matter; it is present in all aspects of one's life. When a person identifies with the gender they were originally assigned from birth, they are referred to as cisgender. People who identify with a gender or genders different from those assigned to them at birth fall under the trans\* umbrella.

The trans\* umbrella is diverse, encompassing many identities and experiences. Identities under the trans\* umbrella include *transgendered*- "the state of one's self-identified gender identity not matching one's assigned [biological] sex" along with "[people] whose identity does not conform unambiguously to conventional notions of male or female gender roles, but combines or moves between these" (Stroud District Council, 2007), including transsexuals, masculine women, feminine men, genderqueer and all those who defy what society tells them their "gender" should be (Beckholt, 2013).

Other terms under the umbrella, utilized and accepted by the trans\* movement and academics involved in trans\* discourse, include *trans man*- a man who was assigned female at birth, *trans woman*- a woman who was assigned male at birth, and *transsexual*- "this term often refers to binary trans\* people (trans men and trans women), or to trans\* people who physically transition in any way. Another word heard in common discourse is *transvestite*- "often used synonymously with cross dresser this term is usually derogatory and isn't preferred by most people today" (Beckholt, 2013). While in the public eye, *transvestite* might seem like a synonymous term for trans\*, it does not describe the same phenomenon. Someone may enjoy cross-dressing in certain social situations, or even for work, but this does not necessarily dictate that their self-identified gender differs from their biological sex. It is important to note that while transsexual is still a preferred term for many, some dislike the term because of "its connection to the medicalization of trans\* people, likening their



condition to a pathology, and the focus it can put on physical transition” (Beckholt, 2013). For the purpose of this paper, I will utilize the more neutral term trans\* in order to avoid any unwanted negative connotations.

It is also useful to consider individuals who don’t identify within any gender, who incorporate elements of both masculinity and femininity, or who perceive themselves as “queer”. *Genderqueer*- “as an umbrella term can include gender nonconforming people, non-binary people, and much more, as a specific identity it can generally be understood as a gender that is neither man nor woman, possible in between the two or seen as a totally separate gender altogether” (Beckholt, 2013). Common pronouns include they, them, etc. Some individuals even prefer to be considered male on one day and female another day.

Finally it is important to define the term *transition*, in the context of the trans\* community. *Transition* is a multi-faceted term, and “may or may not include things like changing one’s name, taking hormones, having surgery," changing legal documents to reflect one’s gender identity, coming out to loved ones, dressing as one chooses, and accepting oneself among many other things (Beckholt, 2013). It is a highly individualistic process, and can include anything that makes someone pass or feel comfortable in the gender with which they truly identify.

### *History of the Trans\* Movement through a Feminist Lens*

The trans\* movement moved forward in the 1990's largely due to progress in other movements that were not directly associated with or focused on transgender issues. Historian and trans\* activist Susan Stryker focuses on the collective political history of the trans\*

movement in the United States- “that is on efforts to make it easier and safer and more acceptable for the people who need to cross gender boundaries to be able to do so” (Stryker, 2008) in her book Transgender History.

She notes that first wave feminism contributed to dress reform; women were attempting to wear "masculine" clothing such as pants. The feminist movement in this era started with the slogan, “The Personal is Political.” Because of their efforts to expand the female wardrobe, feminists introduced the concept of clothing and outward appearance as a political statement about identity and institutional oppression, which became an important foundation stone of the transgender movement. However, a majority of these first wave feminist were "critical of transgender practices such as cross dressing, taking hormones to change the gendered appearance of the body,...or living as a member of a gender other than the one’s birth-assigned gender” (Stryker, 2008). They equated these practices with gender oppression, stating that a woman who passed as a man “was trying to escape the poor pay of 'women’s work’ or to move about more safely in a world that was hostile to women” (Stryker, 2008). They saw these actions as traitorous and undermining the struggle of women against gender oppression, failing to realize that transgender people were fighting the same gender oppression, just on a different front.

Second wave feminism, also known as the women’s movement of the 1960’s and ‘70’s, addressed a wide range of issues such as equal pay, sexual and reproductive freedom, and rape and domestic violence (Stryker, 2008). Furthermore, an increasingly capitalistic society made it possible for women to be free in ways previously unimagined; during this era, there was a marked increase in atypical expression of gender roles. These trends led to a "modern era" for trans\* individuals because people sought different ways to express their

gender and push the boundaries of acceptable gender roles, such as females wearing male clothing to find work, women entering into traditionally male fields of work, etc. (Stryker, 2008).

Trans\* feminism stems from the third wave feminism of the 1990's. Third wave feminism "arose as a response to the perceived failures of and backlash against initiatives and movements created by second wave feminism during the 1960s to 1980s" (Tong, 2009). Third wave feminism is more attuned to overlapping themes and intersections of race, class, and sexuality within gender, and consequently more receptive to critical theory in gender studies such as the concept of queer theory. Feminists that follow third wave feminism make room for trans\* politics, feeling that is crucial to dismantle structures and institutions that utilize gender as a system of oppression (Hardin, 2013). Therefore, they do not pass moral judgment on those individuals who want to change their birth-assigned gender, as opposed to first and second wave feminists. Instead, third wave feminism focuses on a more "post-structuralist interpretation of gender and sexuality" (Hardin, 2013). In "Deconstructing Equality-versus-Difference: Or, the Uses of Poststructuralist Theory for Feminism," Joan W. Scott describes how language has been used as a way to understand the world, however, "post-structuralists insist that words and texts have no fixed or intrinsic meanings, that there is no transparent or self-evident relationship between them and either ideas or things, no basic or ultimate correspondence between language and the world" (Scott, 1941). Thus, while language has been used to create binaries (such as male/female), post-structuralists see these binaries as artificial constructs created to maintain the power of dominant groups (Pierre, 2000).

*Critique of Binary Gender Normativity: An Obstacle to Flexibility and Variety in Gender Identity and Discourse*

Gender binary is the classification of gender into “distinct, opposite and disconnected forms of masculinity and femininity” (Theberge, 2011). There are many limitations to the existence of a rigid male/female gender dichotomy. For example, binary gender normativity discourages people from crossing or mixing these boundaries/ gender roles. Where does that leave individuals who fall under the trans\* umbrella, or identify as gender queer? Are they no longer humans? It can be argued that there are so many more differences within a single gender than between them, exposing that "the gender binary is quite arbitrary and leads to false expectations of both genders. Instead, there is growing support for the possibility of utilizing additional categories that compare people without prior assumptions about who is like whom” (Lorber, 2011). If society were to allow for a more fluid model of genders, people would be able to identify and express themselves more authentically, without feeling the need to fit themselves to pre-established molds.

While the current societal subconscious regarding gender is constricting for both men and women, where do we even begin to place people who fall medically in between? In Cheryl Chase’s “Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism,” she begins by describing the plight of “individuals who arrive in the world with sexual anatomy that fails to be easily distinguished as male or female” (Chase, 1998). These individuals, being labeled by the modern medical discourse as intersexuals or hermaphrodites, are seen as deviating from the norm and must therefore be “fixed” such that they embody their “true sex.” Who decided that sexual ambiguity is abnormal? Who gave the universal

social edict that every individual who walks this earth must be biologically either wholly male or wholly female? There are many species that have hermaphroditic or intersexed individuals, why should humans view this naturally occurring phenomenon so negatively? Societally, being trans\* has been posited as something that is abnormal, partially on the basis of its assumed unnaturalness, but this should be immediately discredited upon observing the animal kingdom. Additionally, from an ethical standpoint, just because something is "abnormal" does not automatically imply that it is an aberration or defect of some kind, rather it is a testament to the rich diversity of the human condition. However, the current situation being what it is, with scientists feeling the need to "correct" sexual organs to fit preset categories, what behaviors should we expect from society when dealing with issues of gender?

Myra Hird, a trans\* activist, argues that people should not see sex as a means for determining gender. Instead she points to how nature “offers shades of difference and similarity much more than clear opposites, and it is rather a modern ideology that imposes the current template of sexual difference” (Hird, 2013). Culturally, our society is one that has repeatedly fallen into this logical trap. In fact, if one is born a trans\* individual, doesn't that make it a "natural" condition? What are the mental health implications of labeling trans\* people as “diseased?” Modern intersexed scholar, Anne Fausto-Sterling, agrees with Hird and “indicates that modern practitioners encourage the idea that gender is a cultural construct and concludes that, we [need to move] from an era of sexual dimorphism to one of variety beyond the number two” (Fausto-Sterling, 1993).

## *Affordable Care Act*

The Affordable Care Act (ACA), colloquially known as Obamacare, attempts to benefit trans\* people who have been historically and politically marginalized in the Western healthcare system. The ACA bans discrimination “based on gender identity or failure to conform to stereotypical notions of masculinity or femininity” (Blumenthal, 2014). Section 1557 is the civil rights provision of the Affordable Care Act. Section 1557 prohibits discrimination on the ground of race, color, national origin, sex, age, or disability under “any health program or activity, any part of which is receiving Federal financial assistance ... or under any program or activity that is administered by an Executive agency or any entity established under [Title I of ACA]...” (Blumenthal, 2014). Section 1557 is the first Federal civil rights law to prohibit sex discrimination in health care.

Much of the conversation around gender-identity nondiscrimination and the ACA has centered on whether or not insurance companies have to cover transition-related care. So far, the answer depends on where you live: Only six states and the District of Columbia have formally issued bulletins clarifying that they are interpreting the gender-identity nondiscrimination provision to mean coverage of transition-related care.

California, Colorado, Oregon, Vermont, and Connecticut have all issued formal statements, according to a spokesperson for Gay and Lesbian Advocates and Defenders (GLAD). Maryland has issued what advocates are calling a “partial statement,” meaning the Maryland Insurance Commission has reaffirmed nondiscrimination while stating “the exclusion should be narrowly applied to items and services that are directly related to the

gender reassignment process” (Blumenthal, 2014). Therefore, many states use the exclusion of transition related care to further marginalize and discriminate against trans\* people.

Furthermore, under the ACA, “most single people earning less than 400% of the federal poverty line per year qualify for advanced premium tax credits to help offset the cost of insurance. To obtain the subsidy, applicants must sign up for insurance through the online state marketplace” (Murtha, 2014). Here’s the problem: To acquire the subsidy, the gender marker on the health insurance policy must match the gender marker associated with their social security card. However, it is very difficult to change the gender on social security paperwork, and therefore this law is still exclusive to those who identify outside the binary. For example, a trans\* woman whose social security card and health insurance policy reflects that she is a “male” may be denied coverage of routine health care like a Pap test. Advocates hope that ultimately the Department of Health and Human Services will clarify their position on transition-related care so that quality of care is not a matter of geography and there are fewer loopholes for insurance companies to provide care.

### Chapter III - Methods

I began my research by investigating access to primary and secondary healthcare in the trans\* community through a comprehensive literature review. I was able to narrow the main barriers of access to health care for trans\* people to the following: educational, socioeconomic, institutional, and communicational. Furthermore, my literature review addressed the key reasons for obstructions for trans\* people in receiving transitional or secondary healthcare. Most of the obstacles stem from the ACA's haphazard enforcement and the power of individual states to ignore or circumvent federal regulations.

After a thorough literature review, I conducted semi-structured/open-ended interviews. Interviewing is an effective method to discern first-hand what people believe, how they think, and how that affects their life. An open-ended interview begins with a distinct set of questions based on certain themes, but I have the flexibility to add additional questions based on the interviewee's responses, which can garner even more interesting new subthemes in my research.

Vanderbilt's LGBTQI office and the director offered to help find/ contact prospective participants for this study. The participants had been interviewed for similar studies in the past and were on a list of people willing to help with research in the gender studies field. Inclusion in the study required a person to self-identify as belonging to the trans\* (transgendered, transsexual, transmasculine, transfeminine, etc.) community or the gender non-conforming population. Psychiatric assessments were not be conducted. The LGBTQI director sent out an email to the pool of prospective participants, informing them of this research project and all that it entails. Participants interested in the study contacted the LGBTQI office, and the



director proceeded to give the tentative participants the PI's (Elina Nektalova) contact information (phone number and email).

All informants signed an informed consent form, which specifically described anonymity with all the information gathered. Participants were limited to individuals over the age of 18. The first meeting consisted of going over the entire study in depth, including examples of questions that might be asked for the interview and the informed consent form. The questions were of a sensitive nature, but the participants were made aware that they could withdraw their participation at any time and were not required to answer questions that made them uncomfortable.

The interviews lasted approximately 45-60 minutes. Interviews were conducted face-to-face at a time of the participant's choosing. Interviews took place in an empty office in the department of Medicine, Health, and Society (MHS) suite.

Before approaching my informants, I had several themes I wished to investigate that would hopefully help me delve into the negative aspects and effects of the gender dichotomy. My first theme was childhood perceptions of gender. How comfortable were they in their own skin at a young age? Another important theme was "coming out." Was it an easy progression, or marked by turmoil and misunderstanding by family members and friends? This theme transformed into a discourse on transitioning. Did they receive hormone therapy? Was it by legal means, or illegally obtained? Were they able to acquire the means to have a sex change surgery? The transitioning theme, subsequently, led to discussing the themes of healthcare and education in the United States. What could be done, in terms of educating doctors to maintain cultural competency when encountering a trans\* person?

My literature review facilitated my questions during the interview. I asked about the Affordable Care Act, and how it affects the situation of trans\* patients. How have insurance companies specifically dealt with handling trans\* health needs? Additionally, I explored the racial theme. What differences lie in being a minority within a minority, such as an African American trans\* woman? I asked this question because during my initial literature review, I read about a trans\* white woman named Christine Jorgenson. Jorgenson was a former Army private from the Bronx who underwent surgery and hormone treatments in Denmark in 1952 to physically change from a male to a female. It seemed that many people supported her in her sex change. Was it easier for her simply because she could more effectively "pass" and people might not even realize she was trans\*? Did it help that she was a young, thin, white woman? Had it been someone else with more masculine features wanting a sex change, would the reaction have been different? Is it viewed and handled differently within the African-American community? The last theme faced was gender itself. Did trans\* people feel discriminated against, constricted, or simply left out by the concept of a strict gender binary: male or female? What does it mean to be a male or female? How do they express the gender with which they identify? Do they feel constricted to act stereotypically masculine or feminine in order to "pass" better?

I utilized the snowball effect profusely throughout my interviewing process. For example, asking about the transitioning process led one of my respondents to mention their cancer, which led to a series of questions about cancer screenings, or lack thereof, in the trans\* community. Thereafter, I questioned my participants' about actual or possible side effects experienced while undergoing gender therapies. This led to many interesting conversations about possible hormone induced cancers, depression, and even possible death.

I realized that most of the interviews were incredibly personal due to the sensitive nature of the topics, and some even felt like a psychological counseling session. I ensured each individual that they didn't have to answer any question if they were even slightly uncomfortable. All of my respondents were fully "out" and many were involved in trans\* rights activism, therefore there were truly no hesitations or even discomfort from them when answering my questions.

## Chapter IV – Results

Primary care is fundamental, basic health care. Typically, a provider of primary health care acts as the “principal point of consultation for patients within a health care system and coordinates other specialists that the patient may need” (WHO, 2011). “Primary care involves the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases” (WHO, 2011). Access is defined as the actual use of health services and everything that facilitates or impedes its use (Andersen & Davidson, 2001). Therefore, access to adequate primary health care is an essential and integral component of a person’s quality of life; a primary care physician must possess cultural competency, as well as a wide breadth of knowledge.

However, the trans\* community has an exorbitant amount of obstructions to overcome when attempting to access quality primary health care. When examined by gender trajectory, 43% of male-identified (female-to-male) trans\* persons had no access to care compared with 14% of female-identified (male-to-female) trans\* persons. One in four respondents had been denied medical care just because they were trans\* identified. Additionally, available data suggests that many trans\* persons are uninsured and that, overall, trans\* people are proportionally less likely to have decent access to medical care in comparison to the general population (Sanchez & Danoff, 2009). According to a national survey, only 30% to 40% of transgender individuals utilize any regular medical care at all (Sanchez & Danoff, 2009). In order to eventually eliminate the disparities faced by trans\* people, it is important that we

understand the determinants of those disparities. The most prominent barriers to access to primary care are educational, socioeconomic, institutional, and communicational.

A critical barrier to quality of and access to care is a lack of trans\* education for health care providers, leading to inadequate care. Clinicians have the responsibility to offer a safe, nonjudgmental, and expert environment in which trans\* people can get support, receive excellent care, and learn how to protect themselves against health risks. However, clinical management of trans\* patients is “complicated by a lack of knowledge, and by ethical considerations regarding treatments—which can be unfamiliar or challenging to physicians” (Snelgrove, Jasudavicius, Rowe, Head & Bauer, 2012). Furthermore, the disciplinary division of responsibilities within medicine further complicates care since few practitioners identify trans\* healthcare as an interest area (Snelgrove et al., 2012). Therefore, trans\* people may have difficulty identifying competent and compassionate providers with transgender patient experience. Additionally, a statewide needs assessment survey in Virginia (J.M Xavier, Hannold, Bradford, & Simmons, 2007) found that 46% of transgender respondents had to educate their regular doctors about their health care needs as a transgender person. They also discussed lack of provider knowledge about transgender health issues such as hormone use and appropriate HIV prevention counseling. High risk for HIV makes access to care even more critical for this population.

An additional barrier to access to primary care is socioeconomic, where trans\* individuals are more likely to be unemployed and living in poverty, increasing the likelihood that they will be unable to receive insurance and pay for health care. In 2009, the National Center for Transgender Equality and the National Gay and Lesbian Task Force surveyed 6,456 transgender people in order to document and record levels of discrimination (Grant et

al., 2011). “Respondents reported 13% unemployment, twice the national average at the time of the survey. Black, Latino, and multiracial respondents fared even worse with unemployment rates of 26%, 18% and 17% respectively” (Grant et al., 2011). Subsequently, 50% of these respondents reported having been fired, not hired, or denied a promotion strictly and primarily because of their gender identity (Grant et al., 2011). An additional 25% reported losing their jobs due to their gender identity or expression (Kessler, Mickelson, & Williams, 1999). This study showed that employment discrimination had a noticeable impact on health care access. While respondents in this study were uninsured at the same rate as the general population in the U.S. (19%), only 40% of the sample had employer-based insurance, compared to 62% of the population at large.

In addition to insurance and access issues, the quality of care is affected by the health care institution and physical environment because trans\* people are less likely to disclose a gender that differs from the male and female binary “norm”. This reflects the continuing existence of homophobia and transphobia. Partially, this problem has to do with the “intake or new patient forms that patients are asked to complete when they have an appointment in a medical facility” (McWayne, et al., 2010). Most of our “data collection surveys and questionnaires ask us to check male or female; sexual orientation and gender identity questions are generally not asked in public health or clinical settings” (Sell & Becker, 2001 ; Auerbach, 2008), but they are an important component of health and health care.

Communication and disclosure are crucial issues that need to be addressed in order to improve access to basic health needs. LGBT clients and patients are more likely to remain silent about important health issues because they fear disclosure “may lead to judgment, individual or institutional discrimination, and stigmatization” (Mcwayne et al., 2010).

Recently, Lambda Legal conducted the first survey that examined refusal of care and barriers to health care among LGBT and HIV communities on a national scale (Lambda Legal, 2010). The final report, *When Health Care Isn't Caring*, documents findings that 70% of trans\* individuals reported experiencing discrimination in health care, “including medical providers who refused to touch them, blamed them for their health problems, used harsh language, and were physically rough with them” (Lambda Legal, 2010). Over half of transgender and gender-nonconforming respondents reported a high degree of anxiety that they would face discriminatory care. This anticipation of discrimination and communication failures became a formidable barrier to seeking care. Almost 86% of trans\* interviewees indicated that overall fear and lack of effective correspondence with health care providers had negatively impacted their ability to receive quality care.

Primary care is not the sole type of health care trans\* individuals are incapable of obtaining because of barriers to access. Transitioning also has many obstacles along the way. The trans\* community suffers unfair treatment by insurance systems and the American law system and therefore often takes matters into its own hands, through illegal hormone usage and the seeking of gender therapies abroad for a cheaper price.

One such problematic law is the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* which is merely a collection of non-binding protocols outlining the usual treatment for individuals who wish to undergo hormonal or surgical transition to the other sex. Clinicians' decisions regarding patients' treatment are often influenced by this standard of care. For many individuals, this law may require a minimum duration of psychological evaluation and living, or “passing,” as a member of the target gender full-time for a year, sometimes called the real life experience (Coleman, 2011). Many

surgeons require two letters of recommendation for sex reassignment surgery. At least one of these letters must be from a mental health professional experienced in diagnosing Gender Dysphoria, who has known the patient for over a year (Coleman, 2011). Interestingly enough, such a diagnosis may preclude a patient from receiving insurance coverage under the guise of being a preexisting condition. The letters must also state that “sex reassignment” surgery is the correct course of treatment for the patient. Given that these surgeries are often placed in the elective category, it is crucial to point out the inequality in demanding letters of recommendation, extreme lifestyle changes, and psychiatric evaluation to ensure the patient is “sure” about his/her/their decision when this is not necessary for other cosmetic procedures, such as a cosmetic breast augmentation. In addition to this discrimination in principle, there is a disparate socioeconomic demand on trans\* people because psychiatric care for up to a year in order to obtain a letter is costly in addition to the costs of “passing,” which have many hidden expenses such as clothing, hair removal treatments, etc.

Additionally, many insurers don’t have to cover surgery related to gender transition, hormone therapy, or mental health counseling. Transgender reassignment surgeries or gender therapies are paid out of pocket by patients with average costs totaling over thousands of dollars. Health insurance providers with less restrictive or intentionally inclusive policies have denied insurance claims for transgender-related care on the grounds that a treatment or procedure is “cosmetic,” “experimental” or not “medically necessary.” However, how can one define “medically necessary?” Most definitions of medical necessity are generally vague. One state employee's health and prescription drug benefits plan defines it as follows: “the care and treatment is recommended or approved by a physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective



treatment of the condition; is not performed mainly for the convenience of the patient or provider; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient” (WPATH, 2008). Therefore, treatment provided by health professionals -- in accordance with the World Professional Association for Transgender Health's Standards of Care -- should be considered medically necessary, reconstructive and not cosmetic.

"Sex reassignment, properly indicated and performed as provided by the Standards of Care, has proven to be beneficial and effective in the treatment of individuals with transsexualism, gender identity disorder, and/or gender dysphoria. Sex reassignment plays an undisputed role in contributing toward favorable outcomes, and comprises Real Life Experience, legal name and sex change on identity documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures...The medical procedures attendant to sex reassignment are not "cosmetic" or "elective" or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition” (WPATH, 2008).

A dangerous result of these insurance barriers is that trans\* people are often forced to obtain hormones from nontraditional sources, “including friends, street vendors, the Internet, and pharmacists, in the absence of a prescribing physician” (Sanchez et al., 2009). The “prevalence of unsupervised hormone use reportedly ranges from 29% to 63% within urban groups of male-to-female trans\* persons” (Sanchez et al., 2009). This can result in many serious complications due to improper hormone administration. One serious potential risk is that of “HIV seroconversion from needle sharing or parenteral administration of hormones”

(Sanchez et al., 2009). Data could not be found on the prevalence of needle sharing and HIV rates among trans\* people in the United States, however a review of US-based HIV prevention literature found an average HIV prevalence of 27.7% (range=16%-68%) among male-to-female trans\* persons (Sanchez et al., 2009).

Hormone therapy regimens pose additional health risks to transgender clients, the most serious of which is hypercoagulability associated with estrogen administration. Additionally, “the incidence of thromboembolism among male-to-female transgender [trans\*] persons on estrogen therapy ranges from 0.4% to 2.6% per year” (Sanchez et al., 2009). These risks are increased dramatically if the MTF patient smokes. Smoking is a contraindication to estrogen therapy. Studies showed that smoking was less prevalent in trans\* people who obtained their hormones with a provider (Sanchez et al., 2009). Other effects range from psychological disorders, such as clinical depression, to physical abnormalities including elevated liver enzymes and decreased insulin insensitivity (Moore, 2003). A review implemented by Johns Hopkins University subsequently found that many “clients use high-dose hormone regimens and utilize multiple hormones concurrently without medical supervision in the belief that this will achieve faster results” (Moore, 2003). Other clients had the perception that health care providers were not fully knowledgeable or lacked the necessary expertise to “supervise hormone therapy” (Moore, 2003). This has led many trans\* people to clandestinely seek hormones from non-traditional sources, especially if they wish to amplify or accelerate their “feminine” or “masculine” appearance.

Stigma and discrimination function as social determinants that affect opportunities and constraints placed on individual behavior. Psychologist Erving Goffman, defines stigma as a relationship between attributes (i.e. characteristics of a person) and stereotypes about those

attributes (Goffman, 1963) in his book *Stigma: Notes on the Management of Spoiled Identity*. It is through this “interpretative social relationship that certain human differences become labeled as negative and thereby stigmatized” (Poteat, 2012).

The process in which a label eventually leads to internalization of a negative characteristic by the individual, and thus transforms into stigma has been described thoroughly in his book. The foundation of labeling theory lies in the fact that society ultimately determines what is and what is not normative behavior. A label is a definition that can be normative or non-normative that suggests how a person should be managed or responded to, ranging from avoidance and disgust to compassion and caring, or even indifference and apathy. Stigma describes the process by which individuals are labeled and thus set apart from others, but also how these labeled individuals are linked to undesirable characteristics and therefore are met with avoidance and rejection (Muse, 2013). In this way, “stigma is not a characteristic of a person, rather it is the relationship between an individual or group's attributes and society's negative interpretation of these attributes” (Poteat, 2012). The stigma faced by trans\* people every day due to a society that refuses to accept the multifaceted nature of gender leads to reduced access to healthcare. Trans\* people do not seek health care or providers because of their ingrained fear of discrimination.

More recently, public health researchers have "re-conceptualized stigma to take into account the relationships between stigma, power, and social inequality” (Poteat, 2103). They point out that stigma should be conceptualized on an institutional or structural level, rather than just an individualistic one. “Most of the subsequent health research on stigma has interpreted it very individualistically and ignored the role of structural power” (Poteat, 2013). In order to correct for this, Link and Phelan (Bruce G. Link & Phelan, 2001) assert that stigma

includes not only negative labeling, stereotyping, and internalization, “but also devaluation and discrimination that leads to unequal outcomes” (Poteat, 2013). Thereby, in order to perpetuate stigma, one must have “access to social, economic, and political power that allows for full execution of their disapproval, rejection, exclusion, and discrimination” (Poteat, 2013). Rather than being a separate concept from stigma, “discrimination is simply an enactment of the struggle for power and privilege that stigma embodies” (Poteat, 2013). Therefore, stigma and discrimination are beacons of more than just individualistic constraints in terms of trans\* people seeking health care, but also facilitate social exclusion at the structural or institutional level.

However, what does it mean to be socially excluded? The term 'social exclusion' describes devaluation and disenfranchisement experienced by certain groups within society (Caceres, et al., 2008). It is “the failure of society to provide certain individuals and groups with those rights and benefits normally available to its members, such as employment, adequate housing, health care, education, etc.” (Free Dictionary, 2013). It is a catch-22 situation; they are pushed to the outskirts of society for not being employed or living in substandard housing or being uneducated, but they were not afforded these basic benefits by that very same society because they were on the outskirts. Because they are not seen as contributing to mainstream society, socially excluded individual are ascribed little to no value in the greater social order (Poteat, 2013). They are “marginalized economically, politically, and socially such that they are not afforded the opportunities available to others in society, including access to health care” (Poteat, 2013). This only perpetuates a vicious cycle of disenfranchisement.

Implicit to this model is an understanding of stigma and discrimination as social forces that determine opportunities and constraints “by reinforcing power and domination at both the interpersonal and the institutional level” (Poteat, 2009). Stigma, discrimination, and social exclusion of transgender people are culturally embedded throughout society. This affects the content of institutional policies, procedures, and guidelines as well as the norms and practices of healthcare workers within that institution. In addition to marking the way in which trans\* people are treated externally, “both structural and institutional stigma impact individual behaviors such as substance abuse, injecting behaviors, sexual behaviors, and gender conforming behaviors” (Poteat, 2009). Stigma can become deeply engrained into the subconscious due to constant social bombardment and seriously impact the mental and emotional wellbeing of transgender people. This is further supported by research which indicates that social stigma against this population which health professionals exhibit leads correlates with a higher rate of self-destructive behaviors such as substance use, risky sexual behaviors, eating disorders, etc. (US Newswire, 2009). "As clinicians, we should recognize how negative societal reactions related to sexual orientation and gender identity can affect our patients' health," says senior author Mark Schuster, M.D. A study in Virginia found that 24% of trans\* identified persons reported that they had experienced discrimination by a doctor or other health care provider due their gender expression. Another qualitative study in Boston reported that some medical professionals refused to call them by the appropriate name or pronoun. Clinicians and practitioners are not even aware of the exact numbers of LGBT people they serve since data is not often collected. This “perpetuates the cycle of transphobia and homophobia, and a type of "don't ask don't tell" is predominant in clinical settings” (McWayne et al., 2010). Simultaneously, the questions about gender identity are not options

on intake and new patient forms. This is likely to cause many patients to feel uncomfortable about disclosing their gender identity, and this adds to the continuing issue of health disparities.

Subsequently, if a trans\* person is required to fill out a form that does not have a category that accurately represents who they are, it could ultimately seriously impact their overall health because they would feel as an “other”, a deviation from the norm (McWayne et al., 2010). Denial of an “individual's gender variant presentation by treatment staff may heighten distress, thus interfering with a collaborative treatment alliance” (Mizock & Fleming, 2011). This should remind us of US Census surveys where until recently categories were not inclusive for race and gender. "Othering" refers to the process that "magnifies and enforces projections of apparent difference," which "reinforce and reproduce positions of domination and subordination," often leading to experiences of "marginalization, decreased opportunities, and exclusion" (Johnson, Bottorff, Browne, Grewal, Hilton, & Clarke, 2004).

This othering process is not only exclusive, it is very dangerous. As shown by a qualitative HIV-needs assessment in Minnesota, being pushed to the fringe increases the likelihood of dangerous behaviors; the investigators “identified transgender-specific risk factors, including shame and isolation, search for gender affirmation, and sharing needles while injecting hormones” (Bockting, Robinson, & Rosser, 1998). In this study, transwomen focus group participants described a sense of being isolated from and rejected by society. The shame and pain involved often led to substance use and a loss of sexual inhibitions. They also described getting involved in sex work both for gender confirmation ("If you can attract a man who will pay you to have sex, you're beautiful") and to pay for hormones and silicone injections which frequently were purchased through underground sources.

## *Results Based on Interviews*

### *Laura*

I met a trans\* woman, Laura\*, at a lecture by Laverne Cox, who is the first African-American trans\* woman to be a regular in a television show, *Orange is the New Black*. I noticed, at once, how at ease she looked from her body language. She informed me that she has done these kinds of interviews before, and she always enjoyed offering her opinions on such a sensitive topic. Her childhood was as ordinary and normative as the next person. Her real metamorphosis came at puberty, not just physically, but also in the way she perceived her gender. She was scared: “I felt uncomfortable at first and then I started doing research, via the Internet. Research showed me why I felt uncomfortable. I didn’t like the form I was taking. Why was I starting to get body hair and a mustache? This wasn’t right. I was severely depressed.” She told me that she had attempted suicide three times. She attributed her sickness and suicide attempts to a lack of understanding from others that she was born in the wrong body.

### *Coming out*

I finally asked Laura when she was ready to “come out.” I finally asked her when she was ready to “come out”, which is possibly one of the more important themes of my interview. As she began divulging this personal information, I sensed the need to use Bernard’s silent probe technique, which consists of “just remaining quiet and waiting for an informant to continue” in order to allow her to present her narrative in an unadulterated way

(Bernard, 2006). It seemed to effectively stimulate her into producing more information. “Many transgendered people think they are gay before they realize what’s goin’ on. I came out as gay. I told my friend that I liked men. Here in the south, man or woman, there’s no gray area and so I branched out and did some research. That’s when I realized it: I don’t like cotton, I like silk.” She meant that she felt she was a woman trapped in the wrong body. From our dialogue, I learned a completely new facet of trans\* life. For some, fully realizing their identity is a struggle and there is much confusion to work around. It becomes even more difficult because there are few people that trans\* or questioning youth can confide in and trust. She also articulated her parents’ emotions when she first told them, “I told my mother in high school and father when I was 19. My mother knew and she said she was waiting for me to tell her.”

### *Transitioning*

Next came the crucial theme of “transitioning.” Transitioning is a very broad and multifaceted process. It is also highly individualistic. For example, she started on illegal hormones because she couldn’t find a doctor that was comfortable treating her. Later, she found a reputable doctor that provided her with the hormones she required, which insurance fully covered. Finally, she had a sex operation in India for a lower cost of \$20,000. However, one of her friends whom identified as trans\* rejected hormone therapy altogether, and only had the sex change operation. Another friend wanted neither. She said she never had any trouble with her insurance company, because she was not diagnosed with gender dysphoria disorder. However, she knew many people who were not able to receive adequate healthcare because of the pathologizing of their bodies. Unfortunately, she had to pay for her surgery out



of pocket because insurance companies still categorize it as an “ elective cosmetic procedure”, no different from a simple breast augmentation. She strongly recommended that doctors study this population more thoroughly than just a 15 minute LGBT course. “I could just tell they didn’t know what to do with me.”

### ***Matt***

Laura was in an intimate relationship with Matt\*, a self-identified F-to-M individual. Matt told me that he has been on prescribed hormonal therapy since he turned 18. He stated that had the option to acquire a bachelor’s degree from a university, but instead chose to go into the workforce in order to pay for his testosterone - an expense that insurance also didn’t cover for him. He has been working odd jobs from waiting tables to bartending for 13 years before he was able to go Thailand in order to obtain his sexual reassignment surgery (SRS). He said that the surgery in America was going to cost him \$50,000-60,000, probably even more, and he could never save that much money in a lifetime.

### ***Transitioning***

Matt fully explained the procedure in Thailand, which he stated was a stage three total phalloplasty requiring several procedures. Matt solemnly said he had to stay in the hospital for 14 days. “Then, I had to return to Thailand after a year for a follow-up and another procedure to insert a penile implant.” My own research on his specific surgery showed that it required (in the most basic of explanations) 1/2 to 2/3 of the vagina to be removed in the form of a sub-total vaginectomy at the same time as the phalloplasty, a scrotoplasty and then, abdominal

tissue was utilized as a graft to create a penis. After about one year, “penile (erection) prosthesis and testicular prostheses can be implanted when sensation has returned to the tip of the penis” (Monstrey, 2011). This would result in a cosmetically “acceptable” and fully constructional penis. Matt confirmed my findings.

Although, Matt\* researched the place and found a reputable international hospital in Thailand, he was not able to find any information on the surgeon who would be performing his surgery. “I mean, what the fuck right? I’m gonna go to an Asian country to get this thing [surgery] and I don’ even know the guy. It’s crazy as hell.” Matt's\* fears were well warranted because one needs years of experience in order to successfully perform a high risk SRS. According to the European Urology Association, many complications can occur for trans\* men who opt to have this procedure performed. “Surgery on cisgender males is simpler than on transsexual males, because the urethra requires less lengthening. The urethra of a trans\* man ends near the vaginal opening and has to be lengthened considerably. The lengthening of the urethra is when most complications occur” (European Urology, 2010). Complications “may include but are not limited to less than anticipated length, torquing of the clitoris (usually amenable to release), loss of sensation, tissue necrosis, localized infection, persistent tenderness or hypersensitivity, transient or permanent narrowing of the vaginal opening which may render the vagina incapable of penile penetration, urethral narrowing, urethral obstruction, and urethral fistula (leakage of urine anywhere along the pathway of urethral extension)” (Reed Center for Genital Surgery, 2014).

Since he was my only interviewee who underwent a FTM surgical gender therapy, I chose to continue asking about his experiences with the surgery and recovery. Matt\* told me that the recovery process was long and painful. Phalloplasty patients can return to work after

about 4-6 weeks depending on the patient's recuperative progress and their particular job requirements. However, if the patient's job requires strenuous activity, returning to work is only recommended after 6-8 weeks. Matt\* said it took him two months to start a new job and he lived with his mother at that time. I concluded the interview by asking him if he was happy overall with his health experiences. "I guess so... I got Laura and we...you know. But I'm still not a man yet here. Trying to get my papers changed and I don't got a doctor here either. I don't got insurance, so what's the point? And doctors don't know anything about us anyway." Matt\*, like many other trans\* patients, admitted that while there were some victories, there is still a long way to go.

### *Mental Health*

Another study showed that post-op depression was also fairly common, with one study reporting 27% of individuals using post-op antidepressants (Chen et al., 2009). Matt\* said "I was real depressed after my surgery because it still did not make me feel 'like a man'. How was I supposed to 'get hard' or have sex?" Currently, there is no technique or special surgery currently available that can create a penis, which can naturally become erect. The Philadelphia Center for Transgender Surgery states that "we simply do not have the ability to create the thousands of small blood vessels required to achieve a natural erection and so the patient must choose another form of support if the patient desires the ability to have intercourse". This support can be either internal or external. Internal support means placing some type of penile implant into the center of the phalloplasty flap. External support can appear in the form of placing one or two condoms or a self-adhesive over the penis in order to give it "sufficient rigidity" in order to allow intercourse (Philadelphia Center for transgender

Surgery, 2014). An alternative option is buying a penile extender or enhancer online. Matt\* said he chose to return to Thailand after one year in order to have a penile implant inserted.

### ***Ken and Bryan***

I was also fortunate enough to have had the opportunity to interview Ken\*, who had undergone a female to male transition. The same themes were discussed as before, but they generated different responses. However, the overall message was clear: health disparities are prevalent in the trans\* community due to society's engrained reliance on gender binaries. I began with questions regarding his childhood. He told me that he always knew he was "different", and felt out of place in his family and society as a whole. Later, when the bodily metamorphosis of puberty hit, he was isolated and depressed about his body, "I was starting to grow breasts and I hated them. I wanted them gone. I didn't know why yet, but I knew I wanted them gone."

### ***Mental Health***

I asked him if he spoke to anybody about his depression. He told me that there was no one he could speak to. His parents would not have understood; coming from a small town in the South where everybody knew each other's "business", he was afraid this his primary-care physician would divulge his medical condition to his parents. From an early age, he experienced a sense of mistrust in the healthcare system. In addition to his fears, Ken also felt that his doctor would not have any answers for him, and would even label and stigmatize him

as “crazy.” He had no one to turn to, except the Internet. After hours online, he learned that he was in fact a trans\* man.

### *Transitioning*

“Now, was the time to do something”, he asserted. His first move was coming out to his parents. That did not go well, as expected. However, he was still on their insurance plan and desired hormones (testosterone) for his transition. Unfortunately, Ken’s mother made him see a psychiatrist in his small town, who subsequently diagnosed him with Gender Identity Disorder. Ken became a little emotional and described all the ways this diagnosis adversely affected his life, “I was not able to obtain any hormones after that, and was forced to buy them illegally. I knew if I didn’t have access to them, I would have eventually killed myself. I needed them. I am not a woman.” Ken resorted to the consumption of illegal hormones after that. He states that he feels no negative side-effects now, but he cannot be sure about possible detrimental effects in the future?

Another female to male respondent, Bryan\*, had a very open-minded family about their (used to denote gender-queer) perception of gender identity and subsequent transition. However, Bryan\* still had a very difficult time with their transition. One problem was the intake forms: male or female? How about neither? Where does gender queer fit into this narrow spectrum? How do they go about discussing that they don’t identify with “male or female”? Bryan\* wasn’t angry, but wished there was a place they could go that would not only tend to their specific transitioning needs, but was also knowledgeable and accepting of their choice to identify as gender queer, excluding themselves from any binary. Bryan\* eventually received hormones for their transition. However, insurance did not cover the

expenses. On top of the financial burden of having to pay out of pocket for the medication, there was also an added fee of \$150 a month in order for a nurse to properly administer the injections into the body. Bryan\* opted out of having a certified nurse assist them with the injections because of their inability to afford an extra \$150 a month and the discomfort it provided them to remove their clothing in front of a stranger. They instead rely on their girlfriend to administer the shot into the buttocks. Their girlfriend saw the nurse do it once and watched a few YouTube videos. I asked Bryan\* whether he was scared that something could go wrong? They told me that they didn't think about it and there wasn't much else they could do.

### ***Gaby and Betty***

#### *Cancer*

Regular medical checkups and cancer screening are of vital importance in the trans\* community. Screening recommendations are fundamentally based on research about which groups of people are more likely to get specific cancers, and “environmental risk factors for cancer and the accuracy of specific tests” (Cancer-network, 2006). Medical associations have “created guidelines to help health professionals decide what tests to use, how often the tests should be done, and who should have the tests” (Cancer-network, 2006). Many cancer screening protocols are not sex/ “gender”-specific; screening for skin cancer, colon cancer, and lung cancer is the same for women and men (trans or not). “Trans\* people should have the same screening as anyone else for these kinds of cancers” (Cancer-network, 2006). Some cancer protocols are gender-specific based on untrue assumptions about what body parts men

and women typically have (e.g., screening for cancer of the breast and cervix for women, and prostate screening for men). Therefore, it can be difficult to know what to recommend for trans\* people. Hormones and surgery can change these body parts, and can also increase or decrease the risks of cancer.

Regarding hormone usage, “estrogen is believed to influence the development of some types of cancer (including cancer of the breast, ovaries, and lining of the uterus). The risk of breast cancer may be increased for MTF patients who have taken estrogen over a long period of time; those who started hormones early in life are at a greater risk than those who start later in life. MTF patients who never take estrogen or progestin have the same low risks as non-trans\* men (Cancer-network, 2006). It is not known whether FTMs taking high doses of testosterone are at increased risk for estrogen-dependent cancers (the naturally occurring enzyme aromatase converts some testosterone to estrogen in FTMs)” (Cancer-network, 2006).

A trans\* woman, Gaby\* discussed her fear of contracting cancer throughout the interview. She was scared to start her gender therapy regiment because the hormones might be linked to an increased chance of cancer. She exasperatingly stated, “I started it anyway because I couldn’t live with myself anymore. I was so miserable and depressed. Hormone therapy made it better.” But, she was still ruminating over the possible adverse consequences of the hormone therapy. How id doctors take this into account when they met with her? She presented a typical scenario at a healthcare facility, “I come in and fill out all the appropriate forms. Female for the gender, but they don’t know about my previous condition and my gender therapy. They don’t know that I might be at a higher risk for breast or ovarian cancer because of the hormones and it’s so frustrating.” It’s important for women who start hormonal gender therapies to obtain regular mammograms earlier than the recommended age of 50

because of their increased risk of a breast cancer diagnosis. She concluded her interview by stating that she has never gone to a doctor who had the breadth of knowledge on trans\* health issues that was suitable to adequately treat her. I a literature review on cancer and trans\* people showed that not enough research has been done to know whether trans\* people get cancer more frequently than non-trans identified people.

Another trans\* female, Betty\*, actually did develop cancer. However, she considered her cancer a blessing or a breakthrough in her life. Betty\* lived in a male role for most her life. She had a very successful engineering career and never complained about her healthcare because she was able to acquire insurance through her job. When she turned 67 years old, she went in for her regular medical checkups and discovered she had prostate cancer. It wasn't an aggressive form, and she did not need to undergo surgery or chemotherapy for it. However, her physician recommended estrogen hormone therapy in order to decrease the size or prevent the growth of the cancer. Betty\* is a natural optimist and said, "I'm just glad it was just prostate. You can live with that for years and nothing will happen to you."

After she started taking the estrogen, she had a new verve for life, "I just started thinking differently and I was happier. I've never felt like that. I always felt something was wrong with me, but I didn't know what and then this [hormone therapy] made me happy." It took Betty months to realize her own identity and she knew she did not want to play the "male" role anymore.

It was incredibly interesting interviewing her because she read many books based on theories behind the gender construct. I asked her about the dichotomy, and she stated, "It's just another label. People need them. I don't like to call myself trans\* for that very reason. I'm not saying I'm not, but I won't limit myself to words and labels. It's not me. Some days



I'm feeling very much like a woman, and other days I just want a beer and watch basketball. The hormones helped. I like them. I like talking to other women. Women understand more. But I still can feel like an outsider...because I'm a *trans\** woman, not an *actual* woman...whatever the hell that's supposed to mean. These labels are for one group to feel better about themselves, a superiority complex. I don't want to have anything to do with that. I am Betty\* and I am *happy* with that.”

Betty was also happy with continuing on with her estrogen therapy, which her insurance covered because of the prostate cancer diagnosis. Therefore, she has not experienced any dissatisfaction with her doctors. She does not want any surgical transformations or alterations of her body, and she is a regular electrolysis client attempting to remove unwanted hair from her face. I asked her if she sought any health care from a *trans\** specialist because she lives in New York City. She said that her primary doctor for over a decade has been a huge supporter of her beliefs and she did not feel the need to switch providers. In addition, she concluded by stating, “It might have been easy for me, but I know how hard it is for others. The one who do their own electrolysis because they live in the boonies far away from a city or the ones who are too scared to come out or the ones who simply can't. People still die for this. Trying to be who they were meant to be. None of us wants to hurt anyone and I wish people learned how to leave other people alone.”

## Chapter V – Discussion

For over a decade now, gender discourse has become more prevalent in the United States among academic scholars and researchers. These researchers have challenged us to cautiously and wisely reconsider the term “gender.” However, this progress has not yet been sweepingly adopted by healthcare workers or institutions; “they still tend to rely on conceptually stagnant notions of gender and sex that contrast masculine males with feminine females” (Sage Pub). Redefining current western conceptualizations of gender in healthcare would require larger institutions such as hospitals and insurance companies to view gender as a socially constructed concept, and therefore subject to change over time.

The question remains: what strategies can be implemented in order to garner adequate healthcare for trans\* patients? Some strategies that have been suggested to encourage both communication and disclosure are to create a clinical climate that provides signals to patients that the facility is a safe place to talk about sexual orientation and gender identity. Medical facility employees could be required to have cultural competency training so they could speak to all patients and clients in a nonjudgmental gender appropriate manner. These techniques could be a component of a professional education curriculum.

Effective communication is essential to quality medical care. The intake forms could include questions that have appropriate responses for gender identity, sexual orientation, and same sex partners as well as other sex partners. Office literature and brochures could include LGBT pamphlets about reproductive issues, health promotions and risks (Mayer et al., 2008). The benefit of this culturally competent climate is far-reaching. The staff, the clients and patients, cisgender heterosexuals as well as patients of other genders and sexual orientations,

would all become exposed to the culturally competent climate, and this would hopefully increase the acceptances of difference and diversity.

Other theorists argue for the establishment of the concept “postgenderism.”

Postgenderism “confronts the limits of a social constructionist account of gender and sexuality, and proposes that the transcending of gender by social and political means is now being complemented and completed by technological means” (Hughes & Dvorsky, 2008). It posits that technology is the means in which society can alter social norms and eradicate binary gender roles (Hughes and Dvorsky, 2008). There are now a range of technologies and “medical advancements that have the potential to radically blur the distinctions between categories of gender, sex, and sexuality” such as artificial wombs, parthenogenesis (a type of asexual reproduction that occurs in female animal and plant species where fertilization occurs without males), and cloning (Hughes & Dvorsky, 2008). These technologies can change the way humans reproduce and therefore the way we classify people.

Postgenderism is often believed to offer a more egalitarian and just system, where individuals are not sexed at birth and instead are classified according to other means, for example, age, talents, etc.(Lorber, 2005). Postgender theories raise thought-provoking questions about the role of gender and ethical concerns about the impact of technologies. If we are indeed able to move beyond the conventional westernized gender binary, does this mean gender will no longer impact human health?

Based upon my literature review and research, one thing becomes abundantly clear: the underlying issue of trans\* health disparities lies in the way that we as a society conceptualize gender. Despite the ACA’s concerted efforts to make the healthcare system more inclusive, the gender binary is still a paradigm that we cannot seem to escape.

Postgenderism seems like a radically futuristic schema, but it tackles the issue at its core; it separates gender from biological function and suggests a completely alternative labelling system. The process of changing the way generation after generation understands gender will not be easy and it will likely take a long time, but it is achievable. Once this shift in public consciousness occurs and people appreciate the diversity and accommodation value of a spectrum instead of a limiting binary, public institutions will follow suit and trans\* patients will finally receive equal care. When, and only when, trans\* people are seen as simply people and not “others” will they finally be fully accepted and taken care of by the medical system.

## Chapter VI – Conclusion

Health care services are evolving, and health care professionals are becoming more aware of sexual minority institutional health disparities. The trans\* movement is currently gaining in visibility and there is an increasing need to be well-prepared to treat this community with dignity and equality. The Obama Administration and other health organizations are beginning to develop the infrastructure needed to provide quality medical care to all Americans, including sexual minorities. Recently, the Department of Health and Human Services (HHS) stated that the Affordable Care Act, which prohibits sex discrimination in health insurance, applies to transgender people too (Mcwayne, et al., 2010). This statement by the HHS adds to recent court decisions and a ruling by the Equal Employment Opportunity Commission in April that the Civil Rights Act's prohibition against sex discrimination applies to transgender people (Mcwayne, et al., 2010). Advocates hope that that this will set a precedent and lead to the enforcement of equal measures for trans\* patients in health care.

Others recommend that sexual orientation and gender identity measures be standardized and routinely included in relevant national, state, and local health research surveys to increase our understanding of the needs of trans\* people. Additionally, this would raise awareness in the medical community of the prevalence of these kinds of situations, which would increase exposure and decrease stigmatization. They also recommend that clinicians receive training through simulated patient experiences on how to appropriately provide comprehensive and sensitive care, and seek out educational resources to help improve the quality of care they provide to trans\* youth (McCarthy, 2009). To be caught uninformed is

not sufficient at this stage and the laws should adapt to meet existing needs; increased education and awareness are essential in raising the quality of health care provided to these, and all, patients.

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