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Inclusive Health Care Practices for People of Transgender and Gender Diverse Experience

Marissa McLellan

OT 615 Occupations Across the Lifespan

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Reflection

My journey on this project started when I realized my discomfort working with transgender and gender diverse (TGD) populations. I felt embarrassed because of my unfamiliarity with the language of gender diversity; this embarrassment had led me to avoid interactions with people who identify as TGD. I started to recognize my cisgender privilege and knew that this project would be a great way to increase my knowledge and cultivate personal growth. My goal was to create a brochure to educate health care providers on how to create an inclusive environment for people who identify as TGD. I decided to do this by finding at least 10 examples of health care disparities or barriers to health care experienced by TGD people and identifying specific ways individual health care providers can combat these issues. I chose this goal to help identify my subconscious and conscious biases and work to educate myself and change them. I wanted to learn about experiences of TGD people, learn appropriate language around gender diversity, become an ally, and learn skills to make me a better health care professional.

My ideas changed from my original proposal as the project developed. Originally, I planned to focus on inclusivity in intake forms and the physical environments of health care clinics, but as I dove deeper other areas of importance arose. During an interview with a local transgender man, I learned that although gender inclusive intake forms are important, they do not mean anything if health care staff are creating a hostile environment. I decided to delve deeper into other ways to improve health care for people who identify as TGD. I also decided that it was important for me to discuss my project with my family. We had several great conversations and I was able to share all of the new information I was learning with them.

My initial knowledge of the TGD community was extremely limited, so I began my project with some entry-level research. As I crafted my project proposal, I found resources to help increase my basic vocabulary and knowledge of the lived experiences of TGD populations. I started by reading *He/She/They/Us*, a small book on vocabulary and basic concepts within the TGD community, and by watching Jackson Bird's Ted Talk on interacting with transgender people (Bird, 2017; Soukup, 2019). Next, I read *The Remedy: Queer and Trans Voices on Health and Health Care*, an anthology of queer and transgender people's stories around their personal health care experiences (Sharman, 2016). I visited University of Puget Sound's Center for Intercultural and Civic Engagement and reviewed their resources for transgender students (Resources for Transgender Students, 2019). I started to feel more comfortable with the language of gender diversity and began to dive a little deeper. I watched Katie Couric's documentary *Gender Revolution*, which looked at several personal stories, academic studies, and the language of gender diversity (World of Wonder Productions & Couric, 2017). I also watched *The Death and Life of Marsha P. Johnson*, a documentary highlighting the invisibility of transgender people and their struggles with homelessness, violence, and discrimination within American culture (Teodosio, Reed, Tomchin & France, 2017). I then spent some time listening to podcasts about TGD people's experiences of discrimination in health care and how to change things for the better.

When I was feeling more competent discussing health care experiences of TGD people, I set up interviews with two people of trans experience to ask them about their personal experiences with the healthcare system. These personal stories helped me understand what it is like to be TGD in a system that refuses to acknowledge your existence. After reviewing personal stories from TGD people, I went into research mode. I sought out statistics and peer-reviewed

articles on TGD people's health care experiences until I felt like I had a well-rounded picture of TGD experiences in health care. I found limited research on how to reduce discrimination, but what I did find helped me brainstorm ways to create inclusive practices within the healthcare system. I concluded this project by collecting what I learned about the barriers to health care faced by TGD people and creating a brochure for health care providers with some of my most important findings. Because of the extreme invisibility of the TGD community until recently, even finding photos to include in the brochure was an exercise in intentional inclusivity. I read a *New York Times* article on transgender representation in stock photography, and worked to locate diverse photos of TGD people so I would not fall into the trap of perpetuating a lack of media representation.

I have learned so much about the barriers to health care faced by TGD people, and the disparities TGD people must deal when accessing the healthcare system. In all, I have completed 56 hours and 15 minutes of effort for this project. At the end of this project, I feel confident in my ability to interact with people of TGD experience, and know that my personal growth will help me on the road to becoming a sociocultural competent health care practitioner. I no longer have feelings of embarrassment and not knowing what to say. I have concrete ways I can help the TGD community receive the quality health care that all humans deserve. The remainder of this paper is a summary of some of the most compelling information I have learned throughout this experience.

Barriers to Health Care and Health Care Disparities Faced by TGD People

People of TGD experience deal with systemic discrimination in almost all aspects of life; the extent of these disparities both contribute to a great need for quality health care, and perpetuate discrimination within the healthcare system. Almost one third of TGD people are

living in poverty, compared to 12% of the U.S. population, and 33% of people who responded to the U.S. Transgender Survey reported that they did not seek out health care when they needed it because of financial reasons (James et al., 2016a). TGD people are three times more likely to be unemployed, affecting their access to health insurance, and 13% reported losing a job because of their gender identity at some point in their life (James et al., 2016a). Twenty three percent of people who identify as TGD have experienced housing discrimination, which contributes to almost one third of TGD people experiencing homelessness during their lives (James et al., 2016a). Violence and harassment is pervasive within the TGD community; 46% of TGD people reported verbal harassment, 9% physical harassment, and 10% sexual assault within the last 12 months (James et al., 2016a). In their lifetimes, 47% of TGD people experience sexual assault, and 40% attempt suicide; the attempted suicide rate is nine times higher within TGD communities than in the general population (James et al., 2016a). Within the month prior to the survey, 39% of people who identify as TGD experienced serious psychological distress, compared to only 5% of the U.S. population (James et al., 2016a). Examining these statistics shows the dire need for quality health care within TGD people's lives.

In spite of the need for quality health care, many TGD people feel required to do extra research to find a gender affirming doctor. A common theme among personal health care stories of TGD people is the difficulty of finding a health care professional who is local, within the parameters set by insurance, and nondiscriminatory towards TGD people (Sharman, 2016). Finding local health care providers can be challenging, and many TGD patients travel long distances for basic health care (Fenway Health, 2019). The extra steps required to find competent care as a person of TGD experience, combined with a variety of other reasons, lead TGD people to avoid health care all together.

Twenty six percent of TGD people said they rarely or never felt comfortable seeking out health care, and only 12.6% reported always feeling comfortable (Harless, Nanney, Johnson, Polaski, & Beach-Ferrara, 2019). Transgender people are much more likely to postpone medical care than cisgender people (Sharman, 2016). A key reason TGD people avoid health care settings is fear of mistreatment; 23% reported this fear in the past year, and this apprehension is justified (James et al., 2016a). Over half of TGD people expected to receive discriminatory care, and 33% of TGD people who have seen a health care provider have had at least one negative experience related to their gender identity (James et al., 2016a; Lambda Legal, 2010). This rate is higher among TGD people of color and TGD people with disabilities (James et al., 2016a). Erica, a transgender woman with experience in the healthcare system, said negative experiences of being treated like a different species have shaped her ideas of medical care (Shonkwiler & Israel, 2019). One way these negative experiences play out is through compounding microaggressions.

According to Foglia and Fredriksen-Goldsen (2014), microaggressions are “brief, daily assaults on minority individuals, which can be social or environmental, as well as intentional or unintentional” (p. 42). Examples of common microaggressions in health care settings include assuming someone is cisgender and asking questions accordingly, having demographic forms that ignore nonbinary gender identities, ignoring or dismissing TGD people, not having gender neutral restrooms and waiting rooms available, and comparing TGD people’s life experiences to cisgender people’s life experiences (Foglia & Fredriksen-Goldsen, 2014; Sharman, 2016). Another common microaggression faced by TGD people is dead naming (Soukup, 2019). Some transgender people chose to change their name to better represent and affirm their gender, cutting ties with their old name. Using a transgender person’s old name “is called dead naming and is often used as a way to show disrespect and lack of acceptance of transgender and gender diverse

people” (Soukup, 2019, p.12). Dead naming and using pronouns that are not preferred by the individual are microaggressions, and can add stress to health care interactions where many forms of identification are required.

According to the Southern LGBTQ Health Survey, “some of the barriers that LGBTQ people face are related primarily to a lack of knowledge and training among health care providers and their clinical and administrative staff” (Harless et al., 2019, p. 9). Implicit and explicit biases among health care staff, can contribute to negative experiences of TGD people. Kristen L. Eckstrand said “whether implicit or explicit, bias and discrimination perpetuate shame and stigma in the clinical environment and can be (re)traumatizing- particularly for populations that experience higher levels of stress, adversity, and health disparities” (Sharman, 2016, p.64) such as TGD people of color. These biases in the healthcare system have led to nearly half of TGD people feeling uncomfortable discussing their health issues with their family doctors (Bauer, Zong, Scheim, Hammond, & Thind, 2015). It is critical to train all health care staff, including clerical staff, on how to avoid microaggressions in health care settings (Fenway Health, 2019). Diversity training is key to providing inclusive environments for TGD people, but health care providers should go a step further and seek out education on common TGD health issues.

Another theme within personal health care stories of TGD people is the need for TGD people to educate their health care providers in order to receive the care they need. Harless et al. (2019) found that a “lack of LGBTQ-specific training for health professional students remains a real gap” (p.10). The average medical school teaching curriculum in the U.S. and Canada only dedicates 5 hours to LGBT content; this is an increase from 1998 when the average was 2.5 hours, but is still far too little (Obedin-Maliver et al., 2011). This gap in education leads many

TGD people to seek out information about their health on their own, and educate their providers. A study in Australia done by Dr. Ada Chung found that 50% of TGD people find most of their health information online, and the most common website used to do this was reddit (Joy 94.9, 2019). Sinclair Sexsmith commented on this troubling pattern saying “I don’t love the idea of crowdsourcing my own health and wellness, getting solutions to medical problems on Tumblr, but with a body that’s an unknown in the medial system, what else was I supposed to do?” (Sharman, 2016, p. 76). This need to crowdsource information stems from the lack of TGD inclusivity in research studies. The long-term health effects of the hormone therapy, that many transgender people participate in, are unknown (Joy 94.9, 2019). There is a lack of research, and of equity in research funding when it comes to TGD health care research (Shonkwiler & Israel, 2019). Even if people of TGD experience are able to navigate the complex health care system and find competent practitioners who are willing to work with them, insurance coverage dictates what practitioners are seen and what services are provided, if any.

Compared to cisgender people, transgender people are more likely to be uninsured (Sharman, 2016). The U.S. Transgender Survey found that 25% of insured respondents had experienced a problem with their insurance related to their gender identity in the past year (James et al., 2016). The Southern LGBTQ Health Survey found that 14.2% of respondents were uninsured, 34.1% had insurance through their employer, 6.6% through the government marketplace, 5.7% used Medicaid and 6.6% Medicare, and only 3.4% had private insurance coverage (Harless et al., 2019). Even with insurance, health care is inaccessible and a lot of care is excluded, especially TGD specific care (Fenway Health, 2019). Fifty five percent of people seeking coverage of transition-related surgery and 25% of those seeking hormone therapy coverage in the last year were denied (James et al., 2016a). These statistics are from people who

have successfully navigated the healthcare system to reach the point of requesting gender affirming therapies and surgeries, but 27% of TGD people are denied care outright by health care providers because of their gender identity; this number increases significantly for TGD people of color (Lambda Legal, 2010; Sharman, 2016).

When dealing with intersections of identity and discrimination, people of TGD experience who are also people of color, people with disabilities, or people living with HIV have compounding biases to deal with. While TGD people are two times more likely to live in poverty than the general population, TGD people of color were more than three times as likely to experience poverty (James et al., 2016a). Forty three percent of TGD Latinx people live in poverty, along with 41% of American Indian TGD people, 40% of multi racial TGD people, and 38% of Black TGD people (James et al., 2016a). Dr. Ada Cheung has found higher rates of autism spectrum disorder and attention deficit hyperactivity disorder among TGD populations (Joy 94.9, 2019). TGD people with disabilities experience much higher levels of economic instability compared to the U.S. population, with 24% being unemployed, and 45% in poverty (James et al., 2016a). Rates of HIV among TGD people are nearly five times higher than that of the U.S. population (James et al., 2016a). The highest instances of HIV occur among transgender women at a rate of 3.4%, and Black transgender women at a shocking rate of 19% (James et al., 2016a). It is essential that health care practitioners educate themselves on the health care disparities and barriers to health care faced by TGD people, and understand how intersections of identities can lead to increased stigmatization. Only when all health care practitioners are educated on these staggering statistics, will there be any change in the healthcare system as a whole. In the mean time, individuals working within the healthcare system can strive to make a difference in the lives of their TGD clients.

Supports to TGD Health Care and Suggestions for Health Care Practitioners

Some of the easiest changes that can be made to support TGD clients in health care settings are changes to the physical environment. Changing intake forms, desegregating waiting rooms, and creating policies that are beneficial to all patients is critical to fostering a welcoming environment for people who identify as TGD. The first aspect of the physical environment that most patients interact with is an intake form, a document that collects demographic information about clients prior to seeing their health care provider. It is important to include a variety of gender options to choose from to avoid alienating TGD clients. According to Soukup (2019), “gender diversity is broad and definitions are constantly becoming more inclusive with new articulated identities being defined all the time” (p.16). She goes on to say a good way to glimpse the variety of gender identity options is to look at the list of options available to Tumblr users (Soukup, 2019). Tumblr is an online platform used by many people all over the world, and it has an extensive list of gender identities for its users to choose from (Gender Master List, 2019). Typically there is not room on intake forms for this long list of choices, so it is important to include an option to write in a term (Goldhammer, Malina & Keuroghlian, 2018). It is also important to include an option to not disclose gender (Goldhammer et al., 2018). Intake forms not only collect demographic information, but also client insurance information.

Health care facilities should incorporate an area for preferred names and pronouns, and an additional area for information on insurance and identification cards. Goldhammer et al. (2018) says “by collecting information from patients on names, gender identity, and pronouns, this registration form signals to patients of diverse gender identities that health center’s staff will make an effort to address patients in accordance to their wishes” (p. 560). Thirty two percent of TGD respondents to the U.S. Transgender Survey reported verbal harassment, denial of benefits

or service, being asked to leave, or assault when presenting identification that did not match their gender presentation (James et al., 2016a). Having an additional area for legal names for insurance purposes ensures that the client feels respected and safe, and that clerical staff will have the information they need for billing and documentation (Goldhammer et al., 2018). Any paperwork required from health care providers such as “forms, questionnaires, and other written materials should be sensitive to and inclusive of LGBT people and their families and communicate the institution’s commitment to providing an environment that meets the needs of all patients” (Lambda Legal, 2010, p.14). Making these changes to documents will provide a welcoming environment to everyone.

Other aspects of health care environments that should be gender inclusive include waiting rooms, restrooms, available reading, and rules for patient support systems. Kara Sievewright discussed her partner’s journey with breast cancer as a transgender man (Sharman, 2016). He was routinely asked by staff to wait in the hallway instead of the waiting room because their waiting room was for women only (Sharman, 2016). Gender-neutral waiting rooms should always be available to those who wish to use them. Having an accessible gender-neutral restroom should also be a priority in health care facilities. More than half of TGD people have avoided using a public restroom in the past year because fear of potential confrontations, and 8% reported having a urinary tract infection, kidney infection, or kidney issues because of avoiding restrooms (James et al., 2016a). Making sure that pamphlets on LGBTQ and TGD health are available and accessible in waiting rooms signals that providers at that facility have access to pertinent health information for these populations. Finally, making sure that policies around who can accompany the client during appointments and who can visit the client in inpatient settings

are inclusive of all genders and support systems is important. These policies benefit not only people of TGD experience, but all people who visit the health care facility.

Arguably the most important aspect of providing quality care for people who identify as TGD is staff training. Lambda Legal (2010) argued that “institutions should provide initial trainings as a part of orientation for new staff and require ongoing education for all staff” (p. 14). They say these trainings should cover the history of stigmatization faced by TGD populations, barriers to health care, and cultural competence education (Lambda Legal, 2010). It is also important to include training around conscious and unconscious biases for all health care staff. Foglia and Fredriksen-Goldsen (2014) explain that “we are all prone to nonconscious bias by virtue of a lifetime of exposure to social and cultural attitudes about, among other things, age, gender, race, ethnicity, sexual orientation, and gender identity” (p. 42). They go on discuss evidence that unconscious bias is present even when people believe they have good intentions and low levels of prejudice (Foglia & Fredriksen-Goldsen, 2014). This shows the importance of training all staff, even those who are accepting of TGD populations, to recognize and eliminate unconscious bias toward minoritized populations.

Staff training should also include a discussion of appropriate language to use with all clients to make a more inclusive health care climate. Goldhammer et al. (2018), explains, “it is impossible to know someone’s gender identity or pronouns just by hearing their voice or looking at them” (p.560) so it is important to practice avoiding gendered terminology, especially when dealing with new patients. For example, using greetings like “hello, ma’am/sir” assumes the client has a binary gender identity, while using gender neutral greetings like “hello, how may I help you today?” is more appropriate and avoids the possibility of a microaggression. Another act of best practice is to assume the information clients tell you is true; many anecdotal stories

from TGD people include being questioned by administrative staff because their gender expression may not match the gender markers on their documents (Sharman, 2016). Instead of questioning the client, administrative staff should politely step away and privately discuss questions with a staff member who is more familiar with the patient. Another strategy is holding a brief staff meeting in the mornings to review clients who are expected at the facility that day. All of these strategies should be used both with clients in person, and over the phone. Lambda Legal (2010) explains, “when fully implemented, cultural competency can reduce the systemic health care discrimination experienced by LGBT people” (p. 14).

Some other aspects of cultural competency when working with TGD people is the use of preferred names, pronouns, and anatomical terms, asking questions rather than assuming information, and apologizing when mistakes are made. Providing space for clients to document their preferred names and pronouns on intake forms is the first step, but actually using them in practice is vital. If you are still unsure how to address a TGD client, ask them politely and directly. Goldhammer et al. (2018) says best practice includes avoiding assumptions, asking for names and pronouns, and then using client’s preferred terms consistently during all interactions. Beyond just names and pronouns, it is also important to use gender-neutral anatomical terms with clients. For example, instead of saying “breast tissue,” which assumes your client has a female gender identity, say “chest tissue” which is more gender neutral (Goldhammer et al., 2018). During the appointment clinicians can ask clients “what terms they use for different parts of their anatomy, and then mirror those terms” (Goldhammer et al., 2018, p. 561). Of course, mistakes are inevitable, but “most patients are understanding and show appreciation for the clinician’s commitment to learning and practicing new terms and pronouns” (Goldhammer et al., 2018, p. 561). When mistakes happen, make sure to acknowledge them without making it a huge

deal, apologize respectfully, and take steps not to make the mistake again (Goldhammer et al., 2018). Adopting these practices with all clients, not just those with TGD identities, fosters an inclusive and client centered environment.

Because 24% of TGD clients report having to educate their health care providers on how best to treat them, it is very important for health care practitioners to take responsibility for educating themselves on TGD health issues (James et al., 2016b). Sean Safia Wall, a Black intersex man described how “in the beginning of my transition, doctors would often tell me, ‘I read a chapter on intersex conditions back in medical school’ or, ‘we don’t know how to work with people like you’ or flat out ‘ your body is too weird’” (Sharman, 2016, p. 42-43). Instead of responding like these health care providers, researching on your own and working with your client to develop a care plan that meets their needs is best practice. TGD clients must work within the healthcare system if they choose to medically transition. Medical staff should recognize their gatekeeping role and use their privilege to help clients progress in their transitions.

Some ways to expand your knowledge on TDG health is to stay up to date on current research and goings on in TGD communities. Familiarity with online forums for TGD health such as trans-health.com can help providers have the latest information on new studies in this area (Trans Health, 2019). Research on TGD population’s specific health concerns is very limited, and people with TGD identities are routinely left out of research studies. Another way to improve health care for TDG clients is to be intentional about including diverse populations in all health care research. Take time to learn about local LGBTQ organizations, and involve yourself in advocating for TGD health care rights. Lambda Legal (2010) calls health care professionals to “advocate for improved laws and policies” (p.7) around TGD health care

disparities and education standards for health care professionals. Health care practitioners can also familiarize themselves with programs that are making a difference in LGBTQ health today such as the Q card project out of Seattle, WA or the trans buddy program in Nashville, Tennessee (Q Card, 2014; Trans buddy program to support LGBT patients, 2015). Both of these programs are great examples of ways individuals are making a difference in the healthcare system for TGD populations today.

People who identify as TGD face many barriers when accessing health care, but there are many concrete ways health care providers can foster safe and inviting health care environments and reduce these health care disparities. It is important to remember that providing a high level of client centered care for TGD clients will inevitably improve the quality of care provided to all clients. Kyle Shaughnessy summarized his feelings on TGD health care by saying, “respect us as who we say we are (and who we say we were), regardless of how we look, how we act, how you remember us, or who you expected us to become. Ask us who we are, how we want our histories to be honoured [*sic.*], and what respect looks like to us. You only get better at it with practice, genuine care, and humility” (Sharman, 2016, p. 29). Client centered practice can go a long way in developing trusting relationships with TGD clients. It is important to remember that each person is an individual and has had their own unique life experiences. Lynn Goralski, a transgender woman, reminds everyone, “once you’ve met one transgender person, you’ve met one transgender person” (Goralski, 2014). Get to know your clients, ask questions, don’t assume you know best, do your own research, apologize when you make mistakes, and advocate for TGC clients in health care whenever you have the opportunity.

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