Transgender inclusive and specific health care

Atticus Wolfe, MPH (c), University of Minnesota School of Public Health

Opinion Editorial
Published November 30, 2018

Introduction

The existence of transgender[1] people in the United States has been downplayed and underemphasized by major institutions, decreasing the visibility of gender variant experiences. As a result, health care that specifically addresses the needs of transgender people, like medical transition and gender therapy, are deprioritized. While this issue is pervasive across the US, it is most observed in diverse urban areas. Generalized health care that is required by all people regardless of cisgender or transgender identity is cisnormative[2], cissexist[3], and transphobic[4] and contributes to the subjugation and medicalization of transgender people. Lack of access to affordable, inclusive health care for transgender people is a human rights violation that requires additional study to determine both the extent of the damage inflicted as well as possible solutions to alleviate the disparity between cisgender and transgender people in health care. This article reviews Medicaid expansion as a means for state supported access to health care for transgender people.

Marginalized populations experience greater health risks as they are often barred from social services and discriminated against through institutional violence [1]. Transgender people face significant barriers to wellness through a prevalence of negative health factors such as increased rates of homelessness, joblessness, addiction, assault, HIV, and stigma [2]. Under the Trump/Pence administration, these issues are becoming increasingly peripheral as members of the Lesbian, Gay, Bisexual, Transgender, Queer-identifying (LGBT+) population are left out of political conversations, which has contributed to dialogue and political actions that dehumanize, objectify, and demonize the LGBT+ community. This is evidenced by the removal of the LGBT page on the White House website, the promise to appoint Supreme Court Justices who are likely to overturn marriage equality, support for state's rights to decide transgender bathroom policies instead of federal regulation, support of the First Amendment Act, and Pence's support of conversion therapy [3]. This is also evident in the Trump Administration's plan to roll back health care non-discrimination regulation through section 1557 of the Patient Protection and Affordable Care Act, which bans discrimination on the basis of race, color, national origin, sex, age, and disability for health programs that receive federal funding [4, 5]. Announced in 2017 and later repealed with the Title IX Supreme Court ruling, the military ban of transgender people as well as the continued push for LGBT+ exclusion through religious freedom acts is yet another way in which transgender people continue to be targeted by federal institutions. These elements contribute to the discussion on government reformation of transgender-inclusive and transgender-specific health care policies and inform care policies and practices for transgender people in the United States.

[1] Transgender is used as an umbrella term to describe all people who identify as a different gender than the one assigned to them at birth in partial or full capacity. This includes but is not limited to transgender, genderqueer, non-binary, gender nonconforming, transfem/trans-feminine, transmasc/transmasculine, two spirit, berdache, gender fluid, demi-gender, agender, polygender, bigender, pangender, transsexual, and trans* identifying people.

[2] Cisnormative refers to ideological or physical characteristics that assume the audience identifies as the binary gender they were assigned at birth.

[3] Cissexist refers to the nature of an interaction, institution, system, or ideal that is biased toward cisgender identities.

[4] Transphobic refers to the nature of an interaction, institution, system, or ideal that is oppressive towards transgender, gender queer, and non-binary people. This differs from cissexist in that it focuses more on the identities experiencing marginalization rather than the oppressors. Something that is transphobic is automatically cissexist

Social Determinants of Health

Poverty and economic stress

Because health care in the United States is cost-driven, health care for individuals is tied directly to their economic standing. For people of lower socioeconomic status, this means a lack of accessible health care is available for their consumption [6]. Since people who are transgender have a much higher chance of facing unemployment if they reveal their transgender identity, they face greater risk of experiencing poverty and food and housing insecurity [7, 8]. The National Transgender Discrimination Survey in 2015 (NTDS) demonstrated that one in six transgender respondents reported facing unemployment at a time in their lives, 13% reported losing a job because their transgender identity was made known to their employer [7]. Twenty-three percent of respondents reported facing other forms of mistreatment due to their identity in addition to the 15% who were verbally harassed, physically attacked, and/or sexually assaulted at work because of their gender identity [7]. Additionally, without insurance coverage from an employer, transgender people are more likely to be uninsured or face higher overall health care costs [9]. According to the report from the NTDS, 29% of transgender respondents reported living in poverty, compared to only 14% of the entire population of the United States [7]. A major component of this rate of poverty was the 15% unemployment rate, which is three times higher than the national average. One third of people did not see a doctor when they otherwise would have due to insufficient funds [7]. These statistics suggest that transgender people are facing greater barriers to health care due to lower socioeconomic status than cisgender people in the United States. Similar data are consistent in state and local surveys [10, 11].

Health insurance

In addition to increased economic stress, transgender people face barriers to obtaining insurance. Twenty-five percent of NTDS respondents experienced a problem related to their gender identity with their insurance company. Reported issues included the denial of coverage for medical transition (such as hormone therapy or gender reassignment surgery), denial of general coverage because they openly identify as transgender, and denial of routine services because they openly identify as transgender [7]. Furthermore, the majority of people who sought coverage for transition-related surgery and 25% of the people requesting coverage for hormone therapy were denied [7]. These data are consistent with results found in additional studies [8, 10, 12].

Housing

Health care is directly related to housing security. When people do not have access to adequate housing (housing free of environmental, psychological, and physical dangers), they are much more likely to experience health problems. These health problems can be psychological, such as stress, post-traumatic stress disorder, and depression, and physical, such as asthma, hypothermia and hyperthermia, and infections [13]. For transgender people, housing access is also limited [7, 14]. Transgender people face further barriers to housing if they are experiencing homelessness [7]. Twenty-three percent of respondents experienced some form of discrimination within the last year (2014-2015) in obtaining or maintaining housing, such as being evicted from their home or denied a house or apartment because of their transgender identity, according to the NTDS [7]. This danger is also reflected in the nature of many homeless shelters being anti-LGBT+ due to religious ties [15]. One third of respondents experienced homelessness at some point in their lives [7]. Seventy percent of respondents reported being harassed, sexually or physically assaulted, or being kicked out of homeless shelters as a result of their being transgender [7]. Sexual assault, abuse, and HIV also threaten an individual long after they are no longer experiencing homelessness. These data indicate that transgender people are more likely to experience the physical, emotional, and mental illnesses associated with housing insecurity [7, 8].

Physical, mental, and emotional wellness

Overall, transgender people are at greater risk for the denial of equal treatment that leads to health care concerns. Homelessness and poverty rates suggest higher rates of communicable and chronic illnesses [16]. Transgender people have a higher rate of HIV (1.4% in comparison to the general US population rate of 0.3%), experienced elevated rates of harassment and discrimination in schools (over 60% in K-12 classrooms and 24% in college or vocational school), and lower employment and housing rates than the rest of the US

population [7, 8]. These contribute to health concerns beyond what the current medical care system can address for transgender people.

Similar to physical wellness, emotional, psychological, and mental wellness are vital to each individual's health. Often overlooked, psychological support is one of the most vital components to an individual's biological, social, and emotional development [17]. Lacking a social safety network or proper emotional support from peers, guardians, and professionals is a significant threat to personal, intellectual, and psychological growth, especially during times of developmental stress, such as adolescence and puberty [18].

Mental health care is a challenge for transgender people. According to the NTDS, 39% of respondents experienced psychological distress within the month before completing the survey. Suicide is also a major concern, with 7% reporting attempting suicide in the last year, twelve times the national average [7]. Furthermore, 40% reported attempting suicide in their lifetime, compared to 4.6% of the general US population [7]. This indicates that there is a serious disconnect between the care needed to support transgender people and the care accessible to them now.

Discrimination in Health Care Settings

Transgender people are under-represented, under-treated, and mistreated in the medical care field. According to the NTDS, 25% of transgender people experienced refusal of care and 33% experienced harassment and violence in a medical setting [7]. These statistics are consistent with additional studies [14, 18]. Because trans-inclusive medicine is not taught to health care providers, many health care workers do not understand how to interact with or medically treat transgender people [19]. This translates into insensitivities that result in a distrust of medical care by transgender people. Without trust, the relationship between providers and patients is severely warped by stigma and discrimination [8, 14, 18, 20]. According to the NTDS in 2015, 50% of transgender patients found themselves explaining trans-inclusive medicine to their providers. For this reason, many providers reported finding transgender people difficult to treat and felt uncomfortable around them [7]. For rural gender nonconforming people, this issue is even more critical [21]. The lack of regulations for medical facilities as safe spaces for transgender patients has resulted in assault, abuse, outing, and denial of services for transgender people despite efforts to regulate medical care insufficiencies through non-transgender specific clinic guidelines [7]. As such, many transgender people feel uncomfortable seeking health care, increasing their risk for health-related complications [7]. Though there is evidence of the abuse of transgender people in clinical settings, theoretical approaches that fail to fully incorporate transgender voices or misrepresent their experiences by victimizing, victim-blaming, or stigmatizing genderqueer people are still dominant [18]. This is a form of transphobia in that it contributes to the mistreatment and medicalization of transgender people's bodies, rather than attempting to address the social issues inspiring cisnormativity [14].

The medicalization of transgender bodies in health care settings contributes to the dehumanization of transgender people and the disregard for transgender people's agency as patients requiring individualized care. Medicalization refers to the manner in which health care providers treat transgender patients as bodies without regard to their personal agency or needs [22]. The medicalization of the transgender individual manifests itself in gatekeeping strategies to prevent transgender people who desire medical transition (pre-operation) from transitioning, as well as the push for transgender people who do not desire to medically transition (no-operation) to undergo medical treatment. Pre-operation transgender people are required to submit to intense scrutiny of their personal identities and private lives to corroborate any desire for medical treatment including (but not limited to) gender therapy, HRT, and surgery [23]. Additionally, most physicians require preoperative patients to prove their identity by presenting and living as their gender for at least a year, which may include painful and expensive physical alterations such as chest binding, genital tucking, and prosthetic packing. Some physicians refuse to treat people who identify outside the binary and ascribe labels such as female-to-male and male-to-female regardless of whether or not the individual identifies with those outdated terms. The regulation of the medical transition process is unnecessary as there is no evidence to support it has any significant impact on the satisfaction of patients [12, 24]. On the contrary, there is strong evidence to suggest that these gatekeeping methods serve to humiliate, ostracize, and depress preoperative transgender people [7]. Furthermore, no-operation transgender people are often pushed to consider medical transition at the risk of having their transgender identity disregarded or

invalidated [12]. All transgender people deserve health care that suits their desires, not the desires of their health care provider [22].

Health Care for Transgender People

Health care for transgender people can be broken into two categories, transgender-inclusive and transgender-specific care. Transgender-inclusive care includes all health care any person needs as a result of existing in the United States, such as primary care, OBGYN, urologic care, reproductive options, hospitalization, and access to prescription drugs. Transgender-inclusive care recognizes the biomedical gender binary reinforced by many aspects of the US health care system and clinical institutions as violent toward transgender and cisgender people alike by forcing people to adhere to stigmatized gender binary identities and presentations which are based on misogynistic and hegemonic constructions. Transgender-specific care, on the other hand, seeks to address the aspects of care that transgender people need as a result of their gender identity. This care may include voice and communication therapy, hormone replacement therapy (HRT), transitional surgeries, and mental health support such as gender assessment, counseling, and psychotherapy [22]. Medical transition will differ for each individual based on how they experience their identity, but access to transgender-specific care allows for the possibility of procedures should the individual deem it necessary for their wellness.

Because health care is difficult to measure, index, and categorize, systemic inequities are often exacerbated [25, 26]. These limitations perpetuate the "silent loser problem" [26]. The silent loser problem refers to populations experiencing marginalization who may have their voices minimized or deprioritized due to their identity or circumstances. This specifically applies to transgender people who fear their identity endangers them if they are outed. For example, transgender people may risk losing their employment, housing, insurance, and social ties if their gender identity is revealed. This is more broadly applied to health care providers who are resistant to working with gender variant and LGBT+ populations and health care workers who may not understand how to treat transgender people in a health care setting. These situations result in misunderstandings, hostility, and interactions that reduce transgender people to their bodies in a process of medicalization [7, 8, 12, 14]. The professionalization of the health care system and workers also contributes to this phenomenon by devaluing patient voices and rushing to diagnose the body's condition rather than address the lifestyle and circumstances of the person as a whole.

Health care policy cements capitalistic controls into health care interactions through institutional procedure, training and education, and institutional resocialization. The tension between human rights and capitalism is most apparent in the medical setting as people often driven by altruism are forced into roles that perpetuate dehumanization through bodily control and binary assumptions. Interactions in health care settings are largely characterized by the spoken and unspoken agenda outside the patient's control. The setting, time frame, and process of diagnosis and treatment is driven by the attending health care worker. As such, the power dynamic between the patient and physician is influenced mainly by the training and expectations of the physician. The professionalization of physicians centers the power in the medical care provider, removing agency from the patient and reducing their autonomy. This process is a byproduct of the intentional move toward increasingly capitalistic social structures and the push for elitist population control [24, 27]. Deprofessionalization, on the other hand, describes the movement of power from the physician to the administrative system, reducing the role physicians play in providing and planning the path to patient wellness. Professionalization has remained a cultural factor evident in US society's positive regard for physicians and normative expectations of the compliant patient and contributes to patients feeling unheard and disregarded. This is especially evident when transgender people have a cisgender physician. The deprofessionalization of health care settings also harms transgender patients as it further distances the physician from the voice of the patient by prioritizing paperwork and bureaucratic methods. Both of these alienate transgender patients by medicalizing their bodies and ignoring their individual needs [17]. Based on this factor, the majority of cisgender physicians that interact with transgender patients reported that they are typically unable or unwilling to fully engage in interpersonal connection to facilitate the best care necessary [8].

Cultural Biases in Health Care Settings

Cultural misunderstanding and biases surrounding assigned gender at birth (AGAB), gender identity, and gender expression impede any discussion of transgender rights until they are accepted as distinguishable features of cisgender and transgender and/or gender nonconforming people, meaning that cisgender health care workers are likely to operate on overt as well as covert biases when dealing with transgender patients and fail to fully acknowledge their gender biases and preference for binary gender expression until US culture shifts to reject cisnormativity. The cultural bias against gender nonconforming and transgender people in health care plays a role in person-to-person care as well as medical records, care accommodations, and health care availability [7, 8, 18]. Reaching beyond interpersonal interaction, the control of health care as a state and federal matter widely affects the standard, type, and nature of health care regionally. This creates a multi-level discrepancy between the care cisgender and transgender people receive. Additionally, the affordability of health care and insurance is also a distributional matter determined by federal health care control [28, 29]. Policy makers play an integral role in the regulation of health care affordability and accessibility through administration and supervision, but often lack a basic understanding of transgender-inclusive and transgender-specific medical needs and nuances. Urban settings are often more accepting of people who push social standards, making them more likely to be receptive to transgender people or people outside the gender binary in their identity and/or expression [30]. However, health care policy is rarely determined by urban policy makers alone, as it is a collaboration between national insurance corporations, national professional organizations (such as the American Medical Association [AMA] and American Nursing Association [ANA]), as well as the tension between local and state sociocultural elements. Furthermore, informal social institutions are vital in determining the political climate and developments in a representative democracy [26]. Rather than measuring this as a separate component to trans-specific health care policy, this is operationalized as vetted political decisions.

Political Protection for Transgender Health Care

Health care for transgender people is managed by individual institutions and insurance companies [29]. Medicaid (Sect. 1557) and the Patient Protection and Affordable Care Act disallows for discrimination on the basis of gender, but is only applicable to certain states and is often subject to variations in implementation as well as monitoring [7]. State nondiscrimination laws are similar in that they vary significantly in their protection, application, and monitoring. Under federal and state laws, it is illegal for health care providers, insurance companies, and other health care institutional programs to discriminate against transgender people in most circumstances. Despite this, transgender people still face increased risk from the social determinants of health and structural, institutional, and interpersonal forms of discriminatory treatment. One of the most influential acts was the Patient Protection and Affordable Care Act (PPACA). Section 1557 of the PPACA stipulates the broadest standard for non-discrimination in health care settings. The protection of the Health Insurance Portability and Accountability Act (HIPAA) provides legal protection for transgender patient's privacy regarding their transition and gender identity. While being relatively unspecific to the particular needs of non-discriminatory practice, both the PPACA and HIPAA provide a baseline for the adoption of more progressive policies. This point is further explored through the implementation and evaluation of health care settings and procedures outlined in Medicaid regulations for patient decisions and familial relations (i.e., Medicaid interpretations from the Department of Health and Human Services [HHS]). These federal policies that regulate insurance coverage and care should grant a basic understanding of the methods undertaken by the US government to control access to care and can be related specifically to transgender-specific care guidelines. Finally, PPACA insurance policies themselves illuminate the coverage and care afforded to transgender individuals for transgender-specific care. With the adoption of the PPACA, institutions that have been grandfathered into the system are evaluated alongside the PPACA insurance options to measure the implementation of procedures, while accounting for medical inflation. Under the PPACA, certified LGBT+ friendly institutions must cover transgender treatment and are evaluated alongside non-certified institutions for a comparative analysis. The US Department of Health and Human Services (HHS) provides guidelines for health care discrimination policy based on the interpretation of the PPACA and what Section 1557 statute requires. Rather than creating a new anti-discrimination law, the HHS interprets this extant

regulation. According to the National Center for Transgender Equality (NCTE), "the regulations discuss many other aspects of Section 1557 [in addition to the inclusion of discrimination based on gender identity], including protections from discrimination on the basis of sex stereotyping, language assistance and disability access in health care settings, and equal treatment for pregnant individuals." [7]

Sociopolitical Prioritization

Inadequate policy ultimately results in the subjugation of transgender people in medical settings. It forces transgender people into situations of inadequate care, discomfort, and trauma [7, 31]. There is an accepted body of medical and legal outlines for the treatment of transgender people in medical settings [22], but the federal anti-discrimination laws do not appear to align with these frameworks [29]. Thus, this paper uses the work of Coleman et al (2012) which advocates for access to psychological and mental treatment for gender dysphoria, support for social changes and changes in gender expression, access to puberty blockers, access to HRT, access to surgery, access to reproductive health, and access to voice and communication therapy. This work, *Standards of Care for the Health of Transexual, Transgender, and Gender-Nonconforming People*, acts as the basic health care standards endorsed by the World Professional Association for Transgender Health.

By failing to properly represent transgender people in representative democratic government, the health of the transgender population is under-prioritized and misunderstood. Transgender people are distributed throughout the United States and, because they have a higher likelihood of experiencing poverty, are less likely to be politically active than cisgender people [26]. This means that political representatives are less likely to prioritize transgender rights and transgender-inclusive health care, translating into a lack of perceived importance for the wellbeing of transgender people and of the urgency in which action is required to care for the reported one million transgender people in the United States [26].

Further Research

Further research is needed in numerous areas regarding the existence and experiences of transgender people in the United States as well as other parts of the world. There is a dire need for research as to the experiences and expectations of gender divergent people in health care settings, not only to push for more specific and inclusive care policies, but also to better the fields of medical anthropology, sociology, biology, and biochemistry. According to the American College of Physicians, the LGBTQ population needs more research that supports their specific needs in medical settings, including expanding our understanding of how physicians treat this population, the social and environmental stressors that are specific to this group, and the intersections of other identity factors such as race, AGAB, and socioeconomic status [32]. Studies should attempt to provide holistic and intersectional understandings of transgender identities and experiences to avoid further stigmatizing and medicalizing this population.

In a systematic review to assess the quantity, type, and focus of extant studies on transgender health and wellness, 1,304 eligible records were found and 41 of these discussed transgender primary or preventative care, a much lower percentage than other minority groups. The majority of studies evaluated HIV rates and risk behaviors. A minority of other articles discussed pelvic examinations, tobacco use, insurance coverage, and cholesterol screenings (specifically related to HRT). This points to a lack of studies that address the experiences of people who identify outside the binary, transgender people of color (outside of transgender women/femme of color who are engaged in sex work), and transgender people living in rural areas [33]. Centering cisnormative versions of patient experiences decreases the benefice inherent in diversity and narrows the possibilities for future success of all people, cis and trans alike. Public health researchers should be continually mindful of the ingroups and outgroups created through binary, cisnormative language as well as the academic, professional, and personal environments cisnormative viewpoints perpetuate. As a field, public health should strive for inclusivity, not just diversity, and work to incorporate transgender individuals, communities, and leaders in their work. Furthermore, it is vital that public health actively and openly advocate for transgender people to represent themselves in research, community outreach, projects, presentations, and boards. This is especially true for transgender people of color as they are most likely to experience marginalization and disempowerment.

Author Contact Information

Atticus Wolfe: wolfe532@umn.edu

References

[1] Whitehead, M. (1991). The concepts and principles of equity and health. *Health Promotion International 6*(3), 217-228.

[2] Blondeel, K., Say, L., Chou, D., Toskin, I., Khosla, R., Scolaro, E., & Temmerman, M. (2016). Evidence and knowledge gaps on the disease burden in sexual and gender minorities: A review of systematic reviews. *International journal for equity in health 15*(1), 16.

[3] Schlittler, R. L., Grey, M. J., & Popanz, T. (2017). LGBT health and LGBT psychology: Emerging policy issues. *LGBT Psychology and Mental Health: Emerging Research and Advances 217*.

[4] Oberlander, J., (2017). The end of Obamacare. *New England Journal of Medicine 376*(1), pp.1-3.

[5] Blas, E., & Kurup, A. S. (2010). *Equity, social determinants and public health programmes.* World Health Organization. Retrieved from https://books.google.com/books?hl=en&lr=&id=7JxutqCmctUC&oi=fnd&pg=PP2&dq=Blas,+E.,+%26+Kurup,+A.+S.+2010.+Equity,+Social+Determinants+and+Public+Health+Programmes.+World+Health+Organization&ots=XETwuor8Di&sig=AwMZSXmU5OojibsZvD9CdkzgV04#v=onepage&q=Blas%2C%20E.%2C%20%26%20Kurup%2C%20A.%20S.%202010.%20Equity%2C%20Social%20Determinants%20and%20Public%20Health%20Programmes.%20World%20Health%20Organization&f=false

[6] Grant, J. M., et al. (2015). *A report of the National Transgender Discrimination Survey.* National Center for Transgender Equality. Retrieved from http://www.transequality.org/issues/resources/national-transgender-discrimination-survey-full-report

[7] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. A. (2016). *Executive summary of the report of the 2015 US Transgender Survey.* Washington, DC: National Center for Transgender Equality.

[8] Roberts, T. K., & Fantz, C. R. (2014). Barriers to quality health care for the transgender population. *Clinical Biochemistry 47*(10), 983-987.

[9] Lerner, J. E., & Robles, G. (2017). Perceived barriers and facilitators to health care utilization in the United States for transgender people: A review of recent literature. *Journal of Health Care for the Poor and Underserved 28*(1), 127-152.

[10] Meyer, I. H., Brown, T. N., Herman, J. L., Reisner, S. L., & Bockting, W. O. (2017). Demographic characteristics and health status of transgender adults in select US regions: Behavioral Risk Factor Surveillance System, 2014. *American journal of public health 107*(4), 582-589.

[11] Feldman, Jamie, George R. Brown, Madeline B. Deutsch, Wylie Hembree, Walter Meyer, Heino FL Meyer-Bahlburg, Vin Tangpricha, Guy T'Sjoen, and Joshua D. Safer. (2016). Priorities for transgender medical and health care research. *Current Opinion in Endocrinology, Diabetes, and Obesity 23*(2).

[12] Butcher, J. N., Mineka, S., & Hooley, J. M. (2017). Abnormal psychology. *Pearson Education India.*

[13] Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2002). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality 42*(1), 89-101.

[14] Durso, L. E., & Gates, G. J. (2012). *Serving our youth: Findings from a national survey of services providers working with lesbian, gay, bisexual and transgender youth who are homeless or at risk of becoming homeless.* Los Angeles: The Williams Institute with True Colors Fund and The Palette Fund.

[15] McMahon, J., Wanke, C., Terrin, N., Skinner, S., & Knox, T. (2011). Poverty, hunger, education, and residential status impact survival in HIV. *AIDS and Behavior 15*(7), 1503-1511.

[16] Cockerham, W. C. (2014). *Medical sociology.* John Wiley & Sons, Ltd.

[17] Gurung, R. A. (2013). *Health psychology: A cultural approach.* Cengage Learning.

[18] Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine 84,* 22-29.

[19] Kelley, L., Chou, C. L., Dibble, S. L., & Robertson, P. A. (2008). A critical intervention in lesbian, gay, bisexual, and transgender health: Knowledge and attitude outcomes among second-year medical students. *Teaching and Learning in Medicine 20(*3), 248-253.

[20] Bell, R. A., Kravitz, R. L., Thom, D., Krupat, E., & Azari, R. (2002). Unmet expectations for care and the patient−physician relationship. *Journal of General Internal Medicine 17*(11), 817-824.

[21] Willging, C. E., Salvador, M., & Kano, M. (2006). Brief reports: Unequal treatment: Mental health care for sexual and gender minority groups in a rural state. *Psychiatric Services 57*(6), 867-870.

[22] Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., … & Monstrey, S. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. International *Journal of Transgenderism 13*(4), 165-232.

[23] Vipond, E. (2015). Resisting transnormativity: Challenging the medicalization and regulation of trans bodies. *Theory in Action 8*(2), 21.

[24] Gridley, S. J., Crouch, J. M., Evans, Y., Eng, W., Antoon, E., Lyapustina, M., ... & McCarty, C. (2016). Youth and caregiver

perspectives on barriers to gender-affirming health care for transgender youth. *Journal of Adolescent Health 59*(3), 254-261.

[25] Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality." *Social Science & Medicine 103*, 126-133.

[26] Weimer, D. L., & Vining, A. R. (2011). *Policy analysis: Concepts and practice.* Routledge.

[27] Weimer, D. L., & Vining, A. R. (2016). *Policy analysis: Concepts and practice.* Routledge.

[28] Khan, L. (2011). Transgender health at the crossroads: Legal norms, insurance markets, and the threat of health care reform. *Yale Journal of Health Policy Law & Ethics 11*, 375.

[29] Stroumsa, D. (2014). The state of transgender health care: Policy, law, and medical frameworks. *American Journal of Public Health 104*(3), e31-e38.

[30] Wilson, Thomas C. (1985). Urbanism and tolerance: A test of some hypotheses drawn from Wirth and Stouffer. *American Sociological Review*, 117-123.

[31] Northridge, Mary E. (2001). Why lesbian, gay, bisexual, and transgender public health? *American Journal of Public Health 91*(6), 856-859.

[32] Daniel, H., & Butkus, R. (2015). Lesbian, gay, bisexual, and transgender health disparities: executive summary of a policy position paper from the American College of Physicians. *Annals of Internal Medicine 163*(2), 135-137.

[33] Edmiston, E. K., Donald, C. A., Sattler, A. R., Peebles, J. K., Ehrenfeld, J. M., & Eckstrand, K. L. (2016). Opportunities and gaps in primary care preventative health services for transgender patients: A systematic review. *Transgender health 1*(1), 216-230.