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SUMMARY: (no more than 250 words single spaced)

This qualitative study addresses gaps in knowledge with respect to physicians' understanding of transgender health care, and trans people's health care experiences in the Winnipeg context. 30 trans people participated in semi-structured in-depth interviews and 11 physicians participated in three small focus groups. Topics included: health of transgender people, experiences of isolation and discrimination, health care access, education of health care providers, assumptions about patients, and medical system issues. Main gaps identified are a lack of free trans-sensitive mental health care; physicians unwilling to diagnose gender dysphoria and prescribe hormones; a way to record a patient's chosen name and gender pronoun on the EMR; and public funding for procedures necessary for transition, such as facial electrolysis and facial feminization surgeries. Recommendations to improve health care for trans people include: further gender education for medical students, residents and attending physicians; gender-sensitivity training for all clinical staff; routine screening for depression, anxiety and suicide ideation for trans patients; that further longitudinal research be undertaken on impacts of hormone therapy and removal of natal gonads to a patient's health; that departments assign numbers to patients rather than call names in waiting rooms; that treatments necessary for transition are financially covered; and that EMR systems are updated with a field for preferred name and gender marker. While acting on these recommendations might seem difficult, they are integral to providing greater health equity to trans people. Pursuing systemic improvements benefiting Manitoba's transgender population helps improve health equity for all Manitobans.



Student Signature



Supervisor Signature

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Assessing Trans People's Experiences of Health Care in Winnipeg

Introduction

Though a growing area of research, the health and health disparities of trans people – people who are transgender, transsexual, transitioning, transitioned or gender non-conforming – remain largely understudied (1,2), particularly at the local level (3). This study, titled *Assessing Trans People's Experiences of Health Care in Winnipeg*, addresses these gaps in the research. Using qualitative methods, including interviews with trans people and focus groups with physicians, we investigate the health care barriers experienced by trans people accessing care in Winnipeg and explore some of the reasons for those barriers. The specific goal of this research is to help improve health outcomes for trans people in Winnipeg. More generally, the research contributes to the overall goal of working towards safe, quality care for LGBTQ populations in Manitoba. The following report is a summary of the conclusions and key themes arising from the *Assessing Trans People's* study. This report is authored solely by Marina Rountree-James.

Please note that the BScMed committee has given permission for this report to be 5 pages longer than specified in the instructions.

Literature Review

Transgender people are a priority group for health care. As a population, trans people experience poorer health than the average Canadian. This is documented in particular with higher rates of suicide attempts, depression, other mental illness, problematic substance use, and STIs, including HIV/AIDS (3,4). These health disparities occur throughout the life span, with transgender older adults reporting poorer physical health and a higher rate of disability than non-trans Canadians (5). Such findings are comparable with other groups dealing with stigma and discrimination (6), as similarities include lacking social support, un- or under- employment, lower income than mainstream Canadians (7), along with increased minority stress – where experiencing stigma and discrimination leads to a stressful environment that causes mental health problems (8). Minority stress is particularly salient when a person is visibly trans, or obviously incongruent with their natal sex.

In addition, research conducted thus far shows a troubling trend of poor health care access for trans people, related not only to an outright denial of care (9-11) – as in the case of being turned away at the emergency room (12)– but also to a denial of certain procedures such as hormone injections (3). Further, data show that trans people experience a significant amount of stigma and transphobia in the health care encounter, which can impact health care access (11,13-16). Recent data emerging from Ontario (17) [demonstrate](#) that trans identities are often disavowed or denied in the clinical setting, as seen, for example, when a receptionist or physician refuses to call someone by a preferred name or gender pronoun. As a result, trans patients often stop attending medical appointments (17). The same research found that 27% of trans people reported frequent ER avoidance because of a fear of discrimination (12).

Trans people who do access health care commonly experience discrimination, whether in preventative medicine, routine and emergency care, or specifically transition-related care (18,19). In a 2006 Manitoba and North-West Ontario trans health needs assessment titled *Nowhere Near Enough* (3), many participants encountered a lack of sensitivity from service providers in a variety of health care settings. Examples include gender insensitivity (incorrect pronouns, specific comments about patient's gender identity), displays of discomfort (ambiguous provider-behaviours such as fidgeting, staring or avoiding eye contact), denial of services (provider refusing to provide transition medical services such as hormone treatment or referrals

for sex reassignment surgery, refusing to meet with transgender patients), substandard care (providers rough during exam, not replying to requests for help), verbal abuse (being mocked, belittled and verbally assaulted), and forced care (being committed to psychiatric institutions, unnecessary examinations). These findings are echoed in other studies (19). While some such experiences may be due to reasons other than a physician's overt transphobia, the literature suggests that the behaviours are attributed to stigma by the patients (19). These experiences may lead patients to avoid health care unless absolutely required, [thereby](#) contributing to some of the negative health outcomes trans people experience (5,17,18). For example, patients have obtained hormones via the internet and self-medicated, which presents a far riskier situation than the patient being prescribed hormones by a physician with appropriate medical follow up and monitoring (20-22).

While many physicians may not discriminate against trans people and may wish to provide good care, studies also show that often times physicians lack the knowledge to be in the position to provide it. Research suggests that physicians feel unprepared to treat health concerns related to transition care (13,23), even when such care falls within a physicians' scope of practice, such as endocrinology (16) or primary care (13,23). Physicians report that clinical guidelines are difficult to find or are non-existent (16,24), yet guidelines are available on the internet and include: the World Professional Association for Transgender Health (WPATH) Standards of Care; Endocrine Society Clinical Practice Guidelines; and Sherbourne Health Centre Guidelines and Protocols for Comprehensive Primary Care for Trans Clients. As a result of this lack of knowledge, transgender patients commonly take on the task of teaching their physicians about the care they require including informing physicians on the specialists to which they should be referred and how to provide hormone prescriptions (16,18,25,26). This can result in inequalities of access to care and treatments, privileging those with more comfort and knowledge of the medical system, possibly more education, and those with fewer barriers to care (26).

[Research is beginning to show that one of the most effective ways in which the above health care disparities can be alleviated is through the improved education of health care professionals.](#) For example, literature has reported positive change in allied health care professionals, such as elder service providers(27,28), pharmacy students(29), occupational therapists (13), and nurses(28,30) after the introduction of trans-specific curriculum to undergraduate and postgraduate education that centered around the distinctions among sexual orientation, sexual behaviours and gender identity, as well as how to ask about and discuss these topics in a respectful and culturally-competent way(31). While such literature is important and has much to teach us in the medical profession, there is a dearth of research focusing specifically on medical education and the ongoing training of physicians.

Overall, then, the literature suggests that trans people experience disparities both in health and health care. However, it is significant to note that apart from the 2006 report *Nowhere Near Enough*, very little research has been conducted to assess the experiences of trans people accessing health care in Manitoba. In addition, while the 2006 report showed that discrimination and denial of care are significant barriers to health care access for trans people, the perspectives of physicians, themselves, are relatively unknown both in general and specifically in the Winnipeg and Manitoba contexts, yet these perspectives are essential to understanding the complete picture of trans health in the city and province.

Research Objectives

The goal of this current study is to address the gaps in knowledge with respect to health care practitioners' understandings about trans health care, and trans people's health care

experiences in the local context using qualitative research methods. The overall purpose of this research is to contribute to health care equity in Manitoba with a specific focus on the LGBTQ community. The specific objectives of this research are:

1. to explore trans people's experiences of health care in Winnipeg and to identify key areas for improvement as guided by research participants.
2. to explore physicians' perspectives on trans health care in order to obtain a better understanding of how shortcomings in care can be addressed through medical education.

Methodology

A qualitative study was undertaken that included in-depth interviews with 30 trans individuals and three small focus groups with 11 physicians, for a total of 41 participants overall. This is a valid sample size for qualitative research(32). Interviews were semi-structured and conversational, meaning that the interviewer asked a few guiding questions before giving participants room to "tell their own stories" and discuss issues of import to them. Focus groups were structured similarly and lasted up to two hours, allowing time for each participant to respond to questions and join the discussion. Questions for trans people during the interviews centered on their experiences of health care as a trans-identified person, and whether or not and how these experiences could be improved. Questions for physicians focused on their experiences with trans patients, barriers to providing good care for trans people, and how or whether medical education or other types of knowledge translation could address these barriers. Trans people were recruited by a variety of methods, including postering in clinics and other key gathering places for the trans community such as the Rainbow Resource Centre, advertisements via Facebook and email listservs, and snowball sampling. Inclusion criteria for trans people included: participants had to be over 18; participants had to identify as trans now or in the past. In this report the terms transgender, trans, gender non-conforming all refer to people who experience gender dysphoria based on the sex assigned at birth being incongruent with their gender identity.

Physicians in the study were recruited through word-of-mouth. For this we relied on the professional networks of Dr. Ian Whetter, the clinical supervisor on this project. Inclusion criteria for physicians were: participants had completed their undergraduate medical education; and participants currently practice in Manitoba. For this study all recruitment activities, interviews, and focus groups were conducted by Marina Rountree-James. Recruitment was extremely successful, and all recruitment targets were met and in fact exceeded.

Interviews and focus groups were digitally recorded and transcribed by a professional transcriptionist who signed a confidentiality agreement. Transcripts were cleaned for identifying information during transcription and again during the coding process. The code list was developed by McPhail and Rountree-James in response to themes that emerged during interviews. Interviews and focus groups were coded in NVivo qualitative software and consolidated into themes using thematic content analysis following consultation by McPhail and Rountree-James(33). These themes form the basis of the final written report and presentation for the BScMed.

In line with ethical requirements and to maintain participant anonymity, all participant names have been removed from the data and participants have been assigned pseudonyms. In addition, the names of clinics and hospitals and any other identifying information mentioned during interviews and focus groups have been removed from the transcripts and thus from this report, with the exception of referring to Klinik Community Health Centre due to their specific expertise in trans health services.

This research was conducted within the research program of Dr. Deborah McPhail who deploys feminist poststructuralist methodology in all of her studies. The current study is no different. Feminist post-structuralism has roots in Foucaultian interpretations of power and knowledge (34), and is heavily informed by feminist science studies which questions the notion of objectivity per se or that *any* research can be removed from bias (35). Within this tradition, it is integral that a researcher notes her/his own “subjectivities” or identities prior to articulating the research question and then be mindful to trace how these identities influence the entirety research process through, for example, field-notes and research journals (36). The point of such is not to remove bias from the research findings because, again, this is not possible, but rather to think carefully and completely about how data collection and analysis is influenced by relations of power and by the privilege the researcher inherently takes when assuming the role of “story teller” and interpreter of other peoples’ narratives. Within the current study, field-notes were taken by Rountree-James, who also engaged in careful reflection throughout the research process in communication with McPhail. Due to spatial constraints, the results of these reflections will not be detailed in this report but may be published at a later date in a feminist methodology journal.

Findings

Overall, the current study reflected much of the literature, as major gaps were found in the health care experiences of trans people, as well as in the education of physicians regarding trans health and health care issues. The overarching themes arising from the interviews and focus groups include: health of transgender people; access to health care; issues related to health care providers; medical system issues, and recommendations.

Health of Transgender People

Health care for Winnipeg’s trans community, particularly transition care, has been made easier to access in the time since the 2006 Manitoba/Northwestern Ontario study *Nowhere Near Enough* was released. At that time the expertise around transgender health care was primarily at Winnipeg’s Nine Circles Community Health Centre. For patients to have sex reassignment surgeries approved and funded by Manitoba Health, they had to go through an approval process that included multiple psychological evaluations over a period of a year or longer at the gender clinic of the Centre for Addiction and Mental Health (CAMH) in Toronto. A recommendation from the report was to create a Centre of Excellence in Trans Care, which was actualized through creation of the Trans Health Clinic at Klinik Community Health Centre in December 2009. Trans Health Clinic has two part-time physicians, a nurse practitioner, a nurse, a social worker, and a medical assistant. In addition, the Gender Dysphoria Assessment and Action for Youth team (GDAAY) was founded in 2011 in Winnipeg. GDAAY provides transition care for youth under 17 years of age (and their families) in Winnipeg is available through a team that includes a Clinical Psychologist and Child and Adolescent Psychiatrist, as well as a Pediatric Endocrinologist and Endocrine Nurse Clinician.

Thus, while health care has improved over time for trans people in relation specifically to transition care, participants in our study still expressed specific difficulties and challenges with respect to both transition health care and general health care. Overall, these difficulties were characterized as isolation, discrimination in health care, and health care access issues.

Isolation

Isolation came up in many interviews. While some participants found face-to-face community with other people at various stages of transition, the necessity for such community is becoming less common with more easily accessed on-line support. However, finding community exclusively on-line may inhibit successful off-line social transition. Sandra, 55, explains: “There’s

all sorts of techniques and things that you can learn from someone who's been through the process... that's broken now, because [people transitioning] don't associate with each other." Techniques such as mannerisms, walking and taking up space, make up application or facial hair grooming, speech patterns and non-verbal communication have to be re-learned when a person transitions as social expectations vary between the sexes.

In other cases, isolation may be a remnant of having had to hide one's deepest knowledge about oneself before choosing to begin transition, preventing the development of intimate relationships. As Sandra noted:

It's a very lonely life. That's one thing they don't tell you. Your chances of finding a partner afterwards are pretty slim. Nobody really connects with you. And we've spent so many years staying disconnected from people to hide ourselves. (Sandra, 55)

Sandra continued to argue that this isolation may mean that the patient deals with all the stress and anxiety associated with making such an enormous life change with inadequate social support. People cope in whatever ways they can, and for some the coping may contribute to negative consequences:

It's a hard way to live, the dual lifestyle and always doubting yourself, and if you're not dealing with that and the self-sabotage and the various other mechanisms you use to cope, including alcohol, drugs and whatever else, high risk behavior (sigh), the list is endless. We find ways to kill ourselves without actually killing ourselves. (Sandra, 55)

Because of the stress and consequential self-destructive behaviours isolation can induce, medical professionals asking about the non-physical aspects of transition such as isolation and related methods of coping can make a huge difference to patients' comfort level and the care they receive. Olivia experienced this during her first medical appointment at Trans Health Clinic:

Because it was the first time in my life that not only was I talking about [needing to transition], but [the doctor] was responding in such a way that I might as well have walked in with a broken arm. He was treating it like any other medical issue, like "we need to deal with this"...And there was no stigma, there was no shame involved. He's sitting across from me, smiling, and calling me by my [chosen] name. (Olivia, 41)

In addition to the importance of *medical* care attentive to the mental health issues associated with transitioning that resulted from isolation, some participants spoke of the importance of counselors or other mental-health caregivers throughout this process. Unfortunately finding the right counselor can be expensive and time-consuming and many people have limited resources to put in that direction. Sean argued:

[More] mental health services would be helpful, like more counseling and that type of stuff, if people want it. Cause right now I think most things happen with peer counseling, which is really awesome lots of the time. But there are some things that are beyond a peer [and their ability to help]. (Sean, 39)

Thus, many participants described how the process of transitioning can create a profound sense of isolation. This isolation becomes a medical issue because it in turn creates a great deal of stress which then lays the groundwork for mental health problems. Physicians, such as those at Trans Health Clinic, who were aware of these mental health issues and sensitive to them were appreciated by participants, as were therapists who would help guide participants through the

transitioning process. However, the lack of affordable, publically funded therapy was a serious issue for many participants, thus creating health disparities in mental wellness for trans people before, during, and after the transition process.

Discrimination in Health Care

Many participants in the study described instances of stigma and discrimination in their health care experiences. Stigma or fear of discrimination, or having experiences with physicians who refuse to treat trans people have led some patients to avoid health care for all except emergency services, and sometimes even then. One participant, a trans man who had been pregnant and gave birth to a biological child, spoke of a time when he was pregnant and had been vomiting for over 24 hours:

I just was too scared to go to the hospital, because I felt so vulnerable...[luckily] I had a midwife's appointment the next day and they put me on IV to get hydrated and everything. But it was dangerous to risk that. I can't believe that I risked that. I just was so scared. But I didn't want to go to the hospital and say I was pregnant and have to deal with everything. (Riley, 29)

This desire to avoid medical attention due to being viewed as abnormal or confusing was unfortunately confirmed to be rational later on when Riley was receiving medical care:

The doctor couldn't understand how I could have possibly been pregnant. He couldn't fathom what a trans man was. And I kept having to explain it to him, and he just couldn't understand it, he had some kind of block. He was jumping around, asking me questions about [having experienced] a violent sexual assault, then he's switching back and being like, "Wait a minute. So you had breasts?" And then I told him that I had been diagnosed with postpartum psychosis, and he was like, "How could you possibly have been pregnant?" Well, it's not that hard to understand. So then he was gruff and annoyed with me the whole time.

In particular, emergency departments were a source of anxiety, as in addition to being concerned about the health emergency itself, the patients were afraid of being mis-gendered and/or called by their former name due to old charts or electronic medical records (EMR). This situation was commented on repeatedly, and is particularly acute given the nature of the emergency department, where other people in the waiting room may hear the name called and the questions asked. After answering personal questions the patient often has to return to the waiting room, where some have been harassed by other patients. Jordan related:

And then everybody that was sitting there in the waiting room was overhearing this. And me walking in there, everyone perceived me as male. And this whole interaction happened, then everybody was starting and then it's uncomfortable between me and the health care workers. And then if I'm already anxious about whatever health care stuff I'm going there for, that just amplified it. So little interactions like that, [the triage nurse] probably forgot about it. But I'm still thinking about it to this day. (Jordan, 24)

Staci echoed:

At one point, while waiting for a lab in the waiting room, I was called by my old name and the secretary asked "Is he here?" It was a very crowded waiting room, and I finally got up and I got laughed at by other people in the waiting room....I felt very unsafe at that point. (Staci, 27)

Patients who ask to be called a name that is not on their Manitoba Health Card have been told that it is not possible, or that the electronic medical record program makes it impossible to record any name other than their legal name. Staci's story again provides an illustration:

It started right from walking in. I was triaged under my old name, which is not my legal name anymore, but because it was still in their systems the change hadn't gone through. It was a very consistent process of "That's not my name. Don't call me that. I don't want to be called that name." But I was told again and again that "We can't change it. We're not allowed to. We have to call you that name." ...A few times they made efforts to write on top of a paper or remember, but a lot of the time it was forgotten. (Staci, 27)

Ultimately, these experiences and expectations of experiences created a situation whereby participants needed to mentally prepare themselves in order to ask for the medical care they required:

...knowing that this is going to become a barrier or hurdle and having to muster the courage to say, 'Okay, now let's put on your armour...Put on your security blanket and move on back out into the world so that you can address this and prepare to shield yourself. (Patrick, 36)

You know, even to get myself into that building, in that waiting room, checking off all these forms, took a year and a half of therapy. And just to build up the confidence to walk in there and ask for that, I've known, I've known that I've wanted that form in my hands, since, like, I can't remember when. But, getting the confidence to go and walk in and do that is an entirely different thing, to do something so life changing and not know the outcome. (Olivia, 41)

Thus, many participants described experiences of stigma when accessing, or attempting to access, health care. However, participants were also aware that, being in a small centre like Winnipeg with not a lot of expertise in trans health, they are in a position of having to take whatever care is offered to them. As Connor noted: "I guess that's what sums it up, as a trans person, you can't ask for better than the worst that is out there. You don't deserve better than what you get, you're lucky to have care at all. That's pretty much the way that you're treated." (Connor, 35)

Others feel like health care has changed for the better, as in Olivia's experience:

My experience in the medical health care system in this city has been amazing. And when I first saw this survey, I thought "I hope you don't get all these negatives from 30 odd people telling you just how crappy the system is and what needs to be fixed." Because it's not always, my experience hasn't been that way. And I think, and I hope that we can illustrate just how good we have it in this city too. And we have some remarkable people working within it and they need to be highlighted and celebrated.

In addition to discrimination in the health care setting itself, it is important to note that, as described in the literature, stigma and discrimination in other areas of life such as education or employment can have negative impacts on people's health (6). Unfortunately, in the current study, experiences of loss of employment or underemployment due to transition were not uncommon. Staci, 27, had left a job in her field of expertise briefly: "[A]nd when I tried to get

back in the field I found it somewhat difficult, given that I was visibly trans and that was an issue I was asked frequently about in interviews.” Jazmyn, 55, lost her job after coming out to her employer as trans, as at that time gender identity was not protected under Manitoba’s human rights code. Un- or under-employment make it harder to access the necessities of life, and mean that patients are unable to access some of what they need for their transition, such as electrolysis or hormones. While many participants did *not* lose their employment after coming out as trans, some described difficult work environments in which they experienced direct and indirect stigma. For example, Shane, 35, “passed” at work but still experienced discrimination indirectly through the comments of co-workers who did not realize his trans identity. Interestingly and importantly, Shane worked in a health care setting:

I haven’t seen any negative comments to patients who are trans. But I have been in a lunchroom where people were making negative comments about trans people in general, and had to really bite my tongue. I do think there’s a lot of education that needs to be done in work places because people just don’t get it. (Shane, 35)

Health Care Access

In the current study, and as is also reflected in the larger literature, participants described poor access to health care. In particular, participants described an inability to find physicians who would provide trans-specific treatment. For example, Sandra described her desperation for this aspect of trans medical treatment: “And like I said, if I don’t get [hormones] from one place, I’ll get it somewhere else, cause it’s that important to me.” When health care is made difficult to access it does not prevent patients from figuring out ways to get what they need, but it greatly decreases the safety of the treatment: “I had been buying [testosterone] anyway, off black market or whatever. A friend of mine had been helping me out. But it was very expensive. I couldn’t afford it.” (Connor, 35)

Providing transition care for those with gender dysphoria is now recognized to be medically necessary, rather than “cosmetic” or “elective” (13,37,38). When physicians refuse to provide transition care, for whatever reason, they are withholding critical medical treatment. This is an important distinction, as physicians, both in the literature and in the current study, may use their discomfort with and lack of knowledge of transition care as a reason to refuse to treat their patients, and in those patients’ eyes, transition is not optional but critical: “It’s a life changing, life saving surgery,” (Connor, 35); “It’s not just a life choice. This is serious. It’s about life or death, and that’s what it is.” (Jody, 52). In line with the literature, physicians in the current study did not deny trans-specific treatment due to outright transphobia, but would deny care based on a lack of knowledge and gaps in their education. As two physicians explained:

I’m not sure that anybody else can help me through those [issues], certainly not in an education format. You can’t educate me to change my views on things. But, the technical things [such as hormone prescription guidelines], I need somewhere where I can look for them. (Focus Group One)

For me there’s this fear that run of the mill problems aren’t run of the mill. What if there’s something related to something I’m not aware of, in terms of their hormonal status, in terms of the medications they’re taking?...I have a lot of anxiety seeing these people, not because of who they are, but because I feel I’m not well educated, I’m not well prepared about what the potential concerns are. (Focus Group Two)

Many participants noted that access to health care is complicated by the fact that some of the treatments necessary for successful social transition are not covered by the provincial medical systems, so that only patients with the financial means to pay out of pocket or otherwise

privately finance treatments are able to access them. These include hormones, removal of facial hair with electrolysis or laser treatments, breast augmentation, facial feminization surgeries, chest binders (used by many trans men prior to chest masculinization surgery), in addition to time off from working to recover from surgeries (even those that are paid for by provincial health care). This can leave some people in a limbo of having utilized all the provincially-covered services, yet still being unable to “pass”:

Manitoba right now only covers two types of surgery for trans women, and nothing else. And there's other things, for instance hair removal, because most trans women need to get their beards removed. And that's very expensive ... it's such a high financial barrier and a lot of my trans-feminine friends are under employed or unemployed or not able to even meet basic needs. (Staci, 27)

At times there have only been one or two surgeons in Manitoba who were willing to provide double mastectomy surgery (removal of breasts for trans men, that may or may not result in a male-looking chest), and if patients did not like their work or had bad experiences there was no recourse.

When I was going through my issues with [surgeon], who did my first surgery,...I went to the emergency room and was admitted five or six times...for infections. You get treated like crap because [surgeon] doesn't see people on weekends, or [they] couldn't get a hold of him....nobody wanted to do [surgeon's] work and work with his patients... [In Emergency] it was like, 'You're losing your nipple? Just cut it off and put it in the garbage can.' That's what the emergency room doctor said to me, which made me (for the first time in that experience) cry like a baby. Because I was like 'I'm completely alone here. Nobody in this building understands what I'm going through right now.' So leaving the province to get [chest-revision] surgery was what I needed to do. (Connor, 35)

Part of the issue is that the government of Manitoba in the past would only pay surgeons for a double mastectomy rather than chest masculinization surgery that reconstructs a visibly male chest. This changed in the summer of 2015, and it will be interesting to observe whether the increased funding will result in a greater number of surgeons who will provide this surgery. For those who are able to access money to travel for surgery, participants mentioned having very good experiences with surgery in the United States and Thailand by doctors who specialize in trans surgery. Olivia, for example, related:

[Surgeon] is one of the top three in the world who does this sort of thing. Thailand is a bit cheaper than the US. Their aftercare is very, very good, where in the US your hospital stay is over with as quick as possible...whereas in Thailand they have a team of support staff who visit you in your hotel room every day. And you get regular visits with the surgeon afterwards...I'm glad I picked him. He was brilliant. And I'm so happy with the work he did, and that couldn't have turned out better. (Olivia, 41)

Another health care access issue noted by most participants was the wait times associated with transitioning. Since December 2009, most patients who need to transition go on a wait list for Trans Health Clinic, often a wait of 6-10 months. Trans Health Clinic uses a team approach with a nurse, nurse-practitioner, social worker, medical assistant and physician. Guidelines for transitioning vary depending on the treatment the patient is pursuing. For hormone treatment, patients are required to have persistent, well-documented gender dysphoria, have capacity to make medical decisions, be over the age of majority (there are other standards of care for children and adolescents), and have medical and/or mental concerns

reasonably well controlled. For genital surgery the requirement includes living in a gender role congruent with their gender identity (39). A psychologist who specializes in working with transgender clients is contracted to see patients who desire surgery to establish their psychological readiness and give a second opinion to the physician on diagnosis of gender dysphoria. Patients, once approved, are eligible for surgery after they have been living full time in the gender they are transitioning to for a year. The wait for surgery will vary, and if a patient is going to have more than one surgery, they will usually have periods of waiting between.

These guidelines are in place in order to give time for patients to reflect on their decision to transition, to help ensure that the patient's choice is consistent over that time; and to provide a "cooling off" period for those who might change their mind or are not psychologically ready to take permanent steps to undergo transition. From a medico-legal point of view, such requirements as the year-long real-life experience make sense. For trans people, however, those requirements may range from a bother to an insurmountable obstacle. Caroline, 55, explains what the wait was like for her: "I understand the [wait] rationally. Emotionally, it's sort of like I waited 55 years for this. Make me wait any longer and it will never happen." This "real life test" can vary in achievability based on the patients' genetic endowment (for trans women examples might include large hands or feet or persistent facial hair; for trans men examples might include large busts that cannot be effectively disguised, or small stature).

Multiple participants also mentioned access issues in relation to mental health, and advocated for better access to free or low-cost counseling around issues involved with transition. There are some places in Winnipeg that people can access this (Rainbow Resource Centre, Klinik drop-in counseling, Trans Health Klinik) but the appointments are limited and may not cover what the patient requires. Specialized counseling by a psychologist who works with trans people frequently is available privately, but is very expensive. As part of the transition process, patients must meet with this psychologist for a psychological examination to allow them to proceed with provincially-covered surgery, but the focus of the visit is on evaluation rather than therapy. Cam, 29, explains his frustration with this set-up: "I didn't feel like there was any opportunity to actually discuss the social impact of transitioning, the mental impact, the legal, all of those things...they are just stuffed inside because no one understands and no one's actually equipped to deal with it."

In addition to care specific to transitioning, participants continuously noted that trans people also need access to health care that is not focused on transition but rather on the plethora of medical issues applicable to *any* body. These health concerns varied far more along age-related lines as with other populations of people. Younger participants (under 40) either had no health concerns, or mentioned preventative health care such as smoking cessation and physical fitness, and the accessibility of safe and private facilities for fitness and substance use treatment, as both are usually gender-segregated. For those over 40, concerns about cancer, heart disease, and other age-associated illnesses were higher, along with preventative health concerns. Two participants mentioned concerns about ways to manage fertility after transition, but for each of them the financial costs associated with banking sperm were too high to have done so prior to starting hormone treatments.

Just like any other population, then, trans people require quality health care that meets their age-specific needs that is delivered respectfully. In these cases, it is important to take it into account their trans-ness as one aspect of medical history. Connor, 35, noted: "But sometimes you get to the point where, 'Okay, I think I'm done with all that – my life isn't just about being trans anymore. And I want to access health care that will deal with other health care concerns.'" For such patients, while their transition history might no longer be the focus, the impact of

transition (both physically and mentally) should not be discounted, and physicians must be willing to explore that aspect of care as it may arise. As Evan, 42, said: “You can’t live with in congruency for forty years and then all of a sudden transition and be a hundred percent...healthy, right?”

Education of Health Care Providers

The lack of education during medical school on how to treat transgender patients has been well documented (20,40). Fortunately, the amount of training required to increase the comfort of medical students with providing transgender care is minimal: the addition of one lecture (not mandatory) and one small group session (mandatory) is enough to create physicians competent enough to effectively work with trans patients (14,41).

The physicians who attended focus groups for this study varied from having zero exposure to transgender education during their training to having a day of LGBT* education every year plus interest groups that allowed students to learn more and have greater exposure to LGBT medicine and patient care issues. When asked about the ideal timing of education around transition medicine, physicians had some varied ideas of ways to approach the content, but agreed that exposure early in training is positive:

[In residency] there is an inner city needle exchange-type rotation that we were all required to do. We learned a lot about trans health that way. Then I actually learned a lot from watching docs do things I would never repeat. (Focus Group Three)

The things that stick out in my mind were patients that I saw. So I personally would not want a lecture on those things. I would want training and opportunity to watch somebody do an assessment and then explain why it’s relevant to me, why I should know this. (Focus Group Three)

I think there is value to having one short trans health session in med one or med two, mainly to put it on people’s radars. It’s not that anybody’s going to be an expert in trans health after an hour, but the idea that there are people who need this service is a valuable seed to plant...It was not on my radar screen. It wasn’t that I was opposed to it. It wasn’t that I wasn’t open to it. It didn’t occur to me until I was in practice. (Focus Group Three)

There was also the suggestion that trans patients could be integrated into case-based learning so as not to over-emphasize an issue that effects a small portion of the population, but to normalize and include education on treating trans patients: “If it’s incorporated into studying... ‘This is what you do for someone who’s transgender,’ then it’s just part of what you learn.” (Focus Group Two)

Assumptions about patients

One of the key themes that emerged in physician focus groups was the number of assumptions physicians make about trans people, their health, and their lives. This is perhaps not surprising; for people who are comfortable with their assigned gender it can be difficult to understand the level of distress that living in an incongruous body presents. For example, one assumption made repeatedly in focus groups was that trans people might grow to regret their transition, as one physician stated when asked to name health issues for trans patients: “In some cases regret from what they’ve done. They want to get back to what they were.” (Focus Group One). Other physicians held the idea that trans people would be dealing with more emotional issues or mental health concerns than non-trans patients. As one physician articulated during the first focus group:

My discomfort has to do with my impression that patients with sexual identity issues, it's often tied with other mental health issues and those are difficult to separate. And so one of my big concerns was whether they would get all the way through this process and now be unhappy about something else. And that it would not have really addressed what their unhappiness about their lives was really about. (Focus Group One)

Another physician discussed how perhaps that gender dysphoria experienced by patients may be the result of severe trauma – trauma that in fact may not be resolved by transitioning:

Whenever there's that issue of, say, a natal female was raped, multiple times as a child, and now is identifying as a male then the question comes, "Well, are you doing this to escape any sort of identity as female, because of all of those horrible rapes that you've been through?" And then, people might question that was "Well, is this gender identity or is there sort of, [another issue]" and certainly we have some patients that have mega mental health issues where they may even identify as going back and forth actively. (Focus Group Three)

As these quotes illustrate, lack of physician knowledge can also lead to inaccurate assumptions about issues that transgender people face. One inaccurate assumption is just this; that patients who undergo transition medical care, from hormone therapy to surgery, are mentally unstable and thus may later regret their decision to undergo treatment and/or the results (16,42). In fact, regret over transition is in reality quite small, with a prevalence of 2-6% patient regret depending on the procedure (43-45). The more pressing issues are those of depression and anxiety, and depression (and suicide ideation) is a particular risk when people experience transphobia or are at the planning stage of a medical transition, but have not yet started (46).

Often participants described how physicians made assumptions about the risk levels that patients are willing to accept, or that physicians are willing to be responsible for, when considering hormone therapy. Sean, for example, noted:

I think there's an idea, often with doctors, that the meds they're prescribing are super, super dangerous compared to other medications...in general they're like 'oh, there's a higher risk of this and that.' And I'm like, 'okay, but you prescribe dozens of medications to people I work with every day that have way higher risks, and some of those people need way more supports to manage their daily life.' I'm a full time, employed, assertive patient and I should be able to have some say and be trusted to take care of myself in the right way. Right? (Sean, 39)

Multiple trans participants discussed the difficulties inherent in balancing the results from blood tests and patients' feelings about the hormone levels most beneficial to them. In general, patients had a higher risk tolerance than did their physicians in order to have the higher hormone levels they felt were most appropriate to their physical and mental health. This was especially pronounced with trans women who desired more estrogen and/or progesterone or more/different anti-androgen medications, some of whom had acquired extra doses using the internet in order to supplement their prescription doses. Many interviewees mentioned that they would have (or did) get hormones through the black market if they were denied prescriptions.

At times the lack of knowledge and assumptions made about transgender people can lead to health care providers or allied staff to ask insensitive questions of a patient to satisfy one's own curiosity or need to learn more:

When I was at the Health Sciences [Centre], I had two nurses ask me if I had gotten the surgery yet. And both of them were doing things: one was drawing blood, the other one was giving me medication. And I asked if it was relevant to my care, and they said no, they were just curious. And I told them that if they're asking questions about my medical history, I'm assuming that it's relevant to my care. And if it isn't relevant to my care they don't need to know it. With the imbalance of power that a medical provider has over me, and given that I was very tired and hungry and vulnerable in that situation, it felt very invasive. (Staci, 27)

Thus, while it is important to ask questions in order to provide quality care, there is a certain point at which these questions become intrusive. It is therefore the responsibility of health practitioners and various medical institutions, including universities, colleges and hospitals, to provide training that would preclude such questions from being asked unnecessarily.

Systemic Issues

Participant interviews show that some of the issues that arise for trans people are due to the medical system itself. Electronic Medical Records (EMR) are increasingly used in all medical settings, yet they can actually make sensitive health care more difficult to access for trans patients, as the ease of creating a commonly agreed upon practice for preferred name and/or pronoun depends on who you ask: "The electronic medical record will have a space for the patient's proper name. One of the things that could very easily be done is to have a name in brackets. And this does not only apply to transgender patients" (Focus Group One). "[Adding preferred names] can not be done within our EMR so easily, because you need another field," (Focus Group One). Patients' experiences of being "outed" to other patients may seem like minor mistakes to triage or front desk staff, but they can put the patient at risk for abuse by other patients in the waiting room (47), and even if a negative event does not happen, the patient's hypervigilance may lead them to experience strong discomfort or even avoid such situations in the future. Reception and other support staff can set the tone and make what could otherwise be a good experience into a negative one.

Situations that do not feel safe to patients may include waiting rooms where they worry they will be mis-gendered by staff or fellow patients, and a lack of privacy when asked to explain the discrepancy that may exist between their Manitoba Health Cards and current gender presentation. Jordan described:

The receptionist was looking at the computer screen and looking at me, back and forth. And then she said, "I don't mean to be rude here, but on your file it says Miss, and an F. Is that right?" And I was like "Um, legally, that's what it's supposed to be right now....But still refer to me as male." And then she said "But it says female and Miss here."...And I think she was trying hard not to be disrespectful, but [it felt] disrespectful. Everybody that was sitting there in the waiting room was overhearing this, and everybody perceived me as male. (Jordan, 24)

In my own personal experience in carrying out my clinical training at Klinik for this BScMed, I have become aware that some individual clinics have taken steps to use nickname fields or to capture preferred pronoun information in alternative ways, but even within those clinics the use of preferred names or pronouns has been inconsistent depending on who is staffing reception. As a staff person at Klinik recalls,

I think it's really important, especially at the front desk, to read the computer instead of people's health cards... We have a space where we put in chosen names, and it comes up differently. And sometimes people [still mis-name patients]. I don't think they're being callous, they're not being careful enough.

Ultimately efforts to improve the EMR to capture this data will require vendors being supplied with support and guidance in what systems need and how best to insert it (48). Even finding ways to ask directly, in a respectful manner, can be appreciated:

There was one time I went in [clinic] and it still had my birth name on the thing. And I was talking to the doctor and she's like, "Do you go by a different name?" She like, asked me that right out. And I thought that was kind of nice, cause she picked up on that instead of ignoring it. (Cory, 21)

Thus, in interviews and focus groups with trans people and physicians, the main gaps in health care delivery are: free or low cost trans-sensitive mental health care, physicians willing to start the transition process by diagnosing gender dysphoria and prescribing hormones, a consistent and well-understood way to record a patient's chosen name and gender pronoun in electronic medical charts, and further publically funding necessary procedures such as electrolysis and facial feminization surgeries. This begs the question: what can we, as health care providers and as a health care system, do to alleviate transphobia and fill gaps in service pertaining to transgender care?

Discussion, Recommendations, and Conclusion

Trans health care in Winnipeg has become more comprehensive and easily accessed since the last needs assessment carried out in 2006, due to greater access to expertise through Trans Health Clinic and GDAAY. In addition, since 2006 more services and protections are offered through the Manitoba government. This contributes to faster and easier access for transition care for trans Manitobans. Work is still needed, however, to decrease stigma and discrimination in order to better offer respectful and safe care to trans and gender non-conforming patients. Physicians across specialties must learn how to care for trans patients compassionately and with skill, regardless of whether the care required is transition-specific or not. Mental health care in particular is an area where greater resources, particularly trans-sensitive ones, need to be made available. More health research is needed in order to develop evidence-based practices in the care of trans patients.

As such, based on the results of this study, we offer the following recommendations which are of interest to physicians, physician educators, and policy makers. These recommendations are drawn from those themes most frequently referred to by patients in interviews and physicians in focus groups. We recommend:

1. Continued trans health information for medical students, residents and attending physicians. This includes expansion of education for medical students, and continuing education credits for physicians to help make it clear their responsibility to ensure their patients are provided with appropriate transition care, in a timely fashion. For undergraduate medical education, we recommend implementing one hour of non-mandatory trans education in lecture format followed by a mandatory small group discussion, with concurrent additions of trans-care into case-based learning. For established physicians, we recommend continuing education credits on topics such as starting hormone treatment and assessing gender dysphoria. These should be offered to both specialists and family practitioners.

2. That all clinical staff should have gender-sensitivity training regarding how most appropriately to be respectful to patients who may present in a gender non-conforming way.

In some places this training is focused on health care providers and reception staff particularly, but participants in this study have described how staff (such as security and phlebotomists) have also contributed to unsafe environments.

3. That physicians should reflect on how best to care for their trans patients, whether that means treating in consultation with guidelines or referring to someone with more experience.

Physicians must recognize that avoiding or delaying treatment of trans patients unnecessarily contributes to worse health outcomes, particularly suicide attempts (55% of those who were awaiting medical transition considered a suicide attempt during the past year (49)). While the fear of making a mistake and inappropriately providing treatment is certainly something that must inform one's practice, it should not be used as a reason to avoid treatment entirely. There are other conditions with a similar population frequency as gender dysphoria that physicians might not know much about, but would learn about in order to care for their patients. Gender dysphoria should be treated no differently. In addition to such research, physicians should know the following ethical and legal obligations for physicians providing treatment to transgender patients (50) made by the Canadian Medical Protective Association (CMPA), and reflect on how their own practices can implement these guidelines, which are: to respect patients' preferred names and pronouns; to refer patients if one feels that one lacks the skills and knowledge to provide good care; and to communicate sensitively with the patient and to treat him/her/them with dignity.

4. That screening for depression, anxiety and suicide ideation in trans patients should be done on a routine basis in medical appointments, with referrals to trans-friendly counseling and psychiatry as appropriate.

5. Greater accessibility of mental health services that are trans-aware and that do not cost patients out-of-pocket.

This is particularly important between the times that patients self-identify as trans and when they are able to access medical transition services, as this is a high-risk time for suicide attempts. This is also an important service throughout a patient's transition process so that patients may monitor, reflect upon, and integrate the effects of such a huge life change.

6. That further longitudinal research on the impacts of hormone therapy and removal of natal gonads to a patient's long-term health be conducted, and that results be integrated into treatment guidelines.

This could be undertaken at Trans Health Clinic and GDAAY through a chart review and continue forward over time and would be an immensely valuable addition to scholarly research on transgender health. Research on trans people is relatively non-existent due to humans being categorized as "male" or "female" within studies, rather than offering people the option to identify, in terms of sex, in other ways.

7. That patients be assigned numbers in offices with large patient volume, such as emergency departments, and that numbers be called rather than patients' names.

This has the advantage of increasing privacy and better fulfilling the personal health information act (PHIA) for all patients, which also incidentally helps increase dignity and personal safety for transgender people.

8. That fields be added on electronic medical records and forms for patient's preferred name and pronoun.

The mismatch of gender marker ("female" or "male" on official documentation) with a patient's gender identification may be reduced after the Manitoba government made a change so that trans people are not required to have surgery in order to qualify to make the change on their Manitoba Health card.

9. That Manitoba Health cover other necessary services allowing trans people to successfully transition, such as electrolysis for trans women and tracheal shaves for those with prominent Adam's apples.

In June 2015 the Manitoba government announced that they will now cover chest masculinization surgery for transmen, which is a positive step in improving care. However, other services such as electrolysis, which is extremely expensive and also ongoing over a long period of time, are not covered by the government. Such services may seem "cosmetic" but they in fact allow trans people to "pass" as their presenting gender. "Passing" as one's chosen gender is not only important to a person's mental health, but also reduces experiences of discrimination. As such, the fact that such services are not covered creates a health disparity that overlaps with another social determinant of health – income.

Though these recommendations may seem difficult to achieve, they are integral to providing an equitable future for trans people both in terms of their health and health care. Health equity is increasingly recognized as necessary in order to improve health and quality of life for people, and increasingly is recognized as the ideal to pursue within health care provision (51). Marginalized groups such as trans and gender non-conforming people have a greater disparity in health care than non-trans citizens. Thus, pursuing systemic improvements that benefit these populations make significant strides in improving health equity for all Manitobans.

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