EXPLORING TRANSGENDER ADULTS' PERCEPTIONS OF, AND EXPERIENCES
WITH, PRIMARY AND EMERGENCY CARE IN NOVA SCOTIA

by

Ella Vermeir

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Abstract

Transgender individuals face many barriers to pursuing health care. Current literature

focuses on physician-client interactions and the negative effects that barriers have on

one's health. Using qualitative research methods, the objective of this study was to

explore eight transgender adults' perceptions of, and experiences with, primary and

emergency care in Nova Scotia. Findings reveal that transgender adults often feel socially

excluded from primary and emergency care. This social exclusion can manifest within

relationships with health care providers and staff, within the place of care, within the

physical care environment, and within the social environment. Some individuals

experience social inclusion, although these experiences appear to be less frequent than

those in which individuals feel excluded. The findings suggest that there is a

"discrimination continuum." Furthermore, the findings indicate that transgender adults

are expected to take an active role in their care. Implications for health care providers and

policy makers are provided.

List of Abbreviations Used

AIDS	Acquired immune deficiency syndrome
CANAC	Canadian Association of Nurses in HIV/AIDS Care
CBC	Canadian Broadcasting Corporation
COREQ	Consolidated criteria for reporting qualitative research
CPATH	Canadian Professional Association for Transgender Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency department
EMT	Emergency medical technician
FTM	Female to male
GP	General practitioner
HIV	Human immunodeficiency virus
HRM	Halifax Regional Municipality
HRT	Hormone replacement therapy
LGBT	Lesbian, gay, bisexual, transgender
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, + (an effort to be more inclusive of other orientations/identities)
MTF	Male to female
PEI	Prince Edward Island
STI	Sexually transmitted infection
Trans	Transgender
WPATH	World Professional Association for Transgender Health

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Chapter 1: The Introduction

Transgender individuals are those whose gender identity does not match their sex assigned at birth (Cobos & Jones, 2009). This population faces many barriers to receiving adequate primary and emergency care. Significant barriers include reluctance to disclose one's gender identity; transphobia and discrimination in the health care setting; fear of being subject to disrespect and harassment; limited transgender-specific resources, such as transgender-focused health clinics, etc.; a lack of knowledgeable, experienced, and understanding health care providers; and previous negative experiences with health care providers. Fear of a negative experience and/or prior negative experiences with health care providers and health care environments can make transgender adults hesitant to utilize services. (Aramburu Alegria, 2011; Beagan, Fredericks, & Goldberg, 2012; Kenagy, 2005; Roberts & Fantz, 2014; Sanchez, Sanchez, & Danoff, 2009).

These barriers have been found to contribute to transgender individuals' under-usage of primary care, which in turn, negatively impacts this population's overall health outcomes (Aramburu Alegria, 2011; Kenagy, 2005; Travers et al., 2013). Furthermore, such avoidance of primary care often means that transgender persons must rely on emergency care when their untreated conditions become serious (Shaffer, 2005). However, even when transgender individuals pursue primary and/or emergency care, they often do not disclose their gender identity for fear of a negative reaction from their provider, thus eliminating from discussion numerous transgender-specific health concerns (Bockting, Robinson, Forberg, & Scheltema, 2005). This is alarming as transgender individuals are at an increased risk for numerous health conditions that can arise due to their under-usage of care (Roberts & Fantz, 2014; Williams & Freeman,

2008). For example, transgender individuals experience higher rates of sexually transmitted infections (STIs) and mental health issues, as compared to the general population (Dean et al., 2000). These illnesses can become serious if individuals avoid pursuing health care. This population is also susceptible to conditions that arise as side effects of medical gender transition processes, such as high blood pressure, liver disease, and cardiovascular disease (Cobos & Jones, 2009).

The existing literature on the health care experiences of transgender adults is limited. Of the existing literature, the majority focuses on the physician-client interaction (Khalili, Leung, & Diamant, 2015; Kitts, 2010). This literature disregards the numerous barriers that could impact an individual's decision to pursue care, regardless of their relationship with the physician. Thus, it is evident that there is an urgent need for research to examine how transgender adults perceive and experience primary and emergency care, in order to help inform programs and policies that might improve these encounters.

This study took a holistic and novel approach to examining these perceptions and experiences. This study was holistic in that it investigated individuals' perceptions of, and experiences with, multiple facets of the health care experience such as relationships with health care providers and staff, as well as the effects of the health care setting's physical and social environments. This approach is novel as most studies on transgender health focus on only one aspect of the health care encounter. This study also included individuals who had tried to pursue care, or had wanted to pursue care, but did not due to perceived barriers. These perceptions of primary and emergency care are very important to consider because individuals may be choosing not to pursue care due to fear of a

potentially negative experience. It is imperative that these perceptions are understood so that programs and policies can be developed to help mitigate these potential obstacles. Yet, these individuals have often been excluded from past research on the topic.

The Research Problem

All Canadians are in need of respectful, informed, and empathetic primary and emergency care. Yet, the needs of transgender individuals are often ignored. This population's health concerns must be addressed as they are at an increased risk for a plethora of health conditions and often have very specific health care needs relating to hormone replacement therapy (HRT) and gender-confirming surgeries (Dean et al., 2000). Transgender individuals often avoid care due to prior negative experiences, or fear of potential negative experiences, in primary and emergency care settings (Sanchez et al., 2009). This means that many transgender individuals are living with untreated or under-treated health conditions (Williams & Freeman, 2008). It is important to consider that access to healthcare is only one of the social determinants of health and thus, it is possible that some individual's poor health is because of other factors beyond barriers to receiving care. However, the issues that impede transgender adults from utilizing health care must be studied. These barriers likely prevent individual's from using health care services all together, or from using them in a timely fashion, which may result in this population being generally unhealthier as compared to other groups (Dean et al., 2000; Grant et al., 2010).

Transgender adults' avoidance and under-usage of primary care means that these individuals may be forced to rely on emergency care services when their under-treated

health issues become critical (Health Canada, 2012; Shaffer, 2005). Acute health care services are much costlier for society than primary care services (Health Canada, 2012). In addition, research has determined that individuals who utilize emergency services for issues that could have been managed by a primary care provider tend to experience more negative health outcomes than those who regularly utilize primary care services (Grant et al., 2010).

Statement of Purpose

The purpose of this qualitative research study was to explore transgender adults' perceptions of, and experiences with, primary and emergency care, in order to gain a fuller understanding of these interactions and contribute to the small body of existing knowledge. Through an examination of these perceptions and experiences, this study provides a comprehensive depiction of the barriers and facilitators that help or hinder access to, and utilization of, primary and emergency care services. This study allowed for transgender adults to voice their opinions regarding strategies that could better improve primary and emergency care for this population. These strategies will be of use to health promoters, primary and emergency care providers, and policy makers in order to better serve transgender individuals.

Research Question

The central research question of this study was: "What are transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia?" More specific questions included:

- What are the key barriers and facilitators that hinder or help access to, and utilization of, primary and emergency care for transgender adults?

- Are there specific types of interactions with health care providers that act as barriers or facilitators to primary and emergency care for transgender adults?

- Are there specific types of interactions with health care staff that act as barriers or facilitators to primary and emergency care for transgender adults?

- How does the physical environment/space in which the health care encounter occurs help or hinder the utilization of primary and emergency care for transgender adults?

Scope of the Research Study

In order to create a holistic understanding of transgender adults' perceptions of, and experiences with, primary and emergency care, a qualitative approach was employed so that participants' own voices were used to describe their experiences. Qualitative research is useful for understanding complex human behaviours and experiences (Guba & Lincoln, 1994). Specifically, in a health care context, a qualitative research approach enables the researcher to gain an understanding of the meanings and interpretations that individuals hold regarding their interactions with their health care providers, health care staff, and health care environments (Pope & Mays, 1995).

This study was theoretically guided by the social constructivist research paradigm, which recognizes that what we perceive as reality is actually a social construction. Thus, under a social constructivist paradigm it is recognized that the concept of "gender" and our societal conceptions of gender roles are socially constructed

(Mertens, 2010). Elements of queer theory were also incorporated into this study, as it is understood that research regarding transgender identity is inherently challenging the hegemony intrinsic in the dichotomized separation of males and females (Creswell, 2013; Mertens, 2010). This dichotomy is very much present in the health care system, as health care settings often operate under the assumption that clients are either male or female (Roberts & Fantz, 2014). Therefore, a queer theory paradigm was necessary in order to investigate how alternative gender identities exist in the health care context. A social and physical environment framework paradigm was also used in order to recognize that various factors and levels of environments (e.g. public policy, societal discourses, etc.) impact the immediate environment in which one receives care (Rhodes, 2002).

There are approximately 4,715 transgender persons in Nova Scotia (Conron, Scott, Stowell, & Landers, 2012; Gates, 2011; Statistics Canada, 2015). Thus, due to the small number of transgender persons in Nova Scotia, convenience sampling was used to recruit participants. Convenience sampling is a practical method in which the researcher accepts all of the individuals who agree to participate in the study and who meet the inclusion criteria (Corbin & Strauss, 2008). There was significant interest from eligible participants to participate in this study, and eight volunteers were quickly attained.

Data were collected through semi-structured, one-on-one, face-to-face interviews. The central research question was purposely broad in order to allow participants to discuss the issues, experiences, barriers, and facilitators that they deemed most important. Specific sub-questions were developed to target more detailed aspects of their perceptions, experiences, and encounters. These detailed questions were used to investigate the barriers and facilitators that hinder or help one's access to or utilization of

primary and emergency care, as well as the types of interpersonal interactions and characteristics of the physical environment/space that effect the encounter. The use of broad and open-ended questions allowed for the participants' concerns and interests to surface and resulted in a wide range of experiences to be understood and analyzed (Mertens, 2010).

Each interview lasted between 45-120 minutes. The interviews were all audio-recorded with the permission of the interviewees. If participants declined to be audio-recorded, there was the option for detailed notes to be taken. However, all participants agreed to the audio-recording. An interview guide was used to conduct each interview (Appendix A). The questions were developed to explore the participants' perceptions of, and experiences with, both primary and emergency care.

Following the interview, a short demographic survey was given to the participants in order to obtain key socio-demographic information, such as their age range, relationship status, etc. (Appendix B). Shortly after each interview was completed, the audio-recordings were transcribed verbatim by the researcher. Framework analysis and the constant comparative method were used to develop themes and patterns from the data regarding transgender individuals' perceptions of, and experiences with, the two specified facets of health care (Corbin & Strauss, 2008; Gale, Heath, Cameron, Rashid, & Redwood, 2013). Excel was used to create a matrix, which assisted in organizing and analyzing the data. Each row of the matrix represented a theme or code, and each column represented a specific interview. This format allowed for the development of overarching themes and ensured that the content of each interviewee's point of view was maintained (Gale et al., 2013).

Significance of the Study

This research study has potential significance for health promotion, primary care, and emergency care policy and practice. This study examined a topical and relevant area of research, which is largely understudied (Bauer et al., 2009; Benson, 2013). The recent increase in transgender characters on television shows, as well as openly transgender celebrities, have all sparked the general public's interest in transgender identities (Aramburu Alegria, 2011). Thus, this study was focused on a topic that is pertinent, but also incredibly important, as transgender individuals have very unique health care needs and like all persons, require and deserve knowledgeable and compassionate primary and emergency care (Dean et al., 2000).

The results provide an understanding of the holistic perceptions and experiences of transgender adults in Nova Scotia, using the participants' own voices to facilitate the creation of themes. This study is novel in that it took place in a relatively small, yet urban, Canadian city. Furthermore, this study is unique in that it employed a qualitative approach to understand this often marginalized population's experiences and examined the entire health care perception or experience, from interactions with health care providers and staff, to the physical environments of the health care setting. Thus, the findings may be used to help guide health promotion policy and health service delivery in regards to best practice strategies for treating transgender clients. The findings may also assist in the development of relevant and culturally appropriate policies and practices, which could improve transgender adults' encounters with primary and emergency care and may lead to improved health outcomes. This study provides thoughtful insight into the current state of primary and emergency care for this unique population.

Chapter 1 Summary

Primary and emergency care environments are often not supportive of transgender identities and therefore, often deliver insufficient care to transgender adults (Aramburu Alegria, 2011; Roberts & Fantz, 2014). The barriers and challenges that transgender individuals encounter when pursuing primary and emergency care are preventing many people in this population from accessing care and utilizing services, which has a negative impact on their overall health (Sanchez et al., 2009). This qualitative study explored transgender adults' perceptions of, and experiences with, primary and emergency care in a holistic context as to better understand these experiences. The findings provide suggestions for health promoters, health care professionals, and policy makers regarding ways to mitigate the negative health care encounters and outcomes common to the transgender population.

Chapter 2: The Literature Review

Terminology

In order to understand transgender identity, one must understand the difference between "sex" and "gender." According to the World Health Organization (2014), "sex" refers to the biological characteristics that differentiate males and females. Whereas "gender" refers to the socially constructed roles and behaviours that society deems acceptable for men and women to express. Thus, an example of a sex characteristic is that females are capable of becoming pregnant and males are not. An example of a current Western gender stereotype is that women are often associated with more domestic roles, such as raising children and caring for the home, and men are associated with more professional responsibilities. Therefore, sex roles correlate to the biological mechanisms that distinguish males and females, while gender characteristics refer to the roles, behaviours, and activities that are culturally assigned to each gender (World Health Organization, 2014).

The Trans* Health Guide developed by Capital Health's (now called the Nova Scotia Health Authority's Central Zone) prideHealth team (2013) uses the inclusive term "trans*" to include anyone who does not identify with the gender they were assigned at birth. In order to thoroughly understand the concept of "trans*," it is important to consider the dominant Western perspective of gender as two binary concepts. This Western viewpoint of two distinct binary gender categories is incorporated even into society's understanding of the gender identity "transgender." It is often assumed that a transgender individual was born as one sex (either male or female), but identifies as the other gender (either as a man or woman). However, gender is actually a continuum with

numerous possible gender identities (American Psychological Association Task Force on Gender Identity and Gender Variance, 2008). Trans* is an umbrella term, which encompasses these various identities, including: transgender, transsexual, gender non-conforming, gender variant, gender-queer, gender-fluid, pan-gender, or non-binary individuals. While transgender terminology is rapidly evolving and varies by source, the definitions provided below were chosen for this project because they are used in the Trans* Health Guide, and thus presumably in Nova Scotian health care settings. Some of the definitions provided below were chosen because they are the most agreed upon explanation for the term. For the purposes of this project, "transgender" or "trans" are the umbrella terms used to encompass all of these gender identities.

The term transgender refers to "a person who has a gender identity that is different from their natal sex and/or who expresses their gender in ways that contravene societal expectations of men and women" (as cited in Cobos & Jones, 2009, p. 341). It is important to note that individuals may or may not engage in processes of transition to align their gender identity with their bodies and/or gender expression. Some transgender persons may opt for complete anatomical reconstruction through gender-confirming surgeries and others may choose to express their gender identity with only clothing choices or other non-medical approaches (Aramburu Alegria, 2011; prideHealth, 2013). In some literature, the word "transsexual" is defined as an out-of-date medical term that is synonymous with "transgender" (Cobos & Jones, 2009). However, this term can also refer to an individual who has undergone surgery to change their anatomical sex to align with their gender identity (prideHealth, 2013). In this project, the terms "transgender" or "trans" will be used to encompass those who identify as transsexual. This term can be

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offensive, so should only be used on a case-by-case basis depending on the individual's preference. Individuals who identify as gender non-conforming or gender-variant usually act or appear in ways that are not typically associated with their sex or gender (prideHealth, 2013). Finally, individuals who identify as gender-queer, gender-fluid, pan-gender, or non-binary, feel like they are neither men nor women, or may feel like they are a little bit of both. The term "cisgender" refers to an individual who feels that their sex assigned at birth and gender identity match (prideHealth, 2013).

Another concept that is necessary to address is the notion of "primary care." Primary care "provides entry into the [health care] system for all new needs and problems, provides person-focused care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere by others" (Starfield, 1998, p. 8). Primary care is most often delivered in a general medicine type setting and aims to provide comprehensive physical, mental, and emotional health care throughout the life span (American Academy of Family Physicians, 2009; Muldoon, Hogg, & Levitt, 2006; Starfield, 1998). For this project, primary care is defined as a setting with a family practitioner or nurse practitioner, such as a family physician's office or primary care walk-in-clinic. Therefore, under this definition, the key primary care interactions are with family physicians, nurse practitioners, reception staff, and nurses. The terms "primary care" and "primary health care" are often used interchangeably, although they are different concepts. Primary care refers to "family doctor-type services" (Awofeso, 2004, p. 93), whereas primary health care is a broader concept which extends beyond care and includes health policy, public health, service provision, and disease prevention type services (Awofeso, 2004; Muldoon et al., 2006).

This study examined individuals' experiences with primary care, but has implications for the more extensive facet of care – primary health care.

Emergency medicine is the aspect of health care devoted to "the diagnosis and treatment of unforeseen illness or injury" and includes "the initial evaluation, diagnosis, treatment, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care" (Annals of Emergency Medicine, 2008, p. 189). In the context of this project, emergency medicine refers to the care received at emergency departments (EDs) and thus, includes interactions with emergency department physicians, nurses, technicians, any other medical professionals, as well as reception and triage staff. Furthermore, this definition of emergency medicine also includes care received by emergency medical technicians (EMTs) and/or paramedics. Therefore, the setting where emergency care takes place may include an ambulance or any location in which EMTs or paramedics are providing emergency services. Primary care and emergency care are important concepts as they serve as the first points of contact into the health care system. Individuals must access one of these two health care settings in order to progress into more specialized care (New Brunswick Health Council, 2014; Starfield, Shi, & Macinko, 2005).

Although they are often thought to be synonymous, there is a slight difference in the interpretation of the terms "patient" and "client." Shevell (2009) discusses how the origins of the word "patient" mean to undergo, suffer, or bear. He contends that the word "patient" conveys an implication of illness and implies passivity, lack of responsibility, and perceived disability or impairment. The term "client" is increasingly being used in a health care context to imply that individuals have power and agency, as compared to

"patients," who may be submissive to health care professionals and treatments. Shevell (2009) also notes that the term "patient" can be construed as stigmatizing and demeaning. Thus, the use of this term will be avoided in this project as to not further stigmatize an already marginalized population. The term "client" will be used to convey the agency that individuals have in deciding whether or not to pursue medical care.

Transgender Identity in the DSM

The term "gender identity disorder" is an out-of-date clinical term meant to describe those who possess strong feelings regarding the incongruence between their sex and gender (prideHealth, 2013). Gender identity disorder first appeared in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980. In the DSM-III, gender identity disorder was found in the "psychosexual disorders" section, which also included disorders such as pedophilia and exhibitionism. Its inclusion into the psychosexual disorders section implied that transgender identity was closely related to paraphilic disorders (Ross, 2015). In the DSM-IV which was published in 1994, this chapter was renamed to "sexual and gender identity disorders," which implied that a gender identity disorder was not necessarily a sexual disorder (Ross, 2015). In both the third and fourth editions, gender identity disorder was automatically classified as a mental disorder (Ross, 2015).

In May of 2010, the World Professional Association for Transgender Health (WPATH), an international multi-disciplinary group that develops standards of care for transgender and gender non-conforming persons, released a statement calling for the de-psychopathologization of transgender and gender non-conforming identities (Coleman et

al., 2012). In this statement, they argued that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative" (Coleman et al., 2012, p. 168). In 2013, this idea was incorporated into the DSM-5 with the creation of "gender dysphoria" as a replacement for gender identity disorder (prideHealth, 2013; Roberts & Fantz, 2014). In opposition to the dichotomized DSM-III and DSM-IV gender identity disorder diagnosis, the type and severity of gender dysphoria can differ within and between individuals (American Psychiatric Association, 2013b). The definition of gender also differs between the two disorders. In gender identity disorder, it was assumed that an individual was born as one sex and identified with the other sex. Whereas gender dysphoria views gender as a continuum, acknowledging the wide variation of gender-incongruent identities (American Psychiatric Association, 2013b). In an attempt to avoid stigma surrounding a gender dysphoria diagnosis and in alignment with the WPATH's statement, the DSM-5 has stated that transgender identity is not in and of itself a mental disorder; rather the distress that can arise from a discordant gender identity is what causes an individual to be classified as gender dysphoric (American Psychiatric Association, 2013a; prideHealth, 2013; Roberts & Fantz, 2014). Thus, unlike gender identity disorder, gender dysphoria is not a permanent label and can be removed once one's distress over their gender identity is controlled and managed (prideHealth, 2013).

The DSM-5 outlines characteristics of gender dysphoria, which are as follows. Firstly, there must be a noticeable difference between an individual's sex assigned at birth and their expressed gender, which must continue for at least six months (American

Psychiatric Association, 2013b). Additionally, one's gender-incongruence must cause

clinically significant distress or impairment in social, occupational, or other important

functional domains. Furthermore, gender dysphoria can manifest in a number of ways,

including a strong desire to be treated as another gender, an urge to be rid of one's

biological sex characteristics, and the conviction that one feels, behaves, and acts in ways

that are typical of another gender (American Psychiatric Association, 2013b).

Although the de-psychopathologization of transgender identity is undoubtedly

positive, some worry that the existence of gender dysphoria in the DSM may follow a

similar trajectory to that of homosexuality (Ross, 2015). In a historical context,

homosexuality was once viewed as an automatic mental disorder under the DSM-I (1952)

criteria. In the DSM-II (1968), homosexuality was classified as a mental disorder only if

accompanied by distress or impairment, similar to how transgender identity is currently

classified under gender dysphoria (American Psychiatric Association, 2013a). Though it

is widely publicized that homosexuality was removed from a reprint of the DSM-II in

1974, there were actually variations of homosexual identity disorders (e.g. ego-dystonic

sexual orientation) published until 1987 (De Block & Adriaens, 2013; Spitzer, 1981).

Many authors have discussed the positive social consequences that arose after the

removal of homosexuality from the DSM, including reduced stigma, as well as the

undeniable facilitation of rights for those who identify as lesbian, gay, or bisexual

(Silverstein, 2009). Gender identity disorder and gender dysphoria seem to be on the

same track as homosexuality, and thus it can be expected that gender dysphoria may soon

disappear from the DSM (Ross, 2015). Although there were obvious benefits to

homosexuality being removed from the DSM, there is concern that the removal of gender

dysphoria could hinder the ability of transgender individuals to receive adequate

treatment. Some authors have argued that the existence of a diagnosis for gender

dysphoria aids in access to health care and effective treatments for transgender

individuals (Roberts & Fantz, 2014; Ross, 2015). Furthermore, the first step in treating

gender dysphoria or pursuing a gender transition is a mental health screening. Such

assessment is currently required by the WPATH, who state that a gender dysphoria

diagnosis must be made by a health care professional before an individual can pursue

HRT or other medical transition procedures (prideHealth, 2013; Roberts & Fantz, 2014).

Due to these requirements, both the American Psychological Association and the DSM-5

have declared that there is a need for a diagnostic term for transgender identity that

reduces stigma, facilitates access to care, and will not be used against transgender persons

in social, occupational, and legal contexts (Roberts & Fantz, 2014).

Transgender Identity in Nova Scotia

Nova Scotia is the seventh largest province in Canada with a population of

approximately 943,000 citizens (Statistics Canada, 2015). There are currently no data

regarding the prevalence of transgender identity in Nova Scotia. Furthermore, very little

data exists concerning the prevalence of transgender identity in a national context (Bauer

et al., 2009). American studies suggest that the percentage of transgender individuals

within the population is likely equal to, or greater than, 0.5%. For example, The

Parliament of Canada website features an American article published by the Williams

Institute, which is a specialized subsection of the UCLA School of Law that focuses on

sexual orientation and gender identity law and public policy (Gates, 2011; Lafontaine-

Emond, 2013). In this report, they contend that approximately 0.3% of Americans identify as transgender (Gates, 2011). However, it should be noted that this percentage includes only those individuals who have pursued some sort of medical transition (Bauer et al., 2009; Gates, 2011; Roberts & Fantz, 2014). Thus, individuals who do not have access to health care or who have chosen not to undergo professional medical treatments are not included in this estimate. Therefore, it can be estimated that the percentage of individuals that identify as transgender is actually much higher than stated in this report (Coleman et al., 2012; Roberts & Fantz, 2014). In addition, a population-based study in Massachusetts was conducted with over 28,000 people and found that approximately 0.5% of these individuals identified as transgender (Conron et al., 2012). Yet, it is likely that even this percentage is an underestimation due to certain locations, such as shelters, not receiving the telephone survey and due to individuals not wanting to disclose their gender identity to a surveyor over the telephone (Conron et al., 2012). When using 0.5% as the estimated number of transgender adults in the general population, it can be assumed that there are approximately 4,715 transgender individuals living in Nova Scotia, as this is 0.5% of the total population of Nova Scotia. As approximately 44% of Nova Scotians live in the city of Halifax, it can be assumed that there are approximately 2,075 transgender persons living in the city (Statistics Canada, 2016).

The number of known transgender persons is rapidly rising as individuals are increasingly coming out and declaring their transgender status (Aramburu Alegria, 2011; Sperber, Landers, & Lawrence, 2008). A prevalence study conducted in the United Kingdom by the Gender Identity Research and Education Society determined that the percentage of known transgender individuals is increasing approximately 15% each year,

such that every five years the number of transgender persons has doubled (Reed, Rhodes, Schofield, & Wylie, 2009). This same statistic was also reported in a Canadian made documentary on transgender identity (de Guerre, 2015).

Efforts to provide high quality care to transgender individuals are being made in Halifax (Capital Health, 2015). A prideHealth division of Capital Health (now the Nova Scotia Health Authority's Central Zone) was established to provide safe and accessible primary care services to lesbian, gay, bisexual, transgender, queer, and persons of other sexual orientations/identities (LGBTQ+) in Halifax. A prideHealth nurse offers health care to LGBTQ+ individuals at numerous LGBTQ+-friendly locations around the city including Menz Bar and the AIDS Coalition of Nova Scotia (Capital Health, 2015). prideHealth has also published a directory of health and wellness providers who have self-identified as welcoming and respectful of LGBTQ+ individuals, as well knowledgeable on the health issues impacting these communities. The prideHealth website features helpful resources such as information on STI testing locations, upcoming events, and bulletins on local STI outbreaks. The prideHealth team also developed the Trans* Health Guide to inform transgender individuals about how and where they can receive medical help and support (Capital Health, 2015). There are currently no other prideHealth type programs through the Nova Scotia District Health Authority for individuals living outside of the city.

In December of 2012, an amendment of the Nova Scotia Human Rights act was passed as law. This amendment added both "gender identity" and "gender expression" to Chapter 214 of the Nova Scotia Human Rights Act. Thus, this law protects transgender persons by stating that discrimination against an individual based on their gender identity

or gender expression is a violation of their human rights (Province of Nova Scotia, 2013a). It is interesting to note that efforts have been made to enact a similar amendment to the Canadian Human Rights Act (Parliament of Canada, 2015). A New Democratic Party Member of Parliament proposed Bill C-279 in 2012, which seeks to fight hate crimes and other forms of transphobic injustices by including gender identity as a prohibited ground of discrimination in the act (Parliament of Canada, 2015). Three private member's bills, C-392 in 2005, C-326 in 2007, and C-389 in 2011, preceded Bill C-279. All of these bills were similar to C-279 and none of them became law (Buterman, 2011). Thus, the fight for human rights protection for transgender persons has been under debate for over a decade. Currently, revisions of Bill C-279 are ongoing. According to the Canadian Broadcasting Corporation (CBC), in February 2015, a Senate committee proposed a change to the bill, which would extremely limit its effectiveness (McGregor, 2015). The Senate committee propositioned that sex-specific locations such as prisons, crisis shelters, and restrooms, should be excluded from the bill. Human rights activists have argued that under this proposed amendment, transgender persons would not be protected from hate crimes in these settings, which would leave them subject to physical and verbal abuse (McGregor, 2015).

In May of 2016, the new federal Liberal government introduced Bill C-16, which is nearly identical to Bill C-279. However, Bill C-16 marks the first time that these proposed amendments have been introduced by way of a government bill, rather than a private member's bill (Mas, 2016). Although Bill C-16 has yet to be passed, the likelihood of it becoming law is high as it was introduced by the government currently in power (Mas, 2016). It can be argued that Nova Scotia's Human Rights Act is currently

more progressive and inclusive of transgender individuals than the national act. However, it is likely that the national act may soon encompass these inclusive laws as well.

In June of 2013, the Nova Scotia Department of Health and Wellness announced that the provincial government would cover eight types of gender-confirming surgeries (also known as sex-reassignment surgeries and gender-reassignment surgeries) for transgender Nova Scotians beginning April 1, 2014 (Province of Nova Scotia, 2013b). Five of these surgeries are of use to female-to-male (FTM) transgender persons, while the other three are of use to male-to-female (MTF) individuals. The publicly funded procedures for FTM persons include mastectomy or removal of the breasts, oophorectomy or removal of the ovaries, hysterectomy or removal of the uterus, phalloplasty or construction of a penis, and metoidioplasty, which releases the clitoris and allows it to take the approximate position of a penis (American Psychological Association Task Force on Gender Identity and Gender Variance, 2009; Grant et al., 2010; Province of Nova Scotia, 2013b). The three government-funded procedures for MTF persons are penectomy or removal of the penis, orchiectomy or removal of the testes, and vaginoplasty or construction of a vagina (American Psychological Association Task Force on Gender Identity and Gender Variance, 2009; Grant et al., 2010; Province of Nova Scotia, 2013b). Some of these procedures are not currently performed in Nova Scotia, or are performed in province but not for the purposes of sex reassignment, which means that individuals must be preapproved by their provincial health insurance provider before travelling elsewhere for these surgeries (Province of Nova Scotia, 2013b). With this health care modification, Nova Scotia became the eighth province in Canada to fund gender-confirming surgeries. This change marked a substantial financial relief for

transgender individuals who previously had to rely on personal health insurance and their own financial contributions to cover the cost of surgery. Depending on the extent of the surgery, the cost can range from $10,000 to $60,000 (CBC News, 2013).

The most recent development for improving the lives of transgender Nova Scotians arrived in April of 2015, with the creation of a bill that would allow for an individual to change the sex designation on their birth certificate without first needing gender-confirming surgery (Laroche, 2015; Province of Nova Scotia, 2015). The Act, Bill 82, came into force in late September 2015 (The Nova Scotia Legislature, 2016). The new law also added social workers to the list of health care professionals who are able to provide letters of support for individuals requiring a sex change designation. Transgender individuals can now receive letters of support from four types of health care professionals – physicians, nurses, psychologists, and social workers – thus, making the process easier and more accessible. Nova Scotia is the fifth province in Canada to loosen the rules regarding sex designation on official pieces of identification (Laroche, 2015; Province of Nova Scotia, 2015).

Transgender Health Inequities Rooted in the Social Determinants of Health

The "social determinants of health model" is useful for understanding why some Canadians are healthier than others. Although discussion of the social determinants of health differs between researchers, Mikkonen and Raphael (2010) contend that there are fourteen determinants that have been shown to have a significant impact on the health of Canadians. These determinants are: income and income distribution, education, unemployment and job security, employment and working conditions, early childhood

development, food insecurity, housing, social exclusion, social safety net, health services, Aboriginal status, gender, race, and disability (Mikkonen & Raphael, 2010). Research reveals that these determinants are accurate predictors of illness and death (Ansari, Carson, Ackland, Vaughan, & Serraglio, 2003; Mikkonen & Raphael, 2010).

Transgender persons are harmfully impacted by many of these social determinants. For example, studies have determined that almost 40% of transgender persons have experienced employment discrimination (Lombardi, Wilchins, Priesing, & Malouf, 2008). Two Canadian studies have highlighted other socioeconomic inequities found in the transgender community. The TransPULSE Project surveyed 433 transgender individuals across Ontario. The findings revealed that even though 71% of transgender participants had a post-secondary education, the majority of respondents lived below the poverty line and only 7% made an annual income over $80,000 (Bauer et al., 2010). In British Columbia it was revealed that nine out of ten participants in one study were receiving income assistance (Schilder et al., 2001). The high prevalence of unemployment, unstable employment, and inconsistent income in the transgender community is worrisome as low socioeconomic status is correlated with worse health outcomes (Bauer et al., 2009; Marmot, Friel, Bell, Howeling, & Taylor, 2008).

Another social determinant of health that inequitably affects transgender individuals is social exclusion. Due to their marginalized social status, transgender persons experience disproportionately high rates of harassment and violence regardless of the extent of their engagement in transition processes (Doan, 2010). A study conducted in Philadelphia, which surveyed and/or interviewed 182 participants, discovered that more than half of respondents had been sexually or physically assaulted or abused

(Kenagy, 2005). The social exclusion faced by transgender persons is often compounded by multiple oppressions. Thus, transgender people are not only excluded from society because they are transgender, but also because they are more likely to be poor, homeless, unemployed, ill, etc. (Clements-Nolle, Marx, Guzman, & Katz, 2001). These complex and interwoven levels of oppression heighten the vulnerability of transgender persons to inequitable health outcomes (Logie, 2012).

There is evidence that transgender individuals are often negatively impacted by most, if not all, of the social determinants of health (Bauer et al., 2009; Bauer et al., 2010; Travers et al., 2013). According to Kimberlé Crenshaw (1989) who coined the term "intersectionality," various oppressions (i.e. gender, race, socio-economic status, etc.) cannot simply be added up to obtain a sum total of marginalization. Therefore, the multitude of ways in which transgender individuals are oppressed is ignored under the single-axis organization, which only focuses on "gender," "race," "socio-economic status," etc. as separate and distinct entities (Crenshaw, 1989). Thus, in order to truly understand the ways in which transgender persons are affected by the social determinants of health, one must view these determinants as overlapping and interconnected and not as distinct units (Crenshaw, 1989).

The oppressions that transgender individuals face in regards to the social determinants of health often cause them to experience substantial health problems (Dysart-Gale, 2010). For example, transgender persons experience disproportionate rates of mental health issues, suicide, substance use and abuse, HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome), other sexual health issues, and other illnesses relative to the general population (Aramburu Alegria, 2011;

Bockting, Huang, Ding, Robinson, & Rosser, 2008a; Xavier, Honnold, Bradford, & Simmons, 2007). Therefore, this study focused on a critical social determinant of health for this population: their access to, and utilization of, health services.

Mikkonen and Raphael (2010) state that "high quality health care services are a social determinant of health as well as a basic human right" (p. 38). Furthermore, The Canadian Health Act contends that every Canadian is entitled to equitable health care, reasonable access to health services, and the right to receive health care services without discrimination (Canadian Health Care, 2007; Health Canada, 2011). Yet, many marginalized populations – including transgender individuals – are excluded from receiving adequate and equitable health care. There are numerous barriers that transgender individuals face in receiving health care. These barriers will be discussed in detail in the following section.

To summarize, the social determinations of health framework recognizes that health outcomes are shaped by the social conditions within which we live, including the social, economic, and political environments (Raphael, 2004). The Canadian Public Health Association (2005) has noted that conditions such as unemployment, poverty, homelessness, stigma, violence, and ignored health concerns create an environment in which illnesses "flourish and spread" (p. 26). The previously mentioned examples and current literature suggest that transgender individuals face a multiplicity of barriers and challenges to accessing key resources, which ultimately hinder this population's well-being (Bauer et al., 2009; Travers et al., 2013). Discrimination based on income, education, employment, housing, etc. can lead to distress, which in turn can cause poor health outcomes (Mikkonen & Raphael, 2010). Thus, access to health care services is a

critical social determinant of health, as utilization of these crucial services can help to lessen the burden of inequitable health outcomes.

Barriers to Care for Transgender Individuals

Transgender individuals experience many barriers that prevent them from receiving adequate primary and emergency care. Roberts and Fantz (2014) organize these barriers into three categories: reluctance to disclose gender identity, provider education, and structural barriers. For the purposes of organizing this chapter, three similar categories will be utilized: reluctance to disclose gender identity; provider knowledge, understanding, and experience; and health care settings and the wider environment. The descriptions of the barriers within these categories explain some of the prominent mechanisms that hinder health care access and utilization for this population. It should be noted that all of these barriers are interconnected and inform one another.

Reluctance to disclose gender identity. Stigma, discrimination, and prejudice against transgender individuals are among the key reasons why transgender persons are often hesitant to disclose their gender identity (Bradford, Reisner, Honnold, & Xavier, 2013; Lombardi et al., 2008). Even in health care settings, which are frequently assumed to be safe and inclusive environments, transgender individuals often do not report their gender identity due to fear and anxiety over the potential negative outcomes of disclosure (Roberts & Fantz, 2014). For those that do disclose their gender identity, stigma can lead to many negative experiences including ridicule, discrimination, and even violence (Aramburu Alegria, 2011; Lombardi et al., 2008).

Transgender persons have frequently described their interactions with health care professionals as insensitive, uninformed, and humiliating (Beagan et al., 2012; Newfield, Hart, Dibble, & Kohler, 2006). Incidences of health care providers expressing transphobic, discriminatory, or neglectful behaviours towards transgender clients are not uncommon (Beagan et al., 2012; JSI Research and Training Institute, 2000). The National Transgender Discrimination Survey was created in Washington D.C. in 2010 to assess transgender discrimination in multiple contexts, including health care settings. Over 7,000 respondents answered the 70-question survey. The findings revealed that 19% of respondents had been refused health care because of their transgender status. In addition, 28% of respondents reported having been verbally assaulted in a health care setting, and 2% had been physically assaulted while pursuing medical care (Grant et al., 2010). The authors concluded that "respondents in our survey reported significant barriers to health care and outrageous frequencies of anti-transgender bias in care, from disrespect to refusal of care, from verbal harassment to physical and sexual abuse" (Grant et al., 2010, p. 16).

In another study, it was discovered that 26% of transgender survey respondents had been denied medical care at some point in their lives (Kenagy, 2005). A transgender woman in Boston reported that her physician denied her care and said that she "…should 'see a veterinarian' as a medical doctor is a 'doctor for people'" (JSI Research and Training Institute, 2000, p. 22). Such expressions of discrimination have detrimental effects on the health of the transgender population. Negative health care encounters can cause an already vulnerable experience to be insufferable, leading transgender clients to avoid or delay pursuing health care, which impacts their overall health (Sanchez et al.,

2009). Even when transgender clients do pursue care, many individuals will choose not to disclose their transgender identity due to fear. This can result in ignored health conditions due to the refusal of screening procedures that would reveal the incongruence between their biological sex and their gender identity (Polonijo & Hollister, 2011; Williams & Freeman, 2008).

The avoidance of professional health services and the reluctance to disclose their gender identity is alarming, as research has shown that transgender individuals may pursue transition treatments from nontraditional sources that may be unsafe. In some urban American locations, the prevalence of unsupervised HRT ranges from 29% to 63% (Sanchez et al., 2009). A study based out of Ontario reported that among current hormone users, 6.4% of individuals were taking hormones that had been obtained through nontraditional sources. In addition, approximately a quarter of participants had taken non-prescribed hormones at some point (Rotondi et al., 2013). These findings are distressing, as HRT without adequate medical supervision can lead to serious side effects (Sanchez et al., 2009; Rotondi et al., 2013). The authors suggested that negative experiences with providers and fear of disclosing their gender identity contributed to transgender individuals' decision to pursue hormones from unregulated sources (Rotondi et al., 2013).

There are numerous incidences of outright transphobia and harassment in the medical setting (Feldman & Goldberg, 2008; Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012). These well-known events work to keep transgender individuals from disclosing their gender identity to medical professionals for fear of experiencing a similar situation. For example, in 1996, Robert Eads, an American transgender man was diagnosed with ovarian cancer (Shield, 2007). Over twenty physicians refused to treat

Eads, citing that treatment of a man for a gynecological cancer could potentially harm their practice. The social stigma surrounding transgender identity caused Eads' cancer to go untreated and he eventually succumbed to his disease (Shield, 2007). Such outright discrimination has undoubtedly left transgender individuals wary as to disclosing their gender identity to medical professionals.

Avoidance of primary health care due to fear of disclosing gender identity can also lead to transgender individuals living with untreated chronic conditions (Williams & Freeman, 2008). This means that transgender persons are often forced to resort to emergency care after such untreated conditions become critical (Shaffer, 2005). At this point, disclosure may be out of the individual's control if they are in serious condition or incapacitated (Gorton, Buth, & Spade, 2005). One famous instance regarding a transgender persons experience with emergency care is the case of Tyra Hunter (Shield, 2007). Hunter, a transgender woman, was injured in a car accident in Washington, D.C. in 1995. After discovering that Hunter was biologically male, the EMTs at the scene uttered derogatory expressions and refused to provide her medical care. Hunter unfortunately succumbed to her injuries, even though it was later determined that a blood transfusion and a relatively simple surgery would have provided her a 90% survival rate (Shield, 2007).

Health care provider knowledge, understanding, and experience. Health care professionals' level of knowledge and experience serving the transgender community is another barrier that transgender individuals sometimes encounter when pursuing medical care. Transgender persons have repeatedly expressed frustration with the lack of health care professionals who are trans-friendly, non-judgmental, and knowledgeable about

transgender health issues (Sanchez et al., 2009). The legitimacy of these concerns is supported in the current research that explores health care providers' experience with transgender clients. For example, in 2009, Rondahl found that only 10% of Swedish nursing students in his study possessed a basic level of knowledge on lesbian, gay, bisexual, and transgender (LGBT) health issues. Furthermore, only 28% of medical students in this study received a passing level of "care knowledge" about LGBT persons. This finding is particularly remarkable as the rights of LGBT persons in Sweden have been regarded as some of the most progressive in the world (Cviklova, 2012). Thus, if Swedish nursing and medical students are unable to adequately serve LGBT persons, it is probable that many health professionals in other locations will be at least as likely to lack knowledge and expertise in this area.

In an American study, it was found that medical students' level of comfort in working with, and knowledge of, the LGBT population was based more on personal experience than on educational training. Thus, medical students who pursued clinical opportunities to care for LGBT persons were more comprehensive, held more positive attitudes, and possessed greater knowledge of the health concerns of this community (Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006). Moll and colleagues (2014) surveyed 124 accredited emergency medicine training programs in the United States. Results determined that only 26% of emergency medicine residency programs had ever presented a lecture specifically on LGBT health. Furthermore, a mere 33% had ever incorporated any LGBT health topics into their curriculum (Moll et al., 2014). These results suggest a substantial lack of education regarding transgender health issues amongst physicians, which may translate into a lack of understanding of these clients

(Moll et al., 2014). Beagan, Fredericks, and Bryson (2015) conducted qualitative interviews with family physicians in Halifax and Vancouver and determined that the training that these physicians received regarding LGBTQ health care was "minimal at best" (p. e20).

It is understood that there are a multitude of pressures on medical and nursing school administrators to incorporate curricula on a vast array of health concerns and populations. However, ignoring the unique needs of the transgender community can prevent these individuals from pursuing care and further stigmatizes their population (Bauer et al., 2009; Poteat, German, & Kerrigan, 2013). In addition, transgender individuals may choose to seek care from non-medical and unsupervised sources because of a lack of knowledgeable and understanding providers (Sanchez et al., 2009). Moll and colleagues (2014) suggest that topics such as communication, legal and ethical considerations, health disparities, specific needs, possible complications, and professionalism in relation to transgender health, should be taught for a minimum of two hours at least twice during residency to ensure that all physicians have at least a basic understanding of the pertinent issues.

It has been noted that even when a transgender individual finds a willing health care provider, the onus often falls on them to educate the physician on transgender specific health issues and culturally appropriate care (Benson, 2013; Williams & Freeman, 2008). Poteat and colleagues' (2013) qualitative study revealed that transgender individuals often feel angered that they have to educate their provider. Some felt that it is an unfair burden to place on transgender individuals as they should not be expected to be health care experts.

In addition to a lack of provider knowledge, transgender individuals can also be deterred from pursuing care because of health care providers' negative attitudes, ignorance, and inexperience (Baker & Beagan, 2014; Sanchez et al., 2009). Such inadequate education and knowledge on transgender health issues can lead to preconceptions and inappropriate care (Rondahl, 2009). For example, there are numerous reported incidences of medical professionals simply not understanding what it means to be transgender. In one such example, a transgender man was given a rectal exam despite telling the physician that he did not have a prostate (Samuel & Zaritsky, 2008). If care for transgender persons is to be improved, it is imperative that health care providers receive adequate education about, and experience with, this unique population (Aramburu Alegria, 2011).

Another factor that contributes to medical professionals' lack of expertise on transgender care is the limited access to reliable sources regarding transgender health. Eliason, Dibble, and DeJoseph (2010) reviewed all volumes of the top ten nursing journals in the United States between 2005 and 2009. Of the almost 5,000 articles, only eight focused on LGBT issues. Furthermore, seven of the ten journals contained no articles at all on this topic (Eliason et al., 2010). Although the interest in LGBTQ+ health is improving, data and resources on transgender health specifically, are substantially less available than resources regarding gay and lesbian health (Roberts & Fantz, 2014). Thus, it is not surprising that physicians have reported feeling overwhelmed and ill-prepared to treat transgender persons (Beagan et al., 2013).

It is necessary to address a common assumption in the existing medical literature – it is often assumed that all LGBTQ+ individuals have shared health care issues and

experiences. Although these individuals do have some overlapping health care needs, the specific needs of those who are undergoing a gender transition are often overlooked. The other members of the LGBTQ+ group are included in this group due to their sexual orientation, whereas transgender persons are included because of their gender identity. Therefore, they are categorically different from the rest of the LGBQ population, but still fall under the "sexual minority" umbrella. Thus, it is important for individuals who are discriminated against based on their gender identity to sometimes be studied separately from those who are excluded because of their sexual preferences. Furthermore, research has revealed that transgender persons may face even greater health challenges and incidences of prejudice and violence than other sexual minorities (Lee, 2000). Thus, even health care encounters that are not regarding transition related treatment could result in discrimination and harassment due to the social stigma surrounding gender non-conforming identities. Moreover, when studies do specifically focus on transgender individuals' experiences, it is often assumed that all members of this population have similar experiences and the within group differences are disregarded.

Research shows that health care providers often make the assumption that individuals identify with one of two binary gender identities (Baker & Beagan 2014; Bauer et al., 2009). A Canadian study discovered that health care providers often attempt to remain neutral, in that they do not bring up a client's gender identity or sexual orientation (Baker & Beagan, 2014). Providers reported that they perceived such neutrality in their practice as a way to remain non-judgmental and avoid discriminatory expressions (Baker & Beagan, 2014). However, this rejection of transgender identity essentially silenced any potential communication regarding transgender health.

Furthermore, transgender clients felt that such avoidance of the topic effectively reinforced the gender binary norms embedded within the health care system (Baker & Beagan, 2014). In addition, the avoidance of the topic by health care professionals meant that clients were left responsible for initiating conversations regarding their transgender status and the consequential health concerns (Baker & Beagan, 2014; Bauer et al., 2009). Such neglect of the needs of transgender clients in the health care system is a barrier that inhibits access and utilization of medical services (Bauer et al., 2009).

Health care settings and the wider environment. Structural barriers are those that "arise when patients are faced with the challenge of obtaining health care from systems that are complex, underfunded, bureaucratic, or archaic in design" (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p. 118). Structural barriers can also refer to the physical infrastructure or organization of the health care environment (Roberts & Fantz, 2014). The existing literature regarding the structural barriers that transgender individuals encounter when pursuing health care is scarce.

The construction of health care settings as gender binary environments can serve as an obstacle for individuals who are not cisgender (Roberts & Fantz, 2014). For example, gynecological care is often performed in "well women's clinics," which can make it very difficult for transgender men to pursue screening, as these environments may be perceived as unwelcoming. Furthermore, health care providers who specialize in "women's health" are often unsure of how to appropriately treat a transgender man, which can lead to awkward encounters (Dutton, Koenig, & Fennie, 2008). The physical environment of the clinic may be geared solely towards women by only providing pink hospital gowns, women's magazines in the waiting room, posters and brochures featuring

only cisgender women, and intake forms that do not offer an option for transgender clients (Coren, Coren, Pagliaro, & Weiss, 2011; Dutton et al., 2008). Thus, even if a transgender man knows that the clinic's physician is knowledgeable about transgender health, the physical environment of the clinic may still deter him from pursuing care (Dutton et al., 2008).

Roberts and Fantz (2014) discuss some frequently confronted structural barriers within the physical organization of health care settings. They contend that access to a trans-friendly washroom is a very important physical amenity, as transgender persons may be hesitant to use gender restricted public washrooms. Thus, the availability of a private, unisex washroom greatly contributes to a trans-friendly health care environment (Roberts & Fantz, 2014). An additional barrier that is especially important in an emergency department context is the option of having a private room. Many emergency departments possess only curtains to separate clients. Doctors may sometimes take clients into the hallway for a private conversation, but confidentiality may still be an issue in this scenario. Thus in emergency department settings, disclosure is often not confidential and could potentially target the transgender individual for prejudice and harassment by other clients (Robert & Fantz, 2014).

Anecdotal evidence indicates that the act of undressing in the health care setting can cause distress for many transgender individuals. For example, the hospital gowns that are often provided in health care settings can leave transgender persons feeling incredibly vulnerable as they often leave a person's backside exposed. The act of simply providing a housecoat or additional hospital gown for greater privacy can greatly improve their experience. Furthermore, in emergency situations, undressing typically begins in the

ambulance. During this time, a transgender person's breast binding, phallic packing, etc.

may be exposed which could result in negative treatment from EMTs and paramedics.

An additional barrier is the usage of the client's preferred name and pronouns.

The correct usage of the preferred name and pronouns are imperative to ensuring comfort

and security for transgender clients (Polly & Nicole, 2011). Failure to be identified by

one's preferred name and pronouns in a waiting room context can "out" an individual,

leaving them vulnerable to discomfort or even harassment. Inappropriate pronoun and

name usage can also negatively impact the relationship between client and provider,

which can impact quality of care (Grant et al., 2010; Roberts & Fantz, 2014).

Research has found that a lack of transgender-focused health clinics and resources

can lead to transgender individuals under-utilizing primary care (Drabble, Keatley, &

Marcelle, 2003). In the United States, only 30% to 40% of transgender persons utilize

regular health care services (Sanchez et al., 2009). Although there are no data available

specifically on transgender individuals' medical care usage in Canada, it is known that

Canadian LGBTQ individuals are twice as likely as other Canadians not to have a family

physician (as cited in Baker & Beagan, 2014). Additionally, Bauer and colleagues

(2015b) surveyed over 400 transgender individuals and discovered that even though 83%

had a family physician, it was common for individuals to feel uncomfortable discussing

trans-health issues with their provider. This discomfort served as a barrier to utilizing

care, even though these individuals had a regular health care provider and universal

health insurance (Bauer, Zong, Scheim, Hammond, & Thind, 2015b).

These statistics are alarming in the context of Nova Scotia for two reasons.

Firstly, the majority of the literature that exists on transgender barriers to care originates

in large American cities. Of the Canadian research that exists on this topic, the majority has been conducted in large metropolitan areas, such as Toronto, Ottawa, and Vancouver (Travers et al., 2013). It is very likely that the experiences of transgender clients in a relatively small Canadian province, such as Nova Scotia, are different from those in bigger cities and provinces, due to a lack of transgender-specific resources and a smaller population of transgender individuals. Another issue concerns the distribution of family physicians in Nova Scotia. Although, the province of Nova Scotia has one of the highest ratios of physicians per capita in Canada, the province is currently experiencing issues with physician distribution rates, which can make it very difficult for individuals to find a family doctor. Furthermore, Nova Scotia actually has fewer family physicians than the national average (Province of Nova Scotia, 2012). This can leave transgender persons without care or can force them to interact with health care providers who do not possess knowledge and skills in working with transgender clients. Furthermore, a lack of supportive primary care facilities could cause transgender individuals to rely more heavily on emergency care (Shaffer, 2005). Yet, in an emergency department setting, individuals have even less control as they would in a primary care setting regarding which health care professionals they interact with.

  Gaps in the existing literature. In general, the research on transgender persons' health care needs is limited. The current research tends to focus on the interaction between physicians and clients. Although these relationships are undeniably important, there is a great need for research to address the numerous other factors that impact a client's experience while pursuing care. For example, there is very little research examining the relationships between transgender clients and other health professionals

and administrative staff, such as nurses, EMTs, paramedics, and receptionists. The literature examining the physical environment of the health care setting including restroom arrangements, privacy for changing, and room sharing is very scant. Furthermore, the existing literature regarding the primary and emergency care experiences of transgender persons mainly focuses on access to, and utilization of, sexual and mental health services (Boehmer, 2002). This narrow fixation disregards other important health concerns. For example, very little literature exists on the barriers that transgender individuals face when pursuing care for other health concerns, such as a sore throat or a broken bone. A glimpse into such experiences would provide a more holistic understanding of how transgender clients perceive and experience care.

Health Concerns in the Transgender Population

Similar to the literature regarding health care encounters, the literature exploring the health outcomes of transgender persons mainly focuses on mental and sexual health (Boehmer, 2002). Transgender individuals experience very high rates of mental health issues relative to the general population including depression, anxiety, and addiction (Bockting, Miner, Romine, Hamilton, & Coleman, 2013). An alarming 65% of transgender persons have considered committing suicide, while 46% have actually made an attempt (Haas, Rodgers, & Herman, 2014; Xavier at al., 2007). This is compared to the 1.6% of the general American population who have attempted suicide (Grant et al., 2010).

In regards to use of addictive substances, one study reported that more than a quarter of transgender adults have abused or depended on drugs or alcohol to cope with

the negative impacts of discrimination. The National Institutes of Health in the United States estimates that approximately 7% of the general public abuses or depends on alcohol, while 1.7% abuses or depends on non-prescription drugs (Grant et al., 2010). Thus, the misuse of addictive substances in the transgender community is more than three times that of the general population (Grant et al., 2010).

The National Transgender Discrimination Survey on Health and Health Care found that respondents were more than four times more likely to have an HIV infection (2.64%) as compared to the general United States adult population (0.6%) (Grant et al., 2010). Certain subgroups experienced even higher rates of HIV. For example, 3.76% of transgender women were infected with HIV, while 4.67% of unemployed transgender individuals were infected (Grant et al., 2010). The researchers discovered that 15.3% of transgender sex workers were infected with HIV, as compared to approximately 6% of cisgender sex workers (Grant et al., 2010; Syvertsen et al., 2013). Studies have found that transgender individuals also experience higher incidences of other STIs, such as syphilis and hepatitis, as compared to the general public (Elifson et al., 1993).

Research examining the effects of medical transitioning on overall health is limited. There is a noticeable lack of research addressing the health care needs of transgender persons recovering from gender-confirming surgeries or pursuing HRT. However, it is known that HRT increases the risk of many adverse health outcomes. For MTF transgender persons taking estrogen, these outcomes include diabetes, liver disease, blood clots, neo-vaginal cancer, and prostate cancer. FTM transgender persons undergoing testosterone therapy have an increased risk of heart disease and liver disease, myocardial infarction, and cancers of the female reproductive system (Dean et al., 2000;

Williams & Freeman, 2008). As previously mentioned, the fear of revealing one's

transgender identity may deter them from pursuing adequate health screenings. For

example, MTF persons are less likely to undergo prostate and testicular exams, and FTM

persons are less likely to undergo mammograms and pap smears (Aramburu Alegria,

2011; Williams & Freeman, 2008). The neglect of these screening procedures leaves this

population vulnerable to an array of adverse health outcomes. Due to the plethora of

negative health outcomes common in transgender individuals, it is clear that this

population is in great need of adequate and effective primary care. As it is known that

transgender individuals often do not pursue primary care, emergency services must be

able to adequately and respectfully treat these conditions when they become serious and

in need of urgent attention.

Chapter 2 Summary

To summarize, efforts are being made in Nova Scotia to improve the quality of

life for transgender persons. The development of the prideHealth team in Halifax, the

government funding for some transition-related medical procedures, and the inclusion of

"gender identity" and "gender expression" in the Nova Scotia Human Rights Act, all

assist transgender individuals as they pursue their transition. However, little is known

regarding how transgender adults in Nova Scotia perceive and experience primary and

emergency care.

Access to health services is a critical social determinant of health and is the focus

of this project. However, it is important to note that there is evidence that transgender

individuals are negatively impacted by most, if not all, of the social determinants of

health and that these influences are interconnected. Oppressions that are rooted in the social determinants of health, such as unemployment, low socio-economic status, etc. all contribute to the negative health outcomes common in the transgender population.

Transgender individuals face numerous barriers when trying to pursue primary and emergency care, including reluctance to disclose their gender identity; limited health care provider knowledge, understanding, and experience; and uncomfortable health care settings and the wider environment. For example, fear of discrimination, harassment, social stigma, and violence are key components of transgender individuals' unwillingness to disclose their gender identity. The high rates of reported discrimination and harassment in health care settings can deter individuals from feeling safe and protected while pursuing medical care. Thus, the fear of experiencing negative encounters in the health care setting, as well as the effects of prior negative health care experiences, discourage transgender individuals from pursuing care and/or disclosing their gender identity (Aramburu Alegria, 2011; Kenagy, 2005). However, nondisclosure can cause individuals to live with untreated or undiagnosed conditions, which impacts their overall health outcomes (Sanchez et al., 2009).

In addition, health care providers are not receiving adequate education regarding transgender health, which translates into transgender individuals not receiving adequate medical care (Rondahl, 2009; Sanchez et al., 2006). Transgender individuals have reported that health care providers' lack of knowledge and understanding about transgender health issues, as well as a lack of transgender-specific resources, prevents them from pursuing the care that they need, which negatively impacts their health outcomes (Drabble et al., 2003; Sanchez et al., 2009). Furthermore, there are numerous

organizational barriers, both social (e.g. the construction of health care settings as gender

binary environments) and physical (e.g. lack of transgender-inclusive restrooms, etc.),

that can impact an individual's health care experience. However, the literature on such

barriers is very sparse even though these structural barriers are incredibly important

components of health care encounters. All of these barriers contribute to the increased

prevalence of mental illnesses, suicides, sexually transmitted infections, and other

negative health outcomes common to the transgender population.

Chapter 3: Methodology

This chapter describes the research approach and methodology that was used to explore transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia. The chapter describes the qualitative, social constructivist approach that was used in this study. This chapter also explains how elements of queer theory, a social and physical environment framework, and researcher reflexivity were incorporated into this project. Furthermore, the chapter describes how the framework analysis and the constant comparative methods were used as data analysis techniques. A discussion of the research design, ethical considerations, data quality and trustworthiness, limitations, and knowledge dissemination plans are also provided.

Research Approach

Qualitative approach. Creswell (2013) contends that qualitative research is best suited to address complex social or human problems. One key feature of qualitative data is that it focuses on "ordinary events in natural settings," in order to gain an insight into what "real life is like" for the research participants (Miles, Huberman, & Saldana, 2014, p. 11). The authors also contend that qualitative data is rich and holistic, and aims to uncover the complexities of "focused and bounded phenomenon embedded in [a social] context" (Miles et al., 2014, p. 11). Qualitative data allows for the researcher to go beyond the questions of "what" or "how many" to discover "why" and "how" things happen. Qualitative research is inherently flexible in that questions or data collection methods may change over time. Miles and colleagues (2014) postulate that such adaptability encourages confidence that the researcher truly understands the participants'

experiences. The key component of qualitative research is the emphasis on understanding participants' "lived experiences." This method is nicely suited to comprehend the meanings that individuals place on the events and happenings in their lives and allows the researcher to connect these meanings to the greater social environment in which individuals live (Miles et al., 2014).

Qualitative methods are useful in health care settings as they allow for a deeper understanding of how clients perceive their interactions with health care providers and the health care system (Pope & Mays, 1995). Research on the users of health services often focuses on individuals' specific experiences, beliefs, and interpretations of the health care encounter. Thus, a qualitative description of these accounts is necessary in order to fully comprehend the client's point of view. Furthermore, these experiences are complex and multifaceted. A qualitative approach respects that the voices of participants are critical to a holistic understanding of health care interactions. Dingwall remarked, "qualitative research requires real skill, a combination of thought and practice and not a little patience" (as cited in Mays & Pope, 2000, p. 52). Although the comprehension of such intricate experiences is not straightforward, this method respects the fact that participants are experts of their own experiences and that there is truth in one's description of their lived experience (LeVasseuer, 2003). Thus, for this study, a qualitative approach was determined to be the ideal method to examine transgender adults' perceptions of, and experiences with, primary and emergency care.

Research Paradigms

  Social constructivism. Mertens describes a "paradigm" as "a way of looking at the world" (Mertens, 2010, p. 7). Research paradigms are composed of philosophical assumptions that are used to guide the researcher's thinking. Similarly, Guba and Lincoln (1994) contend that a research paradigm "defines, for its holder, the nature of the 'world,' the individual's place in it, and the range of possible relationships to that world and its parts" (p. 107). The truthfulness of a paradigm must be accepted on faith and based on solid arguments, as there is no way to truly establish its accuracy (Guba & Lincoln, 1994). Paradigms, or interpretative frameworks as they are sometimes referred to, are a set of beliefs that guide the researcher's actions (Creswell, 2013).

  In this research project, the researcher adopted a social constructivist way of thinking and viewed knowledge and identities to be fluid and dependent on time and context. Furthermore, this paradigm concedes that social realities are developed through individuals' mutual understandings and interpretations of experiences and relationships, which are further mediated by dominant social discourses (Guba & Lincoln, 1994).

  The researcher acknowledged that her own experiences influenced her perceptions of knowledge, as knowledge is a socially constructed phenomenon. Furthermore, she attempted to understand the participants' complex lived experiences from their points of view (Mertens, 2010). Constructivist researchers reject the notion that there is one true, objective reality and instead, understand that there may be multiple social constructions of an experience, which may also change over time (Guba & Lincoln, 1994; Mertens, 2010). Individuals' experiences are often situated socially and historically in social constructivist research, as it is understood that historical and cultural

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norms are influential in understanding one's perspectives of their experiences. Unlike other research paradigms that begin with a theory, social constructivist researchers generate a pattern of meaning throughout the data collection and analysis processes (Creswell, 2013). Therefore, causality cannot be inferred and generalization is not possible, as this paradigm concedes that phenomena exist only within their own specific set of circumstances (Guba & Lincoln, 1994).

The social constructivist paradigm was well suited for the topic of study in this research project, as it acknowledged that even though knowledge and experiences are socially constructed, they still have very real consequences for the individual (Mertens, 2010). Gender identity is not a tangible concept, yet it is still very real and plays a key role in influencing an individual's experiences with health care. Furthermore, one's gender identity and gender expression may evolve over time, and thus the impact of gender identity on a certain health care experience is very much dependent on the time, setting, and context. Therefore, exploring transgender adults' health care encounters with the awareness that knowledge and interpretations of experiences are socially constructed, allowed for recognition that one's experiences do not exist in isolation. These experiences are shaped by the individual's understandings and interpretations of the encounter, which are mediated, in part, by the gender-binary environment of the health care system.

Queer theory. Queer theory is a facet of social constructivism and therefore, elements of queer theory are also incorporated into this project. Queer theory explores how queer identities are embodied in various social contexts and how the construct of gender identity is viewed in various social forums (Creswell, 2013). Queer theorists

critique the dominant theories relating to gender identity and sexual orientation, in an effort to challenge the idea that one's identity is singular, fixed, or normal (Watson, 2005). Queer theorists contend that the binary concept relating to gender identity is inadequate and inaccurate. In addition, they assert that all sexual categories and gender identities are open, fluid, and non-fixed. The concept of a "normal" gender identity is dismissed in the queer theory paradigm (Plummer, 2011). Thus, this paradigm was inherently incorporated into this research project, as this study's participants possessed a wide range of gender identities. Furthermore, the purpose of this research was to give a voice to this marginalized population to better understand their experiences within a health care context. As Crawley and Broad (2008) explain, heteronormative and gender-normative environments work to reinforce the incorrect notion that biological sex causes gendered behaviour. Transgender identity defies this statement and is therefore, often unacknowledged in the gender-binary, health care environment.

  Social and physical environment framework. There are many facets of the environment that impact transgender adults' perceptions of, and experiences with, primary and emergency care. Tim Rhodes, a public health sociology professor in the United Kingdom, has developed a "risk environment" framework, which is used to understand and reduce drug use and drug related harms (Rhodes, 2002). He states that, "a focus on the risk environment encourages us to think about the social situations and places in which harm is produced and reduced" (Rhodes, 2002, p. 88). Although, he is referring to drug-use, comparisons can be made to the "harmful" health care environments, riddled with barriers to care, for transgender persons. Rhodes (2002) contends that harmful, micro-level risk environments are the products of a combination

of social norms, social relationships, peer influences, and immediate social settings. He also contends that larger, macro-level risk environments are mediated by public health policies, societal discourses, and entrenched societal inequalities. He argues that macro-level risk environments shape the micro-level social and physical environments (Rhodes, 2002). Therefore, since the health of transgender individuals' is often not considered to be an important topic of social discourse and/or public policy, and since transgender individuals seem to be continuously viewed as less deserving of adequate care than other members of society, the micro-level environments are likely affected by these perceptions. Such harmful macro-level environments can negatively shape and impact the interpersonal relationships and immediate social and physical environments in which transgender persons pursue care. This overarching marginalization can impact physician-client interactions, the way health clinics and emergency rooms are designed, etc. Therefore, in the context of this study, it is important to remember that social and physical environments do not exist in isolation, but are continually and reciprocally shaped by larger and more powerful structural environments (Rhodes, 2002).

Reflexivity: Researcher identity. Reflexivity is a crucial characteristic of qualitative research and refers to researchers "positioning themselves" (Creswell, 2013, p. 47). In other words, reflexivity suggests that researchers should convey how their life experiences have informed their perceptions and interpretations of the research. As Wolcott (2010) notes, "our readers have a right to know about us…they want to know what prompts our interest in the topics we investigate, to whom we are reporting, and what we personally stand to gain from our study" (as cited in Creswell, 2013, p. 47).

Mertens (2010) asserts that researchers need to acknowledge their own unique position in terms of their sexuality, ethnicity, etc., as research conducted through a social constructivism paradigm always produces contextually specific knowledge. Reflexivity is a continuous process of self-reflection, self-evaluation, and acknowledgment of how personal attributes such as identity, perspectives, and biases could potentially impact all stages of the research project (McCabe & Holmes, 2009). Mertens (2010) states that the researcher must constantly be self-aware and understand the subjectivity that they bring to the project. Acknowledging these characteristics allows for readers of the research to understand how the project may reflect elements of the researcher's "self" and how these elements may have influenced the researcher's perspectives and findings (McCabe & Holmes, 2009).

I am a heterosexual, cisgender, Caucasian woman in her early-twenties, with an urban Atlantic Canadian upbringing. I have an educational background in psychology, neuroscience, and health promotion. My passion for the topic of transgender health has been longstanding, as I have known individuals who have undergone gender transition and have experienced negative primary and emergency care encounters. My interest in transgender health was furthered when I began volunteering at the Halifax Sexual Health Centre and working at Dalhousie University Health Services. In both settings, I had the opportunity to discuss transgender health issues and health care experiences with transgender clients. I am hoping to become a family physician and had originally planned on applying to medical school directly following the completion of my undergraduate degree. I am very interested in working as a physician in a setting similar to the Halifax Sexual Health Centre, in which I would welcome individuals of all gender identities and

sexual orientations. In my final year of my undergraduate degree, I began to realize that due to my cisgender identity, I really had no knowledge about the health issues impacting transgender individuals. I began to do some research on the topic and was surprised by the limited amount of resources and literature, especially the lack of qualitative research and Canadian studies. I decided to pursue a Masters in Health Promotion to learn more about this important topic in a local context. It is my hope to contribute to the small body of existing literature, as well as personally employ the lessons that I have learned from this research when I am a family physician.

Given that I already possessed some knowledge regarding certain transgender individuals' health care encounters, it was important for me to recognize that these casual conservations could influence the data collection and analysis phases of this project. It was important for me to continually reflect on my own experiences and perceptions, in order to minimize the impact that these concepts had on my interpretations of the participants' experiences. I also often reflected on my "position." I am a "privileged" – Caucasian, educated, cisgender – person, and I understand that these attributes may have affected the information that participants disclosed to me. As I am not a member of the LGBTQ+ community, I enlisted the help of several "community liaisons," or members of the LGBTQ+ community, who assisted me in ensuring that I adequately self-reflected, as well as delivered my material in a culturally appropriate and sensitive manner. Such reflexivity was a continual process throughout the course of this project.

I acknowledge that I will never be able to truly understand the struggles faced by many transgender persons, as I myself am not a transgender individual. However, as I am a person who lives with a rare chronic condition, I have felt marginalized as a health care

user. Although this marginalization is different and not as extreme as the marginalization faced by transgender persons in the health care setting, it does help me to have some understanding and awareness of how individuals feel when they are excluded within the health care environment. I was concerned that I would be thought of as an "outsider" because I am not part of the LGBTQ+ community. Corbin Dwyer and Buckle (2009) posit that "the core ingredient [in qualitative research] is not insider or outsider status but an ability to be open, authentic, honest, deeply interested in the experience of one's research participants, and committed to accurately and adequately representing their experience" (p. 59). Although I do not belong to the same population as the study's participants, I was certainly interested in, and committed to, learning about their perceptions and experiences. I made my intentions, as well as my cisgender status known from the very first contact with potential study participants and was pleased to find that most individuals seemed to be willing to share their perceptions and experiences with me, regardless of my gender identity.

My parents, who are both members of the artistic community and film industry in Halifax, Nova Scotia, raised me to have an open mind and an open heart for all people. Growing up in such artistic circles, I was aware of, and personally knew, individuals of various sexual orientations and gender identities. I grew up believing (and still do) that these orientations and identities were just as "normal" as my own heterosexual and cisgender identity. I still remember being very young and having my parents explain to me why gay and lesbian couples could not legally marry. I just could not understand the reasoning. Now, as an adult, I still cannot comprehend why LGBTQ+ individuals are marginalized and discriminated against. In conducting this study, I have been shocked

and saddened by the barriers that transgender individuals often must encounter just to receive basic health care. As a transgender-ally, I am very hopeful that health care providers and policy makers will take note of the participants' experiences discussed within this study, as well as the recommendations that they provided regarding how transgender persons could be better served by the health care system. I may be an "outsider" due to the fact that I am cisgender, but I was very dedicated to this project. The love, acceptance, and kindness that my parents have always exhibited has been instilled in me and was at the root of my interest in, and passion for, this topic.

Methodological Approach

  Framework analysis. Framework analysis was developed for use in policy research during the late 1980's, as it was determined to be a pragmatic approach for investigating real-world issues (Gale et al., 2013; Ward, Furber, Tierney, & Swallow, 2013). Framework analysis is part of a "family" of qualitative analysis methods, which includes thematic analysis and qualitative content analysis. Gale and colleagues (2013) contend that "these approaches identify commonalities and differences in qualitative data, before focusing on relationships between different parts of the data, thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes" (Gale et al., 2013, p. 2).

  The defining characteristic of framework analysis is the matrix output. Each column in the matrix represents a case (or interviewee), while each row represents a specific code. The in between "cells" are composed of the summarized data and significant direct quotations. This organized matrix allows the researcher to

systematically reduce the data, in order to analyze it by individual interviewee and by code (Gale et al., 2013). This structure also allows for in-depth analysis of key themes to take place across the whole data set, while also ensuring that the content of each individual's point of view is not lost. Gale and colleagues (2013) maintain that "comparing and contrasting data is vital to qualitative analysis and the ability to compare with ease data across cases, as well as within individual cases, is built into the structure and process of the Framework Method" (Gale et al., 2013, p. 2). Thus, elements of the constant comparative method are also employed during framework analysis. The constant comparative method involves the researcher continuously re-checking the data to ensure that the emerging themes are adequate, correct, and grounded in participants' experiences (Mertens, 2010).

Framework analysis is an ideal method for the analysis of interview data, as it provides a systematic tool for managing and mapping data, generating themes, and making comparisons within and between cases (Gale et al., 2013; Miles et al., 2014; Ward et al., 2013). The straightforward structure of the framework matrix helps to facilitate the recognition of patterns, contradictory data, and deviant cases (Gale et al., 2013). This method also provides a clear audit trail, as the final themes can be traced back to the original raw data. Furthermore, framework analysis is increasingly becoming a popular analysis tool for health care researchers, as it allows for a practical exploration of the intricate complexities of clients' experiences with the health care system (Pope, Ziebland, & Mays, 2000; Smith & Firth, 2011). Hence, framework analysis was the chosen method to explore transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia, as it was deemed to be rigorous and

transparent, and facilitated the researcher in providing a rich interpretation of clients'

experiences (Smith & Firth, 2011).

Research Design

     Inclusion criteria. In order to participate in this study, participants had to meet

six inclusion criteria. (1) Participants had to speak English, as the researcher does not

speak any other languages. (2) Participants had to identify as transgender (where

transgender was an umbrella term for numerous gender identities). (3) Participants had to

be at least 18 years of age. This was to ensure that participants, and not their parents or

guardians, made the decision as to whether or not they chose to pursue primary and/or

emergency care. (4) Participants had to currently live in Nova Scotia, and had to have

lived in Nova Scotia for at least two years to ensure that they had experienced, had

wanted to experience, or had tried to experience health care in the province. (5)

Participants needed to have experienced, have tried to experience, or have wanted to

experience, primary and/or emergency care in Nova Scotia within the last two years. This

criterion permitted inclusion of those who did not pursue care due to fear of

discrimination or other barriers. However, this criterion excluded those who did not

pursue primary and/or emergency care simply because they had not needed to. (6)

Finally, participants had to be able to meet in the HRM (Halifax Regional Municipality)

for their interview as the researcher had transportation constraints.

     Sample size and sampling strategies. Eight transgender adults were recruited for

this study. The researcher, supervisor, and committee members, determined that a sample

of 6-10 individuals was an appropriate sample size based on the time and financial

restrictions imposed by a Master's-level thesis. As this was an exploratory study, the thesis committee agreed that eight participants would allow for adequate exploration and understanding of participants' perceptions and experiences. This number of participants allowed for the researcher to explore the experiences of multiple persons, while still permitting manageable data analysis. Due to the small number of transgender adults in Nova Scotia, it was believed that a sample of this size would allow for adequate interpretation. Qualitative researchers will often finish collecting data when the themes are saturated, meaning that there are no new insights or concepts being revealed from new data (Creswell, 2014). There are many perspectives regarding data saturation in qualitative research. Some believe that data saturation can never really be guaranteed in a qualitative project as it is always possible that a new participant could add something novel to the data and themes (Corbin & Strauss, 2008; Wray, Markovic, & Manderson, 2007). Others believe that there are methods of establishing the proper sample size that will lead to data saturation (Francis et al., 2010). However, Burmeister and Aitken (2012) suggest that it is not the sample size that determines whether one will reach data saturation, but the constitution of the sample. Thus, using these various perspectives on data saturation, it is likely that this sample is not theoretically saturated due to the small sample size and due to the fact that a new participant could have added something novel to the data. However, the sample was well distributed in terms of gender identities and all concepts that emerged from the interviews were fully integrated into the analysis to ensure that every concept was analyzed and discussed. Thus, there is saturation within the data set. As Corbin and Strauss (2015) state, "eventually, a researcher has to say this

concept is sufficiently well developed for purposes of this research and accept what has not been covered as one of the limitations of the study" (p. 140).

Convenience sampling was used to recruit study participants. This sampling strategy is a practical method, as the researcher accepts all individuals who agree to participate and who meet the inclusion criteria (Corbin & Strauss, 2008). Convenience sampling does not aim to produce a representative sample of the population, but it is a realistic approach for recruiting participants from small communities as it selects the individuals who are most readily available (Corbin & Strauss, 2008; Mertens, 2010). However, the sample was somewhat representative of the various gender identities in the transgender community as there were three male-to-female participants, three female-to-male participants, and two non-binary/gender non-conforming participants. The researcher also prepared to employ snowball sampling, which is a type of purposive sampling. In snowball sampling, the researcher asks the study participants to pass on the study's recruitment information to others in the community who may be interested in participating. However, this method of sampling did not need to be employed as all of the participants were recruited through the original round of convenience sampling.

Recruitment strategies. The researcher had prepared for recruitment posters to be placed in Halifax locations where transgender adults were likely to visit (Appendix C). These locations included health clinics (such as the Halifax Sexual Health Centre), community groups/LGBTQ+ organizations (such as The Youth Project, The Nova Scotia Rainbow Action Project, and DalOUT), and university campuses. The researcher had established relationships with multiple members of the LGBTQ+ community who had offered to provide contacts at these various organizations with individuals who could

grant the researcher permission to post recruitment materials. However, due to the response rate from the recruitment materials that were posted on social media (described below), no hard copy recruitment materials needed to be posted.

Advertisements were posted on Facebook. The researcher contacted the administrators of seven Facebook groups aimed towards the LGBTQ+ community in Nova Scotia and asked them if they would post an electronic version of the recruitment poster on their group (Appendix D). These groups were as follows: DalOUT, Halifax Trans Connect, South House, TRANSform Health Care, Trans Family Nova Scotia, TransAction Society of NS, and the Youth Project. As some of these groups are "private," it was not possible to see which groups actually posted the recruitment material. The groups were contacted in the morning of July 5, 2015 and by the next morning all eight interviews had been lined up. All of the administrations were contacted in the afternoon of July 6, 2015 to thank them for posting (or for considering posting) the recruitment material and were asked to take down the poster as the interview quota had been reached within a few hours.

Recruiting from these Facebook groups helped to ensure that the recruitment information was spread to those who live outside of the city of Halifax. Extra efforts were made to ensure that participants' confidentiality was maintained while recruiting through Facebook. It was clear on the electronic poster that was displayed on the Facebook groups that participants were to email or phone the researcher if they were interested in participating. The instructions stated that, for participants' own privacy, they should not comment on the Facebook post. This was to ensure that participants did not reveal whether or not they were participating, which helped to protect their confidentiality. Due

to some of the Facebook groups being private, it is possible that participants ignored

these instructions and commented on the post without the researcher knowing. If this

happened, the individuals had obviously decided that they were comfortable with others

in the Facebook group knowing that they were interested in participating in the study.

Data Collection and Analysis

      Data collection. The primary data collection method was one-on-one, in person

interviews. However, prior to each interview, participants were screened via a brief email

exchange or phone conversation to ensure that they met the inclusion criteria for the

study (Appendix E). This information was to ensure that participants were able to

comprehend English, that they identified as transgender, that they were at least 18 years

of age, that they currently lived in Nova Scotia, and had lived in Nova Scotia for at least

the last two years, that they had experienced, had tried to experience, or had wanted to

experience primary or emergency care in the last two years, and that they were able to

meet the researcher in the HRM for an interview. Participants were also asked to review

the consent form, which was emailed to them upon their expression of interest so as to

assist their decision in whether or not they wanted to participate (Appendix F). Once an

individual agreed to participate, an interview time and location was scheduled. The

interview locations were chosen with care and in consultation with interviewees to ensure

that the selected sites were comfortable for the participants and safe for the interviewer.

The interviewer wanted to select a comfortable and public location that was

accommodating to transgender persons and possessed a gender-neutral washroom. All of

the participants were willing and able to meet at Dalhousie University's Student Union

Building. All of the interviews were conducted in a private conference room. There was a gender-neutral washroom within the building. The interviews also happened to take place during Pride Month, so the Student Union Building appeared very welcoming as it was decorated for Pride.

Once participants met with the interviewer, they were given their honorarium and asked to orally confirm that they have received the $25 in cash from the researcher. They also acknowledged that they had received their honorarium by checking off the box on the receipt (Appendix G). Next, the researcher reviewed the informed consent form with the participants (Appendix F). During this time the researcher made sure to answer any questions that the participants had. Participants were asked to provide their informed, oral consent to having the interview audio-recorded and for the use of their direct quotations (Appendices H and I). All of the participants agreed to be audio-recorded and allowed for the use of their direct quotations. Participants were informed that they were able to withdraw from the interview any time during its duration and up to seven days following the interview. The seven-day period was determined because after this time, the data were analyzed and included into the existing matrix. Therefore, if the researcher had not heard from an interviewee within the week following the interview, it was assumed that the participant was comfortable with their interview being included in the study's analysis. No participants asked to withdraw from the study. Also during the pre-interview time, participants were asked to choose if they would like a masculine, feminine, or androgynous name as their pseudonym, as well as their preferred pronouns. As the use of correct pronouns and names is imperative to establishing a trusting relationships with transgender individuals (Polly & Nicole, 2011), the researcher determined that it was

essential to allow participants a choice in what their pseudonym would be. Many participants positively commented on being able to choose whether their pseudonym would be masculine, feminine, or androgynous.

The researcher also asked participants for their permission to be contacted by the researcher within two weeks of the interview if, during transcription, the researcher decided that she needed further clarity regarding the participant's story. Only one participant was contacted during this time and was asked to further elaborate upon a point that they discussed during the interview. The participant was contacted through email, which they had indicated as their preferred method of contact. The participant wrote the researcher back and provided more information. This served as a form of member checking, but was only used in the one case where the researcher required further explanation.

The one-on-one, semi-structured interviews each took between 45-120 minutes. The interviews were guided by open-ended questions, which addressed some of the main themes and concepts found in the existing literature (Appendix A). The questions were meant to guide the interview and help keep the researcher on track, while the open-ended nature of these questions allowed for participants to discuss the aspects of their perceptions and experiences that they deemed most important (Mertens, 2010).

After the interview portion ended, participants filled out a short demographic survey (Appendix B). This survey asked participants their age rage; ethno-racial group; whether or not they have a family physician and if not, why not; their highest level of education completed; relationship status; if they were currently living in the HRM; their annual household income; and employment status. This information was useful for

describing the sample of participants. Participants were told that they did not have to answer any of these questions if they felt uncomfortable doing so. However, all of the demographic questions were answered by all of the participants.

Interview questions. The interview was structured around the central question: "What are your perceptions of, and/or experiences with, primary and emergency care in Nova Scotia?" Additional questions were asked to address the central question in more detail such as:

- Can you tell me a bit about yourself, as a transgender person living in Nova Scotia – like how old you are, where you are from, when you first identified as transgender, and so on?

- Describe any positive experiences you have had with primary and/or emergency care. What made these experiences positive?

- Describe any negative experiences you have had with primary and/or emergency care. What made these experiences negative?

- Can you share any times when you may have felt reluctant to disclose the fact that you are transgender in a primary and/or emergency care setting? Why?

- Can you share any times when you may have avoided primary and/or emergency care all together for fear of discrimination if you disclosed your transgender identity? If so, what were your perceptions of primary and/or emergency care at that time?

- Can you share any times when you may have felt that a health care provider's knowledge, understanding, or experience regarding transgender health care impacted your primary and/or emergency care experience or perceptions?

- Can you share any times when you may have felt that a staff member's knowledge, understanding, or experience regarding transgender health care impacted your primary and/or emergency care experience or perceptions?

- Can you share any times when you may have felt that the physical environment of the health care setting impacted your primary and/or emergency care experiences or perceptions?

- Can you share any conditions that influence whether or not you pursue primary and/or emergency care?

- Are there any barriers that prevent you from accessing or utilizing primary and/or emergency care?

- Are there any facilitators that help you to access or use primary and/or emergency care?

- Are there any changes that you would like to see with regards to the primary and/or emergency care services, facilities, or resources offered to transgender adults in Nova Scotia?

Data analysis. Qualitative data analysis is inductive in that it follows a "bottom-up" approach, by organizing data into progressively more abstract patterns and themes. However, deductive thinking is also employed as the researcher must compare the themes they are creating against the raw data to ensure that the themes are adequately representing the participants' experiences (Creswell, 2013). The constant comparative method was employed in this study as part of the framework analysis method. The constant comparison method involved comparing the interview transcripts with one another to discover the similarities and differences (Corbin & Strauss, 2008). This

method facilitated in establishing themes and "is essential to all analysis because it allows the researcher to differentiate one theme from another and to identify properties and dimensions specific to that theme" (Corbin & Strauss, 2008, p. 73).

According to Gale et al. (2013), there are seven steps to follow under the framework analysis method, which help to produce highly structured outputs of the summarized data. This series of interconnected steps guides the researcher through the familiarization, analysis, and interpretation processes (Srivastava & Thomson, 2009). All of the seven steps were used for data analysis in this study. Some of the steps were employed numerous times throughout the analysis process, such as re-reading transcripts. Step 1 involved a verbatim transcription of each audio-recorded interview shortly after it had occurred. During this time, any personally identifying information was removed. This process provided a good opportunity for the researcher to become immersed in the data (Gale et al., 2013). Step 2 required the researcher to review the transcripts numerous times, in order to ensure familiarization with the data. During this time, the researcher jotted down ideas that she had in relation to possible codes or themes.

In step 3, the researcher read each transcript line by line, to "open code," which refers to coding anything that may be relevant from many different perspectives (Gale et al., 2013). The coding process classified the data so that it could be easily and systematically compared with other parts of the data set. The researcher used a colour-coding method to open code. Each code was assigned a colour and the researcher highlighted all of the data that fit into each specific code with the corresponding colour. Step 4 involved the development of a working analytical framework. The specific codes were grouped together into more general categories, as to start to reduce the data into

prominent themes (Gale et al., 2013). It is important to note that, like the constant

comparative method, this method encourages researchers to move back and forth across

the data until a logical interpretation emerges (Srivastava & Thomson, 2009). Step 5

involved applying the analytical framework and step 6 involved the generation of the

spreadsheet matrix. During these steps the interview data were organized to fit into each

code in the Excel matrix. The researcher copied and pasted relevant parts of each

participant's interview into "their" column, and into the row that corresponded with the

correct code. As the interviews progressed and the coding continued, more codes were

developed and refined. At this point, the thematic framework was tentative and

underwent frequent revisions as the researcher continually compared the transcripts of

newer interviews with older interviews to see if any original codes should be modified

(Srivastava & Thomson, 2009). This charting stage is known as the defining

characteristic of framework analysis. The charting process involved summarizing the data

from each transcript by category with each row representing a code and each column

representing each individual interview. The charting process required the data to be

reduced, but still maintained the original meanings of the interviewees' words (Gale et

al., 2013). The significant quotations from the interviews were incorporated into the

chart, so as to not lose the "feel" of the interviewees' expressions. The summarized data

and quotations were charted into the cells of the matrix. The charting process underwent

many revisions and was time-consuming, but allowed the researcher to become very

familiar with the interview data to ensure that the codes and themes were carefully

developed. The completed matrix was composed of approximately 500 cells of data.

The final step involved the interpretation of the data (Gale et al., 2013). By continually asking "what are the participants trying to describe?" the researcher interpreted the participants' experiences in order to develop a rich meaning of the participants' accounts (Smith & Firth, 2011). In this stage, the "characteristics of and differences between the data are identified, perhaps generating typologies, interrogating theoretical concepts (either prior concepts or ones emerging from the data) or mapping connections between categories to explore relationships" (Gale et al., 2013 p. 5).

The framework matrix and systematic analysis stages allowed for a transparent audit trail, which improved the rigor and credibility of this study (Smith & Firth, 2011). Furthermore, the researcher's interpretations of the participants' experiences were grounded in the data, with the matrix providing a clear record of how the interpretations came to be (Ward et al., 2013). The matrix approach helped the researcher to avoid misinterpreting the data by forcing the researcher to stringently examine all cases to ensure that the developing themes were accurate. This method of data analysis was well suited for this project as it provided a systematic way for the researcher to organize, analyze, and interpret the data, while enhancing credibility, transparency, and rigor (Gale et al., 2013).

As with any method, there are some limitations to framework analysis. Firstly, as with other qualitative data analysis methods, framework analysis requires a large time commitment from those involved in the analysis process to ensure that the results are adequately and rigorously analyzed (Gale et al., 2013; Ward et al., 2013). In addition, framework analysis has been criticized for lacking a theoretical underpinning, which is common in other qualitative methods such as phenomenology and grounded theory

(Ward et al., 2013). However, some argue that this is actually an advantage as it allows the researcher to assume a more flexible approach in investigating the topic of study.

Ethical Considerations

The plan for this project was submitted to Dalhousie University's Research Ethics Board on June 1, 2015 and permission for the study to proceed was granted on June 25, 2015 (Appendix J). This research project was guided by the ethical principles outlined in the Tri-Council Policy Statement for Ethical Conduct for Research Involving Humans. The research supervisor and committee reviewed the ethics application prior to submission for ethical review and provided their input on issues relating to cultural-sensitivity and appropriateness. Although this project proposed minimal risk for participants, there are a few ethical issues that were addressed. These issues include participant vulnerability, informed consent, confidentiality and anonymity, and potential harms and benefits for participants.

Participant vulnerability. Although transgender individuals are vulnerable to social stigma and discrimination, they were not subject to particular harms through the conduct of this research, and thus were not considered to be a vulnerable population. The participants were competent adults who navigate social stigma in the course of their daily lives. The context of supportive, respectful research did not heighten the probability of harms. The interview questions were low risk in that they simply asked participants about their perceptions of, and experiences with, primary and emergency care. Therefore, in the context of this study, there was no need to consider this population "vulnerable." The intent of identifying vulnerable populations in conducting research is to protect against

undue influence, coercion, and abuses of power; none of those were applicable in this study.

Informed consent. Potential participants were sent the consent form in advance to assist in their decision as to whether or not they chose to participate in the study (Appendix F). It was hoped that sending the consent form prior to the interview would mitigate the possibility that participants would arrive at their interview, read the consent form, and then decide not to continue. All of the participants had reviewed the consent form prior to the interview and it was reviewed with the researcher at the beginning of the interview. During this time, participants were also notified that they could withdraw from the study at any time during the interview or up to seven days following the interview. None of the participants withdrew from the interview or study.

Participants were told that they had the right to choose not to answer certain questions. However, all of the questions were answered by all of the participants. Participants were told that they were still entitled to their honorarium whether or not they decided to participate and received their honorarium upon their arrival. They were encouraged to ask the researcher any questions that they had throughout the interview process. The participants also received the contact information for the researcher, the researcher's supervisor, and the university ethics board in case they had questions, concerns, or comments after the interview had taken place. The researcher made sure that the participants were comfortable with the informed consent procedures and that all of their questions were adequately answered before beginning the interview.

Confidentiality and anonymity. Although anonymity could not be maintained due to the nature of the interview sessions, confidentiality was strictly upheld. Firstly, the

researcher opted to use oral informed consent and thus, the participants' signatures are not on any forms. Oral consent helps to protect participants' identities, as their names are not attached to any documents. Participants were assigned an interview number and a pseudonym so that their actual identifying information was not used during the process of analysis or writing. At the end of the interview, all of the audio-recordings were transferred to two password-protected USB drives (one for backup). The recordings were then immediately deleted from the audio recorder. After transcription (during which all personally identifying information was removed), the researcher reviewed the transcripts for accuracy and then deleted the audio-recordings from the USB drives. Any notes that the researcher took during the interviews were transcribed and the originals were shredded.

The data were managed and analyzed on the researcher's password protected, personal computer. However, the data were stored only on the two password-protected USB drives that did not leave the researcher's home office. The USB drives were stored in a locked security box in the researcher's home office. Any hard copies of the cleaned interview transcripts, coded interview transcripts, or coded data, were printed from the researcher's personal printer. These hard copies were also stored in the locked security box and shredded once they were no longer needed. All of the participant's contact information was deleted as soon as it was no longer needed.

Direct quotations from the interviews can be found within this thesis and may be used in future papers, publications, and presentations. Participants are identified by their pseudonyms for all direct quotations. Participants were notified that they might also be identified by their age range, relationship status, whether or not they have a family doctor

and why/why not, and whether or not they live in the HRM, if it was relevant to their quotation. However, strict caution was taken to ensure that none of the participants could be easily identified by these demographics.

All participants were assured that the researcher would keep the content of their interviews confidential. It is not uncommon in small, close-knit communities, such as the transgender community, for individuals to know of other persons who have participated in a study. The researcher has received questions from community members regarding whether certain individuals participated in the study. In these cases, the researcher reiterated that all interviews are confidential and that no information regarding any of the participants will or can be discussed. Although many efforts were made to maintain confidentiality, individuals were notified that the researcher had a duty to disclose abuse or neglect of a child or adult in need of protection. If a participant happened to share information regarding abuse or neglect of a child or adult in need of protection, the researcher would have reported the incident to the proper authorities, such as Child Welfare Services and/or the Halifax Regional Police. These situations did not arise and there were no instances where the researcher had to breach a participant's confidentiality.

Potential harms and benefits to participants. This project did not pose any physical harm to participants, as interviews were conducted in public spaces and during daylight hours. However, it was possible that some emotional harm could have arisen. For example, discussing negative or distressing experiences could have caused some participants to become upset. Most participants did not seem to experience any emotional distress during the interview. However, all participants were reminded that they did not need to answer any questions that they found to be upsetting. Ensuring that participants

experienced minimal emotional distress during the interview was of utmost importance.

Furthermore, due to the high prevalence of depression, anxiety, and suicidal ideation in

the transgender population (Bockting et al., 2013; Haas et al., 2014; Xavier et al., 2007),

the researcher had a resource list of local counselors to distribute if anyone seemed to

need help in that regard (Appendix K). All of the counselors on the list had identified

themselves to prideHealth as having had experience with transgender clients

(prideHealth, 2015). All of the participants were made aware of this list, but none asked

for a copy.

In regards to possible benefits, the researcher made sure that the participants knew

the value that they brought to the project. Participants were also informed of the

researcher's knowledge dissemination plans that will deliver the project's findings to a

larger audience. Participants may have benefitted from knowing that their involvement in

the study will contribute to the small body of existing information on the topic of

transgender health.

Data Quality and Trustworthiness

Guba and Lincoln (1989) discuss the importance of four key terms to be used

when analyzing quality in qualitative data and ensuring trustworthiness: credibility,

transferability, dependability, and confirmability (as cited in Mertens, 2010). Each of

these criterion should be employed in a qualitative research study to enhance data quality,

trustworthiness, and ensure a deep understanding of the project (Mertens, 2010).

According to Corbin and Strauss (2008), a credible project is one in which the

reader can make judgements about the components of the research project. They state that

readers should be able to judge how the research was conducted and how the themes and interpretations came to be. Similarly, Mertens (2010) contends that all claims should be clearly grounded in the data and the analysis process should be visible. Credibility can be achieved through rigorous methods, researcher reflexivity, and consultation with the thesis committee (Mertens, 2010).

Transferability refers to the ability of the research findings to be generalized or transferred to other contexts or settings. Mertens (2010) contends that transferability can be achieved by providing "thick descriptions" of multiple cases. To facilitate transferability, the researcher provided comprehensive descriptions of the findings, as well as descriptions of the demographic characteristics of the sample. These descriptions allow for readers to determine if the experiences of the participants in this project can be transferred to their situations.

Dependability is parallel to the quantitative term reliability. Reliability refers to the idea that a study can be repeated and that the same or similar results will be obtained. In qualitative research, the idea of replicability is not possible (Mertens, 2010). Thus, dependability refers to the need for the researcher to account for the context in which the research is taking place. In qualitative research, it is assumed that the research process will be flexible and may change throughout the course of the study. It is important to report how these changes affected the research project (Mertens, 2010). The context of this study, such as information regarding the geographical location and sample, were described in detail in order to ensure dependability.

Confirmability means that the findings and interpretations in a project are not created by the researcher, but are grounded in the data. To ensure confirmability, the

researcher chose an analysis method, which provided a clear audit trail. Guba and Lincoln (1989) suggest providing a "chain of evidence," which demonstrates how the interpretations can be traced back to the original data (as cited in Mertens, 2010).

In addition to these four principles, the "Consolidated Criteria for Reporting Qualitative Studies" (COREQ) checklist was consulted throughout the duration of this study to help ensure high data quality and trustworthiness. This 32-item checklist outlines the important aspects of qualitative research that should be reported, including researcher characteristics, relationship with participants, theoretical framework, participant selection, setting, data collection, data analysis, and reporting (Tong, Sainsbury, & Craig, 2007). As the researcher was new to qualitative research, this checklist was helpful in ensuring that no important aspects of the process were overlooked.

The incorporation of the four principles, as well as the COREQ checklist, helped to ensure that the results of this study were trustworthy and of high quality. This study's findings – which are credible, transferable, dependable, and confirmable – resulted in quality data that will contribute to health promotion, primary care, and emergency care knowledge and practice.

Study Limitations

It is crucial that the limitations of a study are acknowledged, as they provide context regarding how the findings should be interpreted and how the results can inform programs and policies. Thus, the limitations of the present study are discussed below.

First, this study's sample is not representative of the transgender community in Nova Scotia, nor is it intended to be. The individuals who agreed to be interviewed for

this project were comfortable discussing their primary and emergency care perceptions and experiences. Consequently, the voices of individuals who are uncomfortable discussing these encounters were not included in this project. Furthermore, the participants in this study were clearly comfortable "outing" themselves as transgender to a cisgender researcher. It is very possible that some transgender individuals would not want to identify themselves, which excludes their perspectives from this study. In addition, recruitment for this study was solely conducted through Facebook. Therefore, the voices of those individuals who do not use Facebook were not included. However, the goal of this project was to contribute to the small body of existing literature on this important topic, not to produce findings that can be generalized to all transgender persons in all settings.

It is possible that the experiences of transgender adults in Nova Scotia may be different than transgender adults' experiences in other locations. Even within Nova Scotia, different geographical locations can affect individuals' experiences. Again, one must consider that the purpose of this study was to explore a specific population in a specific geographical location, Nova Scotia, rather than to produce generalizable results.

It also must be noted that this project only examined the experiences of transgender adults and not their health care providers. Therefore, only one side of this important interaction was studied. Thus, there may be factors, barriers, and facilitators neglected in this study that impact the care that providers give. However, qualitative research contends that individuals are experts of their own experiences and as such, their accounts of these experiences should be taken as their truth (LeVasseur, 2003). Yet, it is

still important to remember that there are always multiple perspectives in an encounter and that these other perspectives should be considered.

Finally, the researcher has limited experience conducting research. Although the researcher was guided by her supervisor and thesis committee, the various stages of this study may still have been influenced by her limited experience.

Knowledge Transfer

The findings of this project have been and will be disseminated to various local and national audiences with an interest in transgender health, including health care provider organizations and LGBTQ+ organizations (such as the Collaborative Research in Primary Health Care Team at Dalhousie University's Faculty of Medicine, The Halifax Sexual Health Centre, The Canadian Professional Association for Transgender Health (CPATH), and The Canadian Association for Nurses in HIV/AIDS Care (CANAC)). Academic dissemination will include submission to a peer-reviewed journal and further presentations at local and regional conferences.

Results will be disseminated back to the transgender community through knowledge translation tools located at local LGBTQ+ organizations, such as posters or handouts that summarize the key findings. Finally, it is hoped that informal conversation regarding the results of this study will facilitate public interest and discussion regarding the importance of effective health care for transgender persons.

Chapter 3 Summary

     A social constructivist, qualitative research approach was used to explore transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia. One-on-one, semi-structured interviews took place with eight transgender adults. Framework analysis and the constant comparative method were used to interpret the data and provide overarching themes and codes. Ethical considerations and data quality and trustworthiness tactics were continually considered throughout the research process. After data analysis, the researcher will embark on knowledge dissemination and translation to various interested audiences. The results will help to inform health promotion, primary care, and emergency care literature and practice.

Chapter 4: The Importance of Relationships

The following two chapters address the central research question for this study: "What are transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia?" This chapter specifically addresses the sub-research question regarding how the specific types of interactions with health care providers and staff can hinder or help access to, and utilization of, primary and emergency care for transgender adults. This chapter also provides a summary of the participants' socio-demographic characteristics. The first of the three key themes that emerged from the interviews is discussed in detail. This theme – The Importance of Relationships – was what the participants spoke about most often. The results indicate that relationships with health care providers and staff, as well as relationships with peer supports and a sense of community, can influence whether a perception or experience is perceived as positive or negative. Furthermore, it was evident that these relationships can contribute to feelings of social inclusion or exclusion.

This chapter and the one following it discuss the three key themes of this study. These themes represent three components of health care settings – relationships, the physical environment, and the social environment. These components can influence an individuals' perceptions of, or experiences with, primary and emergency care. Figure 1 is meant to assist the reader in understanding each of these three components, as well as their interconnectedness. This figure provides a few examples of each aspect, which will be discussed in detail in the following chapters. It is important to remember that each of these aspects informs the others and that they each play an important role in influencing individuals' perceptions of, and experiences with, primary and emergency care.
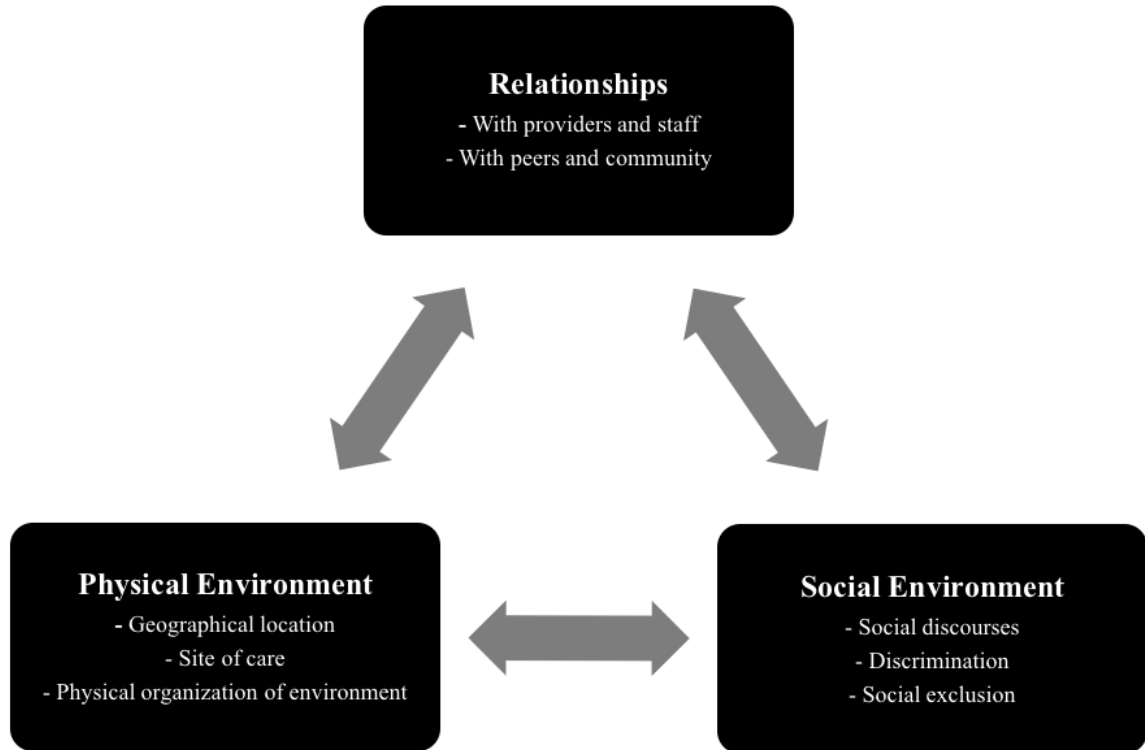
Figure 1. An overview of the three themes. A depiction of three important components of participants' perceptions of, and experiences with, primary and emergency care.

Participants' Socio-Demographic Profile

Eight individuals participated in this study through qualitative interviews. The socio-demographic characteristics of the participants are outlined in Table 1. All of the participants were English speaking, identified as transgender, and were at least 18 years of age. At the time of the interview, all of the participants lived in Nova Scotia and had lived in Nova Scotia for at least two years. All of the participants had experienced, had tried to experience, or had wanted to experience primary and/or emergency care in Nova Scotia during at least the last two-year period. Specifically, all of the participants had experienced primary care within the two-year period. Some participants discussed wanting to, or trying to use primary care, but not being successful due to barriers. Some of the participants had experienced emergency care within the past two years. A few did

not experience emergency care due to barriers and some did not utilize emergency care because they did not need to.

At the start of the one-on-one interviews, each participant was asked to describe their gender identity. Three of the participants, "Claire," "Isabelle," and "Lily," identify as "transwomen" and use the pronouns she/her. "Ben" identifies as a "transman" and uses the pronouns he/him. "Noah" identifies as a "trans-masculine guy" and uses the pronouns he/him. "Jacob" identifies as a "transsexual man" or "a man with a trans history" and uses the pronouns he/him. Jacob stated that he prefers the term "transsexual" over transgender because "I transitioned and now I'm a man and it's done." However, he did state: "I don't care, like in the process of your research, if you call me transgender. That's fine." "Emerson" identifies as a "gender-queer" and/or a "non-binary person" and uses the pronouns they/them. "Hayden" also uses they/them pronouns and stated: "I'm kind of a guy and I'm kind of a girl and I'm kind of a lot in between." For the context of this research they preferred to be called "a dude," "a guy," "a demi-guy," or "a person."

Four participants were between the ages of 18 to 24, three were between the ages of 25 to 33, and one was between the ages of 34 to 44. None of the participants were older than 45. The participants were asked to write down the ethno-racial group that they most closely identified with. Six of the participants wrote "Caucasian" and two wrote "white." Seven of the participants had a family physician at the time of the interview and one did not. In terms of the highest level of education completed, two of the participants had completed some college or university, two of the participants had received a college diploma, and four had received a university bachelor's degree. In regards to their current relationship status at the time of the interview, three of the participants were single and

had never married, three were in relationships, one was married/in a domestic partnership/in a common-law relationship, and one was divorced. Seven of the participants were currently living in the Halifax Regional Municipality at the time of the interview and one was not. When asked about their annual household income, three of the participants stated that their annual household income was less than $20,000, four stated that their annual household income was between $20,001 and $50,000, and one stated that their annual household income was between $50,001 and $80,000. At the time of the interview, five of the participants were employed full-time, one was employed part time, one was casually employed, and one was self-employed.

Table 1

Participants' Socio-Demographic Characteristics

Question	Participant Responses	Number
Age Range	• 18-24 • 25-33 • 34-44	4 3 1
Ethno-Racial Group	• Caucasian • White	6 2
Current Family Doctor Status	• I have a family doctor • I do not have a family doctor	7 1
Highest Level of Education	• Some college or university • College diploma • University bachelor's degree	2 2 4
Relationship Status	• Single, never married • In a relationship • Married, domestic partnership, common-law • Divorced	3 3 1 1
Residence in the HRM	• Yes, I live in the HRM • No, I do not live in the HRM	7 1
Annual Household Income	• Less than $20,000 • $20,0001 - $50,000 • $50,0001 - $80,000	3 4 1
Employment Status	• Employed full time • Employed part time • Employed casually • Self employed	5 1 1 1

Theme 1: The Importance of Relationships

Relationships with health care providers and staff. Participants were asked to share any or all of their past interpersonal encounters with health care providers and staff. Through these discussions, participants identified key persons in these encounters, such as family physicians, specialist physicians, nurses, emergency medical technicians, technicians, and receptionists. Participants discussed both negative and positive experiences with these individuals, as well as the key issues influencing whether an encounter is considered positive or negative. The key issues that participants believed impacted their experiences were: the health care provider's and/or staff person's knowledge, sensitivity, and attitudes, as well as having to provide education for providers/staff. Participants discussed the positive and negative aspects of each of these relationship features and these findings are presented in the following sections.

It is important to note that some individuals recounted experiences with specific types of health care professionals/staff persons, whereas others spoke about their experiences in a more general sense and did not specify the type of health care provider or staff person. Participants reported having most of their memorable encounters with physicians, nurses, and receptionists. Nurse practitioners, EMTs, and technicians were not spoken about as often because participants did not have many encounters with these types of professionals. When an experience relates to more than one type of health care provider, or when the type of health care provider was not explicitly stated, they will be collectively referred to as "health care providers," "providers," or "health care professionals." Similarly, if the type of staff person was not specified, they will be referred to as "staff."

It is also important to note that some participants commented on experiences where their "transition" or "gender identity" had "nothing to do" with the interaction. Due to the subject of this study, those experiences were omitted from the results.

Provider/staff knowledge. All of the participants had encountered health care providers who they believed had very little knowledge of trans-health issues. Most participants suggested that, what they perceived as a lack of knowledge on the part of their health care provider, resulted in a negative encounter. However, a few participants discussed the positive progress that they believed their provider had made over time in regard to learning about trans-health, which often caused encounters to be perceived in a more positive way. Even if participants described their overall experiences with their providers as positive, they still discussed the fact that their provider did not have the level of knowledge on trans-health issues that they believed they should have when they first started seeing them as a client.

The participants who discussed positive experiences spoke about how, in their opinion, their doctors had taken responsibility to learn more about trans-health issues by conducting their own "research" and "looking into" trans-health topics. One participant discussed how her physician took notes during the initial visit so that she could do some research before seeing her client again. Another participant discussed how her physician attended conferences and workshops in order to learn more about the topic. A few of the participants discussed how they believed that their physicians had utilized the assistance of other health care professionals to further their knowledge. These physicians seemed to take responsibility by acknowledging that other providers may have more knowledge on the topic and thus, collaborated with other health care professionals regarding their

client's transition. This interprofessional communication appeared to be of great importance to participants, as it not only demonstrated to them that their health care providers cared about their transition, but also seemed to give the individuals some peace of mind knowing that more than one health care provider was monitoring their health. Claire discussed the positive affect of her doctor taking responsibility to do "research," as well as the positive impression that the interprofessional communication among her health care providers gave her:

> *The first time I went to my family doctor, she was, I think taken aback or it was kind of like "oh." I felt a little uncomfortable about that because she had had some dealings with transgender people before but, she felt uncomfortable. I could tell that. But since then, she's done more research and she's completely opened up, so she's much easier to deal with now. Maybe it's because she just needed to go "oh wow, I have a new thing I need to catch up on." … Yeah, she's come around and that's what sticks in my head for the most part. She's been awesome since… I make sure that each [of my doctors] are given my test results… So between the two of them, there is communication and that works. It really helps. Because it makes me feel comfortable.*

One participant, Noah, discussed another way in which a physician appeared to take responsibility to increase their knowledge of trans-health issues. Noah commented on the positive "partnership" that he had developed with his family physician. He spoke about how he and his physician have a reciprocal relationship, where they help each other

learn. Noah argued that expecting physicians to have all the answers is unrealistic, but

discussed how he hoped that his physician would at least have a basic level of knowledge

so as to provide him some support. He appreciated that his physician was upfront about

his lack of knowledge and was willing to work on increasing his understanding of trans-

health issues. Noah's physician seems to have recognized that his knowledge on trans-

health issues should improve. Furthermore, he appeared to believe that working together

with Noah to gain knowledge regarding his transition was a better solution than them

each working apart. Noah spoke about a few positive aspects of this relationship - his

physician's "acknowledging" of the fact that he did not "have any information," his

willingness to learn, and the "partnership" that he has developed with Noah. Noah said:

> *[My family physician] is willing to learn. Again, he's acknowledging – "here's*
>
> *my privilege, here's my standpoint. I don't have any information. I'm willing to*
>
> *learn. I'm an expert at a lot of things or maybe none at all." I think admitting*
>
> *those things right at the get-go is great. For some people, it might make them a*
>
> *little bit nervous that their physician is sitting there saying "I'm not actually an*
>
> *expert," because those are the expectations that we place on people. I'm willing*
>
> *to remove that and just see them as humans who are trying to do a good thing. I*
>
> *almost like the thought of it being an equal, kind of partnership in the care,*
>
> *instead of looking at somebody as an expert who has all of the answers. When*
>
> *you're trans, you know other people won't have all of the answers for you. It*
>
> *would just be nice to not be the only one with some of the answers… I would*
>
> *much rather somebody say "hey, I have no information about this. Please*

enlighten me a little bit" than them claim to be an expert and do everything that

they can possibly do, intentionally or not, to offend me.

In addition to acknowledging a gap in one's knowledge and a willingness to learn, another common factor shared amongst these positive experiences was the length of time that the physician and client had known each other. These participants all had at least a few years of experience with their doctor with one of them even remarking that their family physician "helped to give birth to" them. Thus, these participants all had time to establish a physician-client relationship. None of the physicians mentioned above were perceived by the participants to have a level of knowledge that would classify them as "trans-experts" when these participants first started to visit them as clients. However, they all contributed to a positive relationship by acknowledging the gaps in their trans-health knowledge and by being willing to expand this knowledge over time. According to the participants, these providers took steps to increase their knowledge, which helped to foster a positive physician-client relationship and increased the client's confidence in the care that they received. These physicians increased their knowledge to what participants seemed to think was an acceptable level.

The above examples showcase instances where physicians reportedly took responsibility to increase their knowledge on trans-health issues. This appeared to positively influence the physician-client relationship. However, many participants discussed the negative aspects of having a provider with very little knowledge of trans-health issues. Almost all of the participants had encountered a health care professional who was unsure of the meaning of "transgender." Some participants discussed how they

had been told by their provider that they were the "first transgender" client that the provider had ever treated. These types of comments seemed to have some participants expressing concern and worry for the quality of the health care they were receiving. For example, Ben experienced an encounter that caused him to wonder if the care he was receiving would be "detrimental" to his health. Ben recalled visiting a walk-in-clinic for a testosterone shot as part of his transition. However, the physician was under the assumption that he was a biological male receiving the shot because of a chromosomal disorder. Ben felt "uncomfortable" disclosing the true reason why he was receiving the shot and noted that he did not want to "surprise" the physician with his transgender status as he was unsure how she would react. However, Ben felt that the physician's inaccurate assumption could potentially jeopardize his health since the physician was unaware of Ben's transgender identity and any other related factors that could affect his health. Ben commented on this experience:

> *The lowest [level of knowledge that I've encountered] would have definitely been the doctor who thought I was a male with a chromosomal thing, because that just kind of blew my mind. It wasn't even like they were confused and were like "hey something's up here, maybe I should ask a question about it" just for their own peace of mind. It was just that they totally assumed something different which, I mean, that's got to be detrimental if you were going to continuing caring for that person.*

Noah commented on, what he perceived to be, inappropriate assumptions. He spoke about how providers often "prefer to assume" that he was "assigned male at birth." However, Noah felt that this assumption was detrimental because "that is not how I see myself. It's certainly not how I would hope a doctor would have to treat me in order to see me for who I am." Noah remarked that "I need a doctor who is willing to acknowledge that I have a specific set of body issues and health issues." Noah said that he "openly admits" and "embraces" being transgender, but feels dismissed when providers' knowledge about transgender persons is "super binary." He said that when he speaks up to correct providers, they "get really defensive." He, and other participants, expressed a desire for providers to ask appropriate questions regarding how transgender individuals' view themselves and how they would like to be viewed, treated, and spoken about.

Some participants commented on the "amount of ignorance" in the area of trans-health and remarked that it was "very, very distressing." Emerson, who was visiting the emergency department for a gynecological issue, was not only asked what it meant to be transgender, but also about why they were taking testosterone and what testosterone does for one's body. Emerson's condition was hormone "fueled" and they thought it was "terrible" for their physician to be seemingly so unaware of the effects of HRT. Noah also experienced issues with physicians' lack of knowledge regarding hormone treatments. Even though he had an endocrinologist monitoring his hormones, the endocrinologist was seemingly inexperienced with transgender clients. Noah said:

My family doctor contacted an endocrinologist and she's not comfortable. Like,

she'd had some trans-patients, but she's never taken on anything to do with their

hormones or their blood work or anything like that. She said she'd be a liaison for

a little while, but she didn't have the knowledge of how the hormones worked. She

didn't understand any of that. So like, I was going to somebody, who is acting as

a liaison, who actually had no clue what she was even doing and how it would

affect me.

Thus, when Noah started to experience uncommon side effects from the testosterone, he became "concerned" when physician after physician was unable to help him. Noah discussed how his side effects have remained untreated and how he felt as though health care providers did not have "any answers" and "ignored it." Noah stated:

I had to talk to several doctors because of the side effects of the hormones. I was

getting a lot of side effects that weren't common and I didn't think that people

would have a ton of answers, but nobody had any answers and they just kind of

ignored it. It's never actually been looked at. There's never actually been any

follow up of "oh hey, what can we try to do to change this?"

Jacob discussed a similar experience with an endocrinologist who did not have what he believed to be, adequate knowledge of transgender HRT. Jacob discussed how the endocrinologist should know more about the types of therapies that they were administering and likened it to seeing a "back specialist." He said that if "you're going to

a back specialist; you want to know that they know something about your back." He said that he got the "sense" that the endocrinologist was "very much learning as she went." He said that he "never really got the sense" that they "knew what was going on." These participants seemed concerned that their health could be negatively affected due to their physician's perceived lack of knowledge. Again, the issue of time seems to be an important factor in these encounters as time is necessary in order to observe any possible advancement in the physician's knowledge. In some cases, the participants were meeting with the physician for the first time, either in a walk-in-clinic or emergency department setting, and therefore, were unable to observe any potential progress that the physician may have made in regards to trans-health knowledge over time. However, in Noah's situation, the endocrinologist and some of the other physicians that he encountered did have the opportunity to increase their knowledge over time, but in his opinion, had chosen not to.

Another issue relating to providers' perceived lack of knowledge had to do with how they obtained their information. Some participants discussed how their providers chose to increase their knowledge in what they believed were inappropriate ways. A few participants mentioned that their physician had "Googled" information regarding trans-health issues right in front of them. Although the participants realized that their providers were only trying to educate themselves, this action did not seem to be well received by participants because, in their opinion, they felt like their time had been wasted and that the physician should have already known the information that they were "Googling." Hayden discussed having to see numerous replacement physicians while their regular family doctor was on a leave of absence. Each replacement physician that Hayden

encountered resorted to "Googling" to get trans-health related information. They remarked that they felt as though they "could have done that at home" and implied that their time had been wasted by the visit. They commented:

> *Each replacement that [my family doctor] had knew next to nothing. No, they knew nothing. They knew nothing about trans things and it sucked. They were young, I'm guessing they understood what trans was, but they were still Googling things on their phones because they didn't know what to do with me.*

Ben expressed disappointment that his physician felt the need to "Google" things even though he had met with her previously. Ben said:

> *There was that one doctor who was just, you know, frantically Googling and I get that we're in the age where maybe it is kind of beneficial to be able to take out your phone and have an easy answer to something that you're not sure about. But, I mean that was also the third time that I saw her.*

Perceptions of a physician's lack of knowledge can also act as a barrier to accessing healthcare. Ben discussed how he did not "trust" that his family physician would have "any knowledge whatsoever" on trans-health issues and that this assumption actually prevented him from visiting his doctor. Ben said:

I have not been to see [my family physician] once since I started my transition. He might know on paper what's going on, but I won't go see him because I don't feel comfortable. I don't know for sure that he has any problem with [trans-people]. But, I just can't see him. So yeah, it's prevented me from seeing my family doctor, which has made it hard to navigate care… I don't trust that he has any knowledge whatsoever of like, caring for a trans-patient or like trans-health issues and stuff…I just feel like that would be quite an awkward situation to come back into and I'm just so far gone that I can't picture myself going back. Which is why I probably need a new [family doctor] and that's kind of a hard thing to do.

Many participants made comments such as "it's nice to know that people know something about you" and "it would be really swell if I had a family doctor who had any knowledge about [trans-health], because no one does." Some participants felt that it was their provider's "duty to keep up with this stuff." Throughout the interviews, it was clear that many participants felt uncomfortable with their care due to, what they believed to be, inadequate knowledge of trans-health on the part of their health care provider. According to a few participants, some providers took ownership in learning about the relevant issues, but many did not. A physician's perceived lack of knowledge sometimes caused participants to feel worried about their care and overall health and in some cases, prevented them from continuing their relationship with a physician.

Provider/staff sensitivity. Each of the participants discussed aspects of their encounters that involved provider or staff sensitivity or lack thereof. Some participants had interacted with providers and staff who they believed exhibited sensitivity by

respecting their preferred names and pronouns and by acting appropriately (i.e. did not ask "inappropriate" questions or make "inappropriate" comments) throughout the interaction. Participants used words like "appreciative," "amazing," and "pretty great" to describe their experiences with health care providers or staff persons who were, in their opinion, sensitive to these matters. The most common positive act of sensitivity that participants spoke about was having their preferred names and pronouns respected. It is interesting to note that some participants spoke about their "hate" for the word "prefer" because "it's not a preference. It's just my name."

Hayden spoke specifically about an experience a friend had with EMTs. They said that the EMTs were "extremely nice," "very respectful," and "referred to [my friend] by her chosen name." Emerson commented on an encounter with health care staff. They spoke about asking the receptionists at the blood collection clinic to call them in for their appointment by their last name or number, so as to avoid their former name being called out in public. The receptionists were "fine" with this request and "did not question anything." Emerson also spoke about how the nurses and staff at the emergency department wrote their preferred name onto their hospital wrist band and remarked that this act "was good." Ben discussed how the receptionists at his usual walk-in-clinic were very "accommodating" about accepting his preferred name. He also noted that the receptionists seemed to pass the information on to other staff as to prevent a mistake from being made. Ben commented:

It was just not a hassle with these particular people to say "look, this is my

preferred name and I really want you to call that out." I've never had my

previous name called out in the middle of a clinic or anything like that…

Sometimes I worry if I've been used to one receptionist for a while and then

somebody else comes in that I don't know. But, I find that somehow the

information has been passed on and nobody makes a mistake. So I'm assuming

that they're probably giving a bit of a heads up.

Some participants spoke about instances of health care providers and staff accommodating them in ways that made them feel more "comfortable." Noah commented on a positive experience where the provider was "respectful" and "not intrusive." He remarked that the provider "followed my lead" and "didn't put it all on me, but they definitely left the door open with room for me to insert how I wished to be treated in there." He remarked that this was "incredible," but "really, really rare." Jacob discussed an encounter with a receptionist at a hospital. Upon checking him in, the receptionist noted that the sex designation on his health card was different than the one in the computer. Instead of "announcing it to the room," the receptionist "slid the health card across the table and pointed at it and said 'is this correct?'" Jacob seemed to be very "appreciative" of the respectfulness and privacy of this experience. Similarly, Emerson discussed an encounter with an ultrasound technician who made accommodations for them to be more comfortable during a gynecological exam:

There was one person when I had the ultrasound and she was actually pretty

good. She asked me, because there's like the external or internal one, she was like

"it might be uncomfortable for you to do [the internal ultrasound], but it's also

the best way that we can do [the ultrasound]. But if you're too uncomfortable, it's

fine." So I said, "okay, let's go for it." So she was like "here, you can put it in

yourself if that will make you feel more comfortable." … And I don't know if she

does that with everyone, but that was my positive experience.

It was clear that the health care providers in these situations were perceived by the participants as demonstrating sensitivity. Participants "appreciated" when health care providers and staff respected their preferred names and pronouns, made accommodations to respect their privacy and bodies, and ensured that information was passed on throughout the clinic, so as to prevent mistakes from being made.

The previous examples all illustrate encounters in which providers appeared to demonstrate sensitivity toward the participants. However, many participants encountered providers and staff who were, in their opinion, not sufficiently sensitive. Some participants discussed situations in which sensitivity was not used, such as being called by their previous name, being misgendered, being "outed," having their gender identity disregarded, undergoing irrelevant and impolite questioning, not having adequate privacy, and experiencing inappropriate medical procedures.

Many participants discussed being misgendered or being called by their "dead name" during a health care encounter. These actions left participants feeling "embarrassed," "angry," and "disrespected." Some participants mentioned that their

physicians did not ask them what pronouns they preferred and mentioned that doing so could have prevented an awkward encounter. Others said that, in their opinions, it is a "luxury" to have your preferred name and pronouns respected. Emerson discussed being misgendered by their surgeon and felt that there was "no excuse" for the mistake:

…My surgeon like misgendered me, even though I'm your only, probably your only, trans-client right now. Why are you still messing up my pronouns? Like, you've never known me as any other pronoun, so there's no excuse really. So yeah, that was not fun.

Similarly, Hayden commented on the "embarrassment" and "anger" that they felt when their preferred name and pronouns were not respected. Hayden mentioned how being misgendered can contribute to their mental health issues. They said:

[The receptionists at my family doctor's office] are nice. They're not impolite, they don't look at me like a freak. But, they don't respect my, like, name. They've shortened my name to a nickname and so far that's reasonable, but like, they're still saying "she" behind the counter when they're speaking about me. They're saying "she" and it's so disheartening because I'm there for mental health care reasons and if I'm hearing people misgender me a few feet away, it's not going to help… I think the reason that I hate [being called the wrong name or pronoun] is because I don't know who they're talking about. Like they're calling out my birth name and it's just so frustrating to me, because I don't even know who that is

anymore. That's not accurate. It's not necessary. I hate it. I'm just immediately

made defensive and embarrassed…I'm walking into that appointment with a flush

of embarrassment and anger. And like, that's not a great way to start off a

medical examination.

Some participants suggested that asking clients how they like to be addressed should be a "standard thing." Emerson remarked that when "you're super sick," you sometimes "forget" to tell staff and providers your preferred names and pronouns. They further suggested that providers and staff "learn about pronouns." They suggested that providers and staff should be aware that "you can't look at someone and just know their pronouns." They also commented about respecting clients' names. One participant commented that it does not seem to be an issue if a person named "Richard" asks to be called "Rick." But "if it's James legally and they ask to be called Jessica – then that's a huge problem and they can't do it." Isabelle stated that it is "silly" that transgender individuals should have to take being properly referred to as a "victory" when it is so "easy" and "basic" to call people by what they want to be called. A few participants expressed their wish for "everyone," "transgender or not," to be asked about their preferred pronouns. Some participants also mentioned how a simple "sorry" will suffice when a provider or staff person uses the wrong pronoun. Noah said that it is a "wonderful thing" when a provider says "they're sorry and moves on." He said that he feels a lot of "anxiety" when a provider or staff person goes "on and on" about their "mistake." Noah said:

Some people make a really big scene out of it and make it a big deal and draw it out and draw it out and draw it out. Which, then puts it back on you to say "everything's okay." Meanwhile, you're having an anxiety attack because they're going on and on about how they've made a mistake and they're so sorry and now there's other people around.

The concept of being "outed" by a health care provider or staff person, or being forced to out themselves, was another common sensitivity issue. Ben discussed going to a walk-in-clinic for his testosterone shot and always being asked "why I'm getting the shot." He said that outing himself is an "uncomfortable thing to do," especially when he was unsure "if they were going to understand" what it means to be transgender. He mentioned that he feels "awkward" when he says "because I'm transgender," due to the uncertainty of the physician's response. Emerson spoke about being outed by a receptionist at a hospital in front of a waiting room full of other clients. Emerson wondered "why she would do that" to them:

…I had just said "can you make sure to call me by my number or last name?" And then I left my health card at the desk. She just starting yelling my name with all of these other people around… I mean, I had just been up there. She could have just been like "excuse me, you left your health card" and I would have known it was me.

Some participants discussed the privacy issues that come with having to out yourself in a health care environment. Ben commented on the "fear" that he experienced when he would ask a receptionist to call him by his preferred name. He mentioned that he was worried that he would be "singled out." He said that before he legally changed his name, he was "always afraid that they were going to make a mistake" in calling out his name. He also spoke about it being "uncomfortable" to have to out himself or to "be misgendered in front of a bunch of people, because you just don't know how people are going to react to seeing or hearing that in public." Emerson said that it is "unfortunate" that individuals cannot ask to speak to the receptionists in "private" in order to prevent themselves from having to declare their gender identity to the waiting room. They said that they felt as though it would "probably be an issue" if they responded to being misgendered by saying "that's not my name."

Some participants spoke about encounters with health care providers and staff, during which their gender identity seemed to be disregarded. For example, Noah spoke about feeling as though some physicians assume that "people's identities aren't real or that this is a phase or just a temporary thing." He spoke about having to "constantly struggle for your identity to be valid." He also discussed the negative consequences of speaking up to say "I would prefer you to speak to me or about me in this way." He remarked:

> *[Providers and staff are] not seeing me. That's the way I feel about health care in Nova Scotia, in general, is that they're not seeing me. It's like I don't even exist right now to you. So I'm always trying to justify my existence and if you speak up*

and you say "actually I would prefer you to speak to me or about me in this way,"

they get really defensive because they don't have the information. It's like you're

coming off as if, you know, you're asking too much.

Some participants discussed the feeling of having their gender identity or wishes

dismissed during a health care encounter. For example, Emerson's gynecological issue

was often referred to as a "women's problem," even though they do not identify as a

woman. In Emerson's opinion, the physicians also "insisted" that they keep their ovary,

even though Emerson expressed that they "did not care" if it had to be removed:

They continued to say like, you know, "however many percentage of women have

this problem" and it's a "women's problem" and just really not getting it, that

like, I'm not a woman… They were like… "we're going to try really hard to save

that ovary." And I was like "I don't really care about the ovary. Don't bother."

You know? And they were like "well, you know, you really want to keep that

ovary, just in case." And I was like "no. I don't care." And I had to keep telling

doctor after doctor… A couple of different residents as well as like the actual

doctors and things. They were all just insisting that I keep my ovary. And they

were saying "well, you're going to want to have kids." And I was like "well,

nope. My partner is going to do that, not me." Um yeah, so that was really

stressful and frustrating.

Emerson also spoke about a friend, a transman, who was undergoing a

hysterectomy consultation. Emerson said that the doctor "kept talking to [their friend's]

partner]" and ignoring the client who was actually going to be receiving the procedure.

Emerson remarked that this encounter made them feel more hesitant to pursue these kind

of gendered care environments. Jacob discussed a similar situation with gendered care.

Upon arriving at the hospital for a hysterectomy, Jacob encountered several health care

providers, who he believed to be nurses, who did not seem to understand that a man could

undergo a hysterectomy. Jacob said that the encounter was "Abbott and Costello" like

and although in retrospect he finds it "funny," he said that at the time it was "annoying."

Jacob commented:

> *I had to convince several people that I had a uterus so that I could get it taken*
>
> *out. It was like "I'm here for an appointment with [doctor's name]." "Oh okay,*
>
> *you are?" "Yes." "For you?" And so it was kind of a process of like "yes, it's for*
>
> *me. Can you just tell me where [the doctor] is?" kind of thing. And they would*
>
> *say, "well it doesn't make sense that you would be here for that kind of thing."*

Experiences in which participants' transgender identities were dismissed in

gendered care environments were perceived as negative by participants. These

participants believed that their health care providers did not perceive their gender

identities as "valid." It appeared as though participants felt that their requests were

disregarded, that they had to prove their identities, and that they had to continuously fight

against gendered care. Again, these examples illustrate incidences where a perceived lack of sensitivity negatively affected the health care encounter.

Experiencing "inappropriate" questioning from health care providers and staff was another sensitivity issue discussed by many participants. Almost all of the participants discussed having encountered a health care provider or staff person who asked questions regarding their transition or bodies that they deemed to be "inappropriate." "Have you had any surgeries?" was one question that numerous participants reported being asked. Participants commented that this question and others like it were often "irrelevant" to why they were receiving care and they felt as though the provider "did not need to know" the answer. One participant was concerned that providers "were not even realizing that they were making things ten times worse by asking such invasive questions." They said it "distresses me that not more people understand being trans – respecting a person's identity – is life and death." Jacob said that it is easy to get "bogged down" in an unwanted discussion regarding irrelevant issues and that it is "sidetracking" from the actual reason why he pursues care. Jacob said:

> *…I don't disclose my trans status unless I feel like it's absolutely necessary, because I think once you get into that discussion, you get pretty bogged down with like "okay, so wait, so wait, let me get this straight. So like you had boobs and now you don't?" Like that kind of thing. And it's like "yes! And I have a sore throat. Can we talk about that?" You know, like, it can be very sidetracking, so I think that's part of it for me. Like I don't want to get into that discussion at all.*

A few participants discussed receiving inappropriate questions from health care providers that seemed to be completely "out of left field." For instance, Jacob spoke about an incident with a physician where he felt as though the physician was asking things that were "really none of his business" and "not even relevant." Jacob said:

…For instance, [the physician] asked me how a man would have sex with me. For how to instructions – like how to have sex with me? Well, I don't want to tell you that! It was also like not even relevant, like not that it would have been relevant anyway, but I wasn't actually seeing a man at the time. I was seeing a woman and he knew that. It was just like so out of left field.

Participants seemed to feel that these types of questions were "inappropriate" and "irrelevant." Ben suggested that physicians "should know not to ask [inappropriate questions] unless it's totally relevant." Many participants reported feeling as though these questions were asked out of "curiosity" as opposed to being asked out of relevance to their health care. Thus, this type of invasive questioning was perceived as a lack of sensitivity and appeared to lead to perceptions of a negative encounter.

Another issue that participants discussed within the category of sensitivity were matters relating to how health care providers respected their bodies. A few participants discussed the importance of having health care providers ask "how would you like me to refer to certain parts of your body?" or to give a warning like: "I'm going to touch you here right now because of this and is that okay?" One participant remarked that, in their experience, these questions are rarely asked even though "it's a huge thing and it's

simple." Another participant acknowledged that this is "not a trans-specific issue" and thought that all clients would appreciate this kind of warning before being touched. However, they suggested that transgender people might "sometimes have a more negative reaction to [not receiving a warning] than other people" because of "trauma histories" or other reasons. Another participant said that being asked about how they refer to their body and receiving a warning before they are touched means a "greater deal than people realize." They said that they feel "a lot more at ease if I realize that people are going to see my body the way that I wish it to be seen." One participant remarked that when they were asked about how they refer to their body, they felt like they were "looked at" like "a person" rather than "an object" or "a medical experiment."

Jacob felt that providers should be aware of "the loss of autonomy" or "loss of control" that transgender individuals "seem to feel in health care situations." He said that "medical terminology for bodies" is a "sensitive area" and suggested that providers ask participants how they like their bodies and body parts to be referred to. Jacob also discussed undergoing, what he perceived to be, "unnecessary exams" and "exams that are conducted in a non-professional manner."

> *…So, like, for instance, I had a breast exam and a pelvic exam… Neither of them was particularly relevant in terms of the care that I was receiving… I would expect that if you were going to get both of those exams, that you would do one, probably you would have the breast exam first and whatever, then the doctor leaves, and you get undressed. That kind of thing. I had the pelvic exam and then he did the breast exam while I was still naked from the other exam. So, I*

essentially was completely naked… Once he was actually looking at [my chest]

and touching it and looking at the scars and poking them and whatever, I just kind

of got the impression that he hadn't seen that before and that he was curious… I

think he just wanted to have a science experiment.

Some participants reported feeling "worried" about these types of encounters. Jacob even reported that he "tends not to get exams, particularly pelvic exams" from anyone except his family doctor due to these types of negative experiences. Participants reported that these types of encounters could be avoided if physicians had an "open dialogue" about how the client refers to their body parts, if they explained the relevance of the exam first, and if they informed the client before they touched them.

A few participants remarked that there should be more "continuity between health care professionals" so as to make transgender clients feel "safe and comfortable." Jacob expressed feelings of gratitude when there was "continuity" amongst health care providers, but also spoke about the consequences of not having continuity. He said:

I feel like there needs to be continuity between health care professionals…I've

had friends who've had surgery and they go and they talk to the first person and

they tell them some of their concerns about the surgery and how they need it to go

for them to be safe and comfortable and they're like "yes, absolutely, that makes

sense. I'll make sure to pass that on." But it never seems to get there, you know.

So you end up in the recovery room and you're all drugged up and they're pretty

vulnerable and the things that they have said that they need are not things that

are being respected. Because I think it's one thing to go in knowing that your

needs are not going to be met, which is shitty for sure. But, it's a whole other

thing to go in thinking that they're going to be met because someone told you

they're going to be met and then finding out that no, actually that didn't happen.

Almost all of the participants had encountered an issue relating to a perceived lack of sensitivity on the part of a health care provider or staff person. These problems, which ranged from misgendering mistakes to inappropriate examinations, all appeared to be detrimental to varying degrees. Participants often mentioned that they wish they had been "asked" about their preferred name, pronouns, terms for body parts, etc. and that if this dialogue had been established, the encounter would likely have been perceived as more comfortable and positive. Participants suggested that physicians "should always follow the lead of the patient" to ensure that they are comfortable with the encounter.

Client providing education for provider/staff. In many cases, a provider or staff person's perceived lack of knowledge or sensitivity resulted in the client having to educate them. One participant noted that they are responsible for educating their provider "99% of the time" if their health care visit is due to "anything trans-related." Some participants discussed the mixed emotions that arise when it comes to educating providers. Some participants said that they did not want to have to educate their providers. However, some participants felt that they were making a positive contribution to that provider's future encounters with other transgender clients when they educated the health care professional. Some participants mentioned that they were "happy" to educate providers when they felt that they were "asking out of an actual genuine interest and with

respect." They felt that by providing this education, providers would be able to give "better care to trans-people who would be coming in the future."

Claire, who was the oldest participant in this study (age range 34-44), remarked that she was "not concerned" by having to educate her providers. She said that she is "an open book" and believes that "knowledge is power." She felt that by educating her providers, she was promoting "acceptance" for the transgender community. In Claire's opinion, by helping to educate providers about how to appropriately treat transgender persons, she felt as though she was "paving the way" for transgender individuals that would interact with that provider after her. She said that she could not "fathom the idea of just standing aside and letting my life happen the way it happens and not find a way to help others."

Thus, for Claire, educating her providers appeared to be a positive experience. Some participants felt that they needed to inform their provider that not all transgender persons would respond well to having to educate their provider. Noah spoke about wanting to teach providers that they "can't paint [all transgender people] with the same brush." Similarly, Jacob spoke about trying "to be educational" about the topic of interest, as well as warning providers and staff that certain types of questions are not always received well by transgender clients. He noted that he is willing to answer questions when he feels like he is being "respected."

However, he also understands that not all transgender people will want to educate their providers. Jacob commented:

I got asked a bunch of questions that were, you know, not necessarily the most

politically correct or even relevant. But I also feel like I was okay with that. I

know a lot of trans-people wouldn't be okay with that, so that's another thing that

I'm cognizant of all the time. Like, I'm okay with this experience right now and I

do tell health professionals that as well, like: "I'm okay to talk to you about this,

but a lot of people wouldn't be though, so don't just go asking that to everybody."

… So, I'm happy to [answer the questions] most of the time, when I feel like I'm

being respected and you know, what have you. But like, I understand that not

every trans-person that is going to the doctor wants to have to do that and I think

that's also very reasonable.

Some clients though, did not perceive educating their providers as a positive experience. For these participants, having to provide education was "frustrating," made them feel "uneasy," and gave them "a lack of faith" in their care. Many participants felt that the reason they were pursuing health care in the first place took a backseat to their educational lesson. Numerous participants made comments like "I can [educate], but it's not what I'm here for" or "I'm here to receive care. I'm not here to take time out of both of our days to tell you what this means." Some participants further commented on the time that it takes to educate their provider, such as: "I don't have the time to sit here and educate. I only have twenty minutes for this consultation." Lily discussed how friends of hers "had to jump through six or seven therapists and counsellors" because "every single time" they visited the provider, they spent "an entire session" educating. Lily feels as though having to take the time to educate providers increases "wait times" and makes

clients feel "dissatisfied," which could cause transgender individuals to utilize "health care less." She mentioned that "part of the reluctancy [sic]" to utilize health services stems from the belief that she will likely have to educate her providers. A few participants seemed to express frustration that their providers were "expecting" them to educate about transgender health topics in the first place. For example, Ben noted that "these are people in a population which you are inevitability going to be treating, so I mean, why are you asking me something you should know?" Emerson discussed having to request a referral during their visit to the emergency department. In their opinion, they also had to educate the physician on why they were requesting the referral in the first place. They said:

> *I asked [the doctor], I was like "have you gotten an endocrinologist on board here?" and he was like "no, why would we do that?" Like, I'm taking testosterone, and I have an estrogen fueled disease here and you're not acknowledging that. So he was finally like "okay. Fine. We'll send off a referral."*

Hayden commented on an encounter that they witnessed while accompanying a friend to the emergency department during a drug overdose situation. Hayden said that they understood "that [the providers] were trying to educate themselves," but believed it "was not appropriate" for their friend to be expected to provide "Trans 101" during a medical emergency. Some participants remarked how educating can be tiresome "because it's not just one person that you have to educate, it's every single person that you're interacting with."

Noah discussed how he holds an "educator" position in his work and within the transgender community in his town. However, he commented on the difference between general education and educating within a health care context. He said:

I'm an educator. I educate people on a daily basis. But sometimes you get really tired of having to stand up for yourself. And sometimes you don't want to be somebody's educator, especially if it's a health care situation and it's a serious thing and you're just trying to get through the day to get through with what you need... It's again, sometimes I don't want to be somebody's educational moment. I do that a lot and I'm very passionate about it and will never stop. But when you're vulnerable and not well, or you are well and you just have another step to go, you don't always want to [educate]. And it's a constant because it's not just one person you have to educate, it's every single person you're interacting with.

Some participants mentioned that they had brought in resources to assist with their educating. One participant noted that they felt as though they had to do "all of the back work" for their provider. Some participants discussed printing off various resources for their doctors to use as a "guide." For instance, Isabelle discussed how her friend was finding her transition progression "really slow and not at the level that she likes," so she brought in research to support her request for an increase in hormones after the doctor initially "brushed her off." Isabelle said:

One of my friends went and got her hormone levels tested recently… and her

estrogen was a little bit lower, like, not as high as she would have liked it to be.

So she was requesting to increase her dose and the doctor just pretty much

brushed her off and said, you know, "oh well. No, we don't need to do that. You

don't need that." When it's the client who is requesting it and saying they think it

would be beneficial. She actually had to bring in research to show than an

increase in levels would actually help her and help her in her transition.

The participants had differing outlooks on having to educate their providers, with some finding it to be a positive experience and one in which they felt as though they were "paving the way" for other transgender persons. However, some participants were "frustrated" and "uneasy" with the responsibility of educating their health care providers. Some participants even felt that they needed do all the "back work" and bring research with them to assist with their educating.

Provider/staff attitudes. Numerous participants spoke about how the attitude of their health care provider or staff person influenced their visit. Some participants spoke about providers and staff expressing "support" and kindness towards them, and the positive impact that this display of encouragement had on the relationship. For instance, Ben discussed an encounter with a receptionist at a walk-in-clinic. Ben believes that the receptionist knew he was transgender after she noticed the "preferred name" spot on his chart. Ben commented:

Maybe not all people would appreciate this, but I did. [The receptionist] said

something like "oh, just so you know, I totally understand what you're going

through. I have a friend that's doing the same thing and I totally support you." I

just thought that was really nice to hear from somebody. Although, some people

might think that was a bit much. But, I think she was probably just excited to have

found somebody else like her friend... So that was really, really, really nice.

Emerson perceived their emergency department visit as mostly negative due to constant misgendering. However, they did discuss an encounter with a kind and "sympathetic" nurse, who seemed to leave a positive impression on Emerson. They said:

One nurse in particular, she was super great. She was like "what's going on?" …

And I told her [about my gynecological issue] and she's like "that's not anything

that anybody should have to go through, especially a boy!" She was precious. So

that was, yeah. She was just really good and sympathetic, I guess.

There was a common shared theme amongst participants who had the same family doctor before and after their transition began. These participants remarked that they were glad when their doctor's positive attitude towards them did not change after they told their physician that they were transgender. Jacob said that his family doctor "is treating me like he has always treated me… which is great." Claire commented that her doctor has always been "very kind… She's putting forth an effort to make it a very good relationship between the patient and doctor and I appreciate that." Lily commented that it

was a "pleasant surprise" to discover that her family doctor was "trans-positive" and "non-judgmental." These characteristics helped to maintain their already positive physician-client relationship. Thus, participants appeared appreciative when providers' already positive attitudes were not changed due to their new gender expression.

These supportive and kind interactions seemed to be perceived as positive by participants. However, some participants spoke about providers and staff persons with, what they perceived to be, negative attitudes. These participants also commented on the consequences of these attitudes. Some participants discussed how their provider gave off an "uncomfortable" attitude. Others talked about friends' experiences in which the client felt as though they were being "mocked" by the provider. Noah commented on a visit with a physician who, in his opinion, was giving off an "I don't really need to do this. I'm doing you a favour" kind of attitude. Noah had to ask the physician to stop asking "inappropriate" questions and to stop making "assumptions," which only seemed to worsen his attitude. The physician, who Noah was seeing in regards to a consultation for a gender-confirming surgery, said to him: "It's not like I need the money. So you can go back home and think about it for a couple of months." Noah was upset by this negative attitude and alluded to the potential ramifications of such an unpleasant encounter. He said:

> *At the point in time that I was [having this gender-confirming surgery consultation], it was such a necessity to me that I wasn't sure if I was going to make it another week, right? So doctors don't have any of this background*

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information and you need to be really careful with what you say to people and

how you say it, because you just don't know what's going on under the surface.

Ben discussed how "excited" he was to get his very first testosterone shot, which he said was a "big deal." He stated that he had his girlfriend and a friend accompany him to this exciting appointment only to have it "soured" by, what he perceived to be, a doctor with a negative attitude. This experience was "extremely upsetting" for him. Ben commented:

The doctor came in and asked why I was there and so I said "oh, I'm here to get a

testosterone shot." She didn't, like, understand what I was saying at first and I

was like, "I have this prescription and I'm here to get this shot done" and she

kind of looked at me weird and looked at my girlfriend and looked back at me and

said like "I don't want them in here." She told my girlfriend to leave and then she

said to my face "I'm not comfortable doing this." She gave it to me anyways, but

it totally soured the experience, because I was super excited and she was just in

front of me saying like "I don't know what this is and it makes me uncomfortable"

type-thing. In retrospect, I really should have made some sort of complaint, but it

was my first time doing that and I just didn't know what to do. It sucked that it

had to be that way too, like in health care. That was my first experience with it

and it was a really, really bad one and it was extremely upsetting to have that

happen. My girlfriend was affected by that too because she was told to leave the

room and it's like "why?" I wanted her there.

Jacob also had a negative encounter with a physician who appeared to be "uncomfortable" treating a transgender client. Jacob was seeing this physician to begin his transition and was a client of his for over a year. During this period, Jacob had numerous exams and interviews to determine that he was ready to begin HRT. However, in Jacob's opinion, the physician ultimately decided to not continue treating him due to his discomfort. Jacob noted that he "had gone through all of that and [the doctor] was just kind of like, 'yeah, I don't think I'm comfortable doing this, so, bye.'"

Ben spoke about an encounter with a physician who he perceived to be "distrusting" of him. Ben said that the walk-in-clinic physician "gave me a hard time" because his usual dose of testosterone was not recorded in his chart. She questioned Ben and commented that "maybe you're giving [your shot to yourself]." Ben interpreted this as "basically, we don't trust you." Ben wondered: "Does this rule exist or did she just make it up so that she didn't have to deal with me?"

Some participants described their provider's attitude as "curious" and felt as though some of the questions they were asked, or care that they received, was "not relevant." Participants spoke about feeling as though they were an "experiment" or "project" when their providers seemed more concerned with "irrelevant" and "personal" issues than with the actual reason why the participant was pursuing care. Noah remarked that he felt that providers were "calling other nurses and other doctors to come take a look at you like 'oh what do we have going on here?' They were poking and prodding [me]." Jacob remarked that he has felt like a "specimen" with doctors in particular, while nurses seemed to be more concerned with him "as a person." Isabelle commented on her perceptions based on friends' experiences with health care:

I think the biggest thing that I'm getting from my friends and from my peer group

is that they feel like trans-health is the wild west and their body is the frontier.

That there is so little understanding and the science is evolving behind it, but they

feel like they are the test subjects for it all.

Participants did not seem to appreciate when their provider's attitude and

approach appeared to be one of "irrelevant" "curiosity." Noah made a comment about

feeling as though he were a provider's "entertainment." Remarks similar to his were

common among participants who had experienced these types of encounters. Noah

commented "I'm not here for your entertainment… I'm a person. I'm a patient. And I

would like the same level of care as anybody else who is in this facility right now."

Thus, a provider's attitude influenced the perception of a positive or negative

experience. Providers and staff who were "supportive," "trans-positive," and "non-

judgmental" were mostly perceived as positive. Whereas those with "uncomfortable,"

"distrusting," and "curious" attitudes were usually perceived as negative.

Impact of the client's personal attitude on the relationship with provider/staff. It

appeared that the participants' personal attitudes towards a health care encounter also

influenced whether they perceived it to be a positive or negative experience. Some

participants spoke about having "pretty good experiences" because of the way that they

personally approached the situation. A few participants commented on how they assumed

"that the people who are rude to me are just rude people, as opposed to them being rude

because I'm trans." Participants acknowledged that this might not always be a correct

viewpoint, but that this assumption "benefits" them as it can prevent them from feeling

"defensive." Some participants spoke about assuming "the best of doctors" and believing that the encounter is "going to go well, until it starts to look like it's not." They remarked that this was a "useful" perspective to have as it has contributed to their perceptions of a positive encounter. Jacob spoke about his personal "expectation" regarding how his health care encounters would unfold. He commented on his assumption that there will be "awkward moments" during his interaction, but that he would also not settle for anything less than "good health care." He said:

> *I expect that there will be awkward moments. I expect that I will have to do some explaining. I also expect that when I leave I will have, you know, the prescription that I need to cure whatever I've got. Or that if they couldn't figure out what it is, that I will be referred to someone who can figure it out. I expect that, you know, generally speaking, things are going to go how they should, but that there is going to be some awkward bumps in the middle…My expectation is that those things are going to happen, but also that I'm going to get good health care.*

Claire, who had hardly any negative health care encounters, said that she feels her good experiences are due to the fact that she is "a positive person." She also mentioned that "accepting yourself as you are" and purging negative emotions such as "shame, guilt, anxiety, and fear" leaves a "beautiful, happy person." Claire says that she likes to "joke" with people, especially when "they're uncomfortable" with her. She spoke about wanting to "leave an impression" on people and that she does her best to "leave a positive impression." For example, she spoke about getting into a small car accident. Even though

the other driver was at fault, Claire recognized that this experience was "probably their first time dealing with a trans [sic]." She told herself to "be nice" because she did not want the person's impression of transgender people to be negative. This type of personal attitude carried into Claire's interactions in the health care setting. Claire believes that this personal positivity helps others, such as health care providers, to "embrace the 'new' person." She discussed wanting to "write a book" so as to share her message of positivity with others. Claire commented:

> *Well I'm hoping that, you know, I'm sure you're going to hear some negative [stories] and I hope there are at least a couple of positives. If everyone who reads this sees that they might go "well what's different?" And "why can't I have that experience?" I wish I could just write a book and explain to people "this is how you do it. This is what's worked for me." If I knew a magic formula, I would send it to every person that I know. Because, I remember what it was like to be very afraid of going out and all those things. But, I decided for me, I had to do it. There was no other way for me to continue. I mean I could have, but I would have been miserable. And I want to be happy.*

Thus, participants' personal outlooks and beliefs regarding how the health care encounter would unfold or how they would approach the encounter seemed to affect their experiences. This concept was not discussed by many participants, but those who did mention it seemed to strongly believe that their attitude was very influential on their perception of the overall encounter.

Comparing physicians and nurses. Although most participants did not compare and contrast their experiences with physicians versus those with nurses or other health care providers, some did comment on the distinction. Of the participants that mentioned a difference, most were in agreement that nurses were more "accepting" and "open" than physicians. Participants remarked that nurses' "beside manner tends to be higher than some of the other health care professionals." One participant remarked that out of all the health care providers that they have dealt with, nurses seemed to have the best "intentions." One participant commented that although "some nurses are really great," they have encountered nurses who are "really set in their ways" and who make "assumptions" about transgender-related care.

One participant was in disagreement with the general consensus and felt as though physician-client interactions were superior to nurse-client interactions. They stated that "at least with doctors there is something physically that you can focus on… it's easier to steer discussion in a way that doesn't lead to something along the lines of genitals or gender identity." Thus, it appeared that most participants felt more comfortable interacting with nurses over doctors. However, one participant remarked that they preferred interacting with doctors due to the ability to "steer" the conversation away from inappropriate topics.

Relationships with peers, family, and community. Participants commented on the importance of relationships beyond those with health care providers and staff when they discussed the impact of social supports and peer influences. Specifically, many participants commented on the importance of having relationships with friends, family, and the broader transgender community. Some participants spoke about the significance

of having social support while pursuing care, whether that meant having a friend accompany them to an appointment or just having a support person or group to turn to. Similarly, participants discussed how their perceptions of health care were influenced by observing or hearing about peers' experiences. Some participants discussed the transgender community as a whole and the positive influence that it has. Whereas others discussed the "scare mongering" stories that often prevail amongst discussions within the community.

    Interpersonal social support. Many participants discussed how social support can be helpful when pursuing health care. A few participants spoke about accompanying other transgender friends to doctors' appointments, whereas others discussed having peers (transgender and/or cisgender) accompany them to appointments. Giving and receiving this type of social support seemed to lessen the effects of a negative experience. Hayden spoke about accompanying an ex-boyfriend to his testosterone shot appointments. They said that they "obviously made the trip easier" for him because if he were to be misgendered, Hayden would be "the first to speak up." Hayden said:

> *It's nice to have that support. Because you know that someone has your back and they're supporting you. They respect you. And even if a person misgenders you, you have someone to look at and be like "is this really happening right now?"*

Emerson spoke about being the recipient of social support during their trip to the emergency department. Similar to Hayden's account, Emerson's partner accompanied them to the hospital. Emerson discussed how their partner was the one to correct the

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provider when they misgendered them. Emerson said that this was "really good" because they were too "scared" and "exhausted" to correct the provider themselves.

Some participants attributed their positive experiences to the social support they have in their lives outside of their health care encounters. For example, Claire remarked how "awesome" and "incredible" her friends, family, and co-workers have been since she has come out as transgender. Claire spoke about how they have contributed to her happiness. The social support that Claire has received from those around her has also helped her to "pay it forward." She spoke about mentoring other transgender people to help them build "confidence." Claire seemed to take a lot of pride in her mentorship role and remarked that "I wish I had had a mentor when I was trying to learn how to deal with everything… I might have transitioned earlier." In Claire's opinion, serving as a mentor as well as receiving social support from her friends and family, helps her feel "confident" and allows her to not have "fear of going to a walk-in-clinic or emergency room."

Thus, participants valued giving and receiving social support. Participants seemed to feel that interpersonal social support was a facilitator in that it appeared to make health care encounters easier and more positive.

Secondhand experiences: The impact of witnessing or hearing about peers' ***health care encounters.*** Participants remarked that peers' health care experiences impacted their own perceptions of health care. One participant remarked: "when you're trying to navigate care and you're surrounded by people who are doing the same… you collect their experiences." Although accompanying friends to appointments was often considered positive, some participants "witnessed" incidents that negatively impacted their own perceptions of health care. Hayden recalled a visit to the emergency room with

a transgender peer for a mental health crisis. Observing the encounter made them feel "extremely reluctant to go into any sort of medical health care system or mental health care system because of the horror stories that I've heard about and witnessed." Hayden said that it makes their "heart sink just thinking about it." Other participants shared similar concerns. They described how their perceptions of health care had been negatively affected because of these secondhand experiences. Jacob discussed how observing or hearing about other people's health care encounters has impacted how he interacts with doctors:

My friends' experiences impact how I deal with doctors. Because I also go to the doctor with my friends quite frequently, because I have a lot of friends who don't like to go alone because they've had some really negative experiences and so they are not really excited to do that by themselves. And so I've seen the different ways, and like, some of my friends are pretty, like, when they get asked questions about their transition and that kind of thing, they're pretty defensive about it and not really receptive to talking about it. That seems to make the doctors really mad. So, I always answer [the doctor's] questions, even when they're unpleasant, because it like, tends to go better, from what I've seen.

Noah recalled hearing about friends' "devastating experiences" with health care and because of these stories, he felt "hesitant" about coming out to his own family physician. He was nervous that by coming out, he might "sever a tie" with the "only

doctor" he had. He commented that "luckily" this did not happen. He recalled coming out to his doctor:

> *I wasn't sure [how he'd react]. I knew he was a good guy. I knew he was a great doctor. I just wasn't sure given it being [a rural location] and having friends who have tried to navigate the system through transition and it being a really, really devastating experience. So I didn't want to sever a tie with the only doctor I had, right? Because it is so hard to get a doctor these days. Period. So I was really hesitant.*

Providing social support to peers was often considered to be positive. However, some participants appeared to be negatively affected by witnessing or hearing about peers' negative health care encounters. These observations or stories seemed to spoil the participants' impressions of primary and emergency care.

Relative gratitude. A few participants spoke about their health care encounters in comparison to those of personal friends or members of the broader transgender community. These participants spoke about feeling "lucky" that their experiences were not as bad as others'. Even some individuals who discussed negative experiences or experiences in which they felt "discriminated" against still discussed feeling "lucky," "privileged," or "blessed" compared to other people. Jacob discussed the fact that he feels "lucky," but that he is also "mad that I feel lucky." He said:

I feel lucky and I also feel mad that I feel lucky. So I don't, I'm not complacent or happy about how things are, but given that I know how things are, yes, I do feel lucky. I feel lucky to have a family doctor. I feel lucky to have a good family doctor. I feel lucky to have had positive experiences with doctors. I have had some negative experiences and I, you know, don't feel lucky about those. But, generally speaking, yeah, I do feel lucky and that doesn't preclude my feeling upset about the general state of health care for trans-people.

Although this concept was only briefly spoken about by participants, most participants did touch upon it. Participants made statements relaying how grateful they were that their experiences, although bad, were not as bad as peers' or community members' experiences.

Impact of the transgender "community." Some participants spoke about the positive aspects that come from being connected to the transgender "community." A few participants discussed how their health care experiences seemed worse in locations where there was not a well-established transgender community to gain support from. Some participants spoke about finding support through "transgender online chat groups," "Facebook groups," as well as in person "support groups." Participants remarked that these means of uniting the community are ways to share resources or ask for advice. Ben said that the community has been helpful for sharing information such as "[certain physician] is a good doctor to go to if you're trans."

Some participants discussed how health care encounter stories are shared throughout the community network and that, for the most part, these stories are about

"negative" encounters and "difficulties" within health care. As Emerson remarked: "I don't think I've heard about any great experiences. Besides like [trans-friendly clinic]." Isabelle discussed how "scare mongering" stories from the media can make their way through the community network. She mentioned that these stories "impact your perceptions," but also acknowledged that the negative stories are the ones you most likely "pick up on." Isabelle said:

> *There's a level of scare mongering that always comes with the media. Like, they lead on blood. Anything that they can get to shock the audience into keeping up. But, it still sticks in your head and it impacts your perception because it's directly affecting you or could directly affect you… But, I've heard so, so many horror stories. So many from across Canada and from across the globe. I mean, again, you probably pick up on a lot of the negative ones. I've heard a couple of positive ones as well.*

Noah commented on the transgender "community" in his rural location. He spoke about how there are relatively few transgender people in the community and that these people feel like they have to become "gurus." He mentioned that many transgender individuals "move away" in order to pursue their transition, so that those left have to take on the "guru" responsibility. He spoke about the challenges associated with this role:

> *…So folks who, you know, have navigated the system themselves are then looked as gurus for other people in the community who are doing the same kind of*

thing… I've had to set up boundaries, because everyone is coming to me like

"hey, how do I do this?" and "what do I do next?"… I'm not an expert. I'm not a

health care professional. I'm not a provider… I believe in taking care of people,

but there is only so much I can do. I have no power. I have no authority.

Participants expressed gratitude that they were able to gain social support from

the transgender "community" through online resources and support groups. Some

participants mentioned that connectivity to the community was useful for sharing

resources and gaining information. However, it appeared that negative experiences were

the ones that were most often transmitted throughout the community. For some

individuals, being a leader in the community left them with unwanted responsibilities and

roles.

Chapter 4 Summary

This chapter provided a detailed explanation of the first major theme that emerged

from the participant's accounts of their perceptions and/or experiences with primary

and/or emergency care in Nova Scotia. This theme highlights that strong relationships are

a key, if not the key, component of a positive health care encounter. Participants

commented on numerous characteristics within their relationships with providers that can

influence their perception of a positive or negative experience. Participants expressed a

need for health care professionals to be knowledgeable, sensitive, and to possess as

positive attitude. Some participants also spoke about how their personal attitude

regarding their expectation of health care can influence how they perceive their

encounter. Within their accounts of interactions with providers and staff, participants offered suggestions on ways that relationships could be improved to better the health care experiences of transgender adults.

Participants also spoke about the importance of having social supports, whether they be interpersonal or through larger community networks. Social support was a complex concept. Participants discussed the multitude of ways that social supports can have positive and negative influences on them. It appeared that participants were glad to have the opportunity to connect with other transgender individuals whether interpersonally or through larger community networks. It was evident that participants valued having family, friends, and community members who they could lean on in times of need. Some participants seemed to take great pride in providing social support to others. Although these relationships often had positive aspects, they still often left participants feeling somewhat "reluctant" to pursue care after hearing about or witnessing negative encounters. Some participants briefly discussed how they feel "lucky" that their negative health care experiences are not as bad as ones they have heard about through their social networks.

In the next chapter, participants commented on other important factors that influence their perceptions of, and or experiences with, primary and emergency care in Nova Scotia. The participants commented on the numerous barriers and facilitators to care within the physical and social aspects of health care environments.

Chapter 5: The Influences of the Physical and Social Environments

This chapter specifically addresses the remaining two themes that emerged from the interview data. These themes – "The Role of Place and the Physical Environment" and "Beyond the Office: Practices and Policies of Social Inclusion and Exclusion" – answer the original research question and sub-research questions regarding the barriers and facilitators that transgender individuals experience when pursuing care, as well as the aspects of the physical environment/space that help or hinder access to, or utilization of, health care services. This chapter also addresses the influence of the social environment, which was a concept that emerged from the interviews but was not specifically asked about. The results indicate that there are many aspects of the physical and social environments that influence healthcare experiences.

Theme 2: The Role of Place and the Physical Environment

Place. Some participants discussed the role that "place" has in their perceptions and/or experiences of primary and emergency care. A few participants discussed the concept of place in terms of a geographical location. For example, some participants had experienced health care in both rural and urban Nova Scotia and were thus, able to comment on the similarities and differences between the two "places." Some participants spoke about place in relation to a specific site of care. These participants remarked on how the particular place of care could impact their encounter. These participants discussed experiences with consistent places of care, such as their regular family doctor's office. Some participants also commented on more occasional places of care, such as walk-in-clinic and emergency department settings.

Geographic place: Rural versus urban experiences. Many participants used the term "rural" to describe their experiences outside of the HRM. Most of the participants did not provide detail on the population or geographic size of the "rural" location. Thus, the term "rural" as used in this thesis describes areas located outside of Nova Scotia's main urban centre, the HRM.

There appeared to be a consensus among participants that rural health care experiences were often perceived as more "negative" and "uncertain." One participant remarked that Halifax is a "pretty liberal," "pretty open," and "accepting city," with "pockets of prejudice and discrimination." One participant said that urban locations offer "a wide variety of different clinics" and said that in some rural locations you have very limited choices of clinics and providers. They said that if they lived rurally and "heard anything bad about those places" they would "by all means delay [pursuing care] as long as possible."

Some participants briefly remarked that they were more afraid of violence in rural locations versus urban locations. These participants seemed to believe that rural locations were less tolerant than urban locations. One participant remarked that individuals in the town where they lived were "so redneck" that they would not "even look at the gay flag without turning furious." Other participants did not seem to fear outward displays of violence, but were concerned with the unfamiliarity of transgender identity in rural locations. Ben commented on the "smallness" of his hometown and linked the lack of a transgender "community" to the "uncertainty" he felt when pursuing health care there. He also discussed how having "no community" in his hometown left "literally like five

people" to get health care professionals and the rest of the town used to seeing transgender individuals in the health care setting. He commented:

> *…I guess it's just the smallness of it… I think "ok, well I know every trans-person in [my hometown]." Yeah, it's just that there aren't that many of us, which leaves literally like five people to get an entire community caught up on seeing us in hospitals or just walking down the street… Yeah [I had more negative experiences in my hometown as compared to urban locations] due, I think, to unfamiliarity. And it's not that [my hometown] is full on negative. They're not like aggressive or anything like that…But, I'm definitely more uncertain there than I am here. I mean, because there is no community there and there is here.*

Ben connected the lack of a transgender community to the uncertainty of pursuing care in his rural hometown. He commented about the "unfamiliarity" that his rural town's providers had with transgender clients. Like Ben, Noah also discussed how "community" affected his health care experiences. However, Noah commented on how too much familiarity with individuals in his town and the tight-knit community in general, made it difficult for him to pursue health care because "everyone knows everyone's business." He discussed feeling "a lot of anxiety" because he often knows the people working in the health care setting and he has to reintroduce himself saying, "I'm trans and you may remember me by [my former name]." Noah discussed having his confidentiality breached, as he has been "outed" to others in the community because he had pursued health care. He said that "the health care system isn't as confidential as we'd like to think

it is." Noah believes this happened because he lives in a small town where "everyone knows everyone." He said:

> *I live in a town of 15,000 people. Everyone knows everyone. Everyone knows everyone's business…. I'm really reluctant [to disclose that I'm trans] because I might know the nurse. I might have experiences with them from years prior and now I have to reintroduce myself. I just dread that every time because, I know that sooner or later, that information is going to get out there. Maybe not necessarily why I was there, but like "oh hey, did you see so and so lately? By the way, I think they might be trans."… I've been outed on more than one occasion because I went into a hospital or a clinic space.*

Noah also feels that the "small town thing" affects the "training" opportunities for health care providers and staff. He said "I feel like the bigger centers at least have some baseline information." He also felt as though he would not be as "invisible" as a health care client in an urban location as compared to his rural location. He believes that "there are some gaps in the [health care] system that definitely have to do with location."

Jacob commented on his experiences in both urban and rural Nova Scotia. Although Jacob was "hesitant" to chalk up the differences in his experiences to a "rural-urban distinction," he did say that his rural experiences were "quite different" and more "awkward." Jacob remarked:

I don't know if I can say that [the differences in my care] was a rural-urban

distinction. In [urban location], I've mostly accessed health care through my

family doctor and so I have a longstanding relationship with him. So I would

hesitate to assume that the difference is based on location and not based on the

fact that they don't know who I am… But yeah, I would definitely say that my

experiences in [rural town] were quite different from here… Anytime I went to see

a doctor in [rural town], it was pretty awkward and involved a lot of invasive

questions about my transition and body and those types of things.

Jacob also remarked that his perceptions of rural care are more negative than his perceptions of urban care. He discussed how friends of his have had experiences with rural physicians who "were refusing to give them care." He mentioned that although he has friends in urban locations with "negative experiences," "no one has had quite the level of like [the doctor] won't see you [in an urban location]." Even Noah, who commented on very negative rural health care experiences where he was "outed," still mentioned that other people have it worse in even more rural locations. He said:

As bad as it's been for me, there are people in the more isolated places that

simply can't go to the hospital and they don't have a family doctor because they

came out as being trans. [Their doctor] dropped them. Completely. And they

can't get another doctor.

Overall, it appeared that most participants correlated rural locations, more so than urban locations, with worse health care experiences. Ben and Lily both remarked that if they were to get sick while in rural locations, that they might "wait until I got back to [the city] before getting it checked out" or just "wait [the illness] out."

Site of care: Continuity of care and the impact of having a family physician. A few participants discussed the impact of having a place of care that they felt "very comfortable" going to. For most, this place of care was their family doctor's office. Others had developed connections with specific walk-in-clinics. Participants discussed not wanting to "branch out" from the place of care where they felt most comfortable. Participants mentioned that they had become "familiar" with the staff at these consistent care locations and that they had established an "understanding" of how they like to be treated and spoken too. Each of the participants had developed these connections over a period of time and straying from these consistent places of care left them vulnerable to potential "misgendering" or other "uncomfortable" experiences. Participants mentioned that it was nice to know that their consistent physician was not going "to ask me any new questions about [being transgender]." Lily spoke about feeling at ease in her community, but the idea of pursuing care in a different part of the province would make her "nervous" and cause her "concern," because she would not feel "comfortable."

Some participants spoke about feeling "lucky" to have a family physician and thus, a consistent place of care. Jacob commented on the fact that it is "hard to find" a family doctor in Nova Scotia, let alone a trans-friendly doctor. He said:

I think one thing is that I'm pretty lucky in terms of being someone who is living

where I'm from. I'm from [the city] and I live here now, so I actually had the

family doctor that I had growing up as a kid. It's pretty hard to find a doctor [in

Nova Scotia] period. But it's really hard, I have lots of friends who aren't from

here and it's even harder to find a trans-friendly doctor in [the city]. So I feel

pretty lucky myself to have the doctor that I have.

Jacob also discussed taking comfort in knowing that he had a family doctor who

he could fall back on if other clinics or physicians did not provide him "good health

care." He compared his experience of having a stable family doctor with friends who

have to rely on more occasional places of care. He said that if his friends "don't get

health care from the walk-in clinic" their "only option is to go to another walk-in-clinic

or the same walk-in-clinic another day and hope for a better doctor." He said that he does

not think that that is "acceptable" and said that he is "lucky" to have his family physician

as "a fall back." He said that knowing that he had a family doctor, and a comfortable site

of care, was a "helpful thought." He said:

I think having a family doctor is really huge. I keep saying it, but I think it's a

huge thing. Because any time that I've had to access like walk-in-clinics or even

when I was away at school, when I had the campus clinic, like I knew if I didn't

get good health care there, that I would take a bus home or that I could.

Theoretically, I could take a bus home and see my family doctor. That's always

been a very helpful thought to me.

Similar to Jacob, Lily discussed the positive aspects of having a family doctor. However, she commented that even though her family doctor is "amazing," she is only "one person" and "isn't necessarily the person who you would immediately be able to go to for primary care." Lily commented that she sometimes has to wait "an entire month to go see her" and that this can pose a "serious problem." Thus, even having a consistent physician or a comfortable site of care that one goes to for health care does not always mean it is the most accessible.

Participants felt "lucky" to have a "comfortable" and consistent place to pursue health care. Individuals seemed to be reluctant to go to new health care locations because they were confident in the relationships they had established at their consistent care locations. However, some participants' consistent care location was not always the most accessible, and therefore, they may have to "branch out" if they come to require more urgent care.

Site of care: Occasional care environments. Some participants commented on occasional care settings, such as walk-in-clinics and emergency departments, being "unfamiliar" and "unknown" environments. Lily stated that her hesitation to utilize, and her avoidance of, certain medical settings stems from a fear of the "unknown." She said that having to access these services will cause her to "worry" if the doctor is "knowledgeable" and "respectful." She says she worries about getting into a "big thing" where the providers and staff are "wondering about names and genders." She remarked that "nobody's got time for that" when you are just in need of "medication for a common cold." However, Lily did comment that she feels comfortable using her local emergency department because she is "very comfortable" in the area that the emergency department

is located. She remarked that the area is one that she has "always been in" and where she has "grown up."

Some participants spoke about having to "deal with being misgendered" in order to avoid issues during their visit to an occasional care location. Emerson says that they "just kind of have to deal with being misgendered" because they feel as though health care providers and staff would not "get it or care." They commented that "I'm only there for like five minutes or whatever, so it's just a pain in the ass." Emerson remarked that they feel their experiences at walk-in-clinics have been "good," due to the fact that they have not said "these are not my pronouns. This is not my name." Similarly, Hayden commented that they will "do what I have to do in terms of making it a brief visitation… I can handle being misgendered for ten minutes."

Lily said that visiting walk-in-clinics is not worth the "extra questions and the extra unknowns" and that she will usually avoid going to one if she is sick. Noah spoke about avoiding the emergency department during a life-threatening illness because he was so frightened of entering the unknown environment. Noah said:

> *I almost died. There is no way around that… It was life-threatening… And I didn't want to go [to the emergency department] because I was so caught up in my own mind trying to figure out who I was and how I would explain it to other people. I was thinking about how they were going to see my body and about how much of a big deal is this going to be? What kind of care am I going to get?*

It was clear from the participants' accounts that having to utilize unknown health care environments such as walk-in-clinics and emergency departments could cause them distress. This worry sometimes outweighed their perceived need for care and prevented them from accessing these services.

Physical environment. The participants discussed aspects of the physical environment that affected their experiences. Features such as gender-neutral washrooms, explicit signs of a "safe space," posters and information, waiting room and emergency department set-up, and intake forms are all aspects of the physical environment that participants believed influenced their health care encounter.

Washrooms. All of the participants mentioned the concept of gender-neutral washrooms in health care settings. For some participants, having a gender-neutral washroom was not an issue. These participants did not experience problems when using the washroom for the gender that they identify with. These participants noted that "once in a while" somebody may comment on them being in the washroom or will make sure that they are in the "right washroom." This was described as "annoying." Other participants commented on the "nerve wracking" situation that can arise when there are no gender-neutral or single-stall washrooms in the health care settings. One participant said that they feel as though they are "failing" themselves when they have to use the bathroom corresponding to their birth sex. Another participant remarked that "bathrooms can be tricky for trans-people. Like how am I presenting? Am I going to get read a different way?"

Although having to use a gendered or multi-stalled bathroom can cause "anxiety," most participants reported that many hospitals have recently started implementing

gender-neutral or unisex washroom facilities. Participants said that it is "always great" and "nice to see" gender-neutral or single-stall washrooms and that they are "widely available in the health care system now." Jacob commented on the new washroom signs that have recently been implemented in some Nova Scotia hospitals, which portrays a "male," "female," and "transgender" stick-figure. Jacob said that the signs are "great," even though he does not "identify" with them. Jacob commented:

> *In the hospital they now have like those bathroom signs that have some sort of trans stick-figure person on them. That kind of thing is like, I don't super identify with that sign, but it shows that they're, somebody somewhere is thinking about it enough to actually put up a sign. I think that's great.*

Lily discussed how creating a gender-neutral washroom is "simple" and that it is a "reasonable" thing to ask for. She said:

> *I would hope that… every emergency [department] whatever, would have access to an accessible, gender-neutral washroom, in general. It's just as simple as throwing a sign on one that happens to be wheelchair accessible. It can be for everybody. There it's waiting for you! People don't ask for a lot at the end of the day. Just sort of the reasonable stuff.*

Participants seemed very happy that some hospitals now have gender-neutral washrooms. Having a gender-neutral washroom as part of the physical environment

appeared to help reduce the "anxiety" that a transgender individual may face when utilizing a health care service. Although it appears that gender-neutral washrooms are becoming widespread throughout hospital settings, some participants noted that they have not seen any in walk-in-clinic settings. They remarked that "[walk-in-clinic washrooms] are all gendered."

Information and resources. Another aspect of the physical environment that some participants discussed was the inclusion or exclusion of transgender resources from health care settings. Participants remarked how posters, pamphlets, and other means of information regarding trans-health are, in their opinions, not readily available. Participants mentioned that they had not seen such resources "at any walk-in-clinics or emergency rooms." A few participants mentioned how the only trans-health resources that they have seen have been at "sexual health clinics" and even then, they were often not trans-specific resources, but rather grouped with "LGBT" resources. One participant commented that transgender identity is an "inner personality, social thing," but that it is also "medical and that is very different from sexuality." Participants expressed interest in seeing information specifically for the transgender population. Isabelle commented on how having information available for trans-individuals, especially on the topic of mental health, could be "huge for somebody" and "might be just what somebody needs." Furthermore, she added that having more accessible information for trans-people in the health care setting could help with "inclusivity" and give the community more "representation." When asked if Isabelle had seen trans-health resources in the health care setting, she replied:

No, not really. No. I don't think I've ever been to a doctor's office where there has been any information on trans-health. Unless it's specifically a sexual health clinic. But then again, it's more tilted towards sexual safety and more of the LGB part of the LGBT spectrum... Which is funny because ... there's more visibility, more people coming out. Having those resources available might be just what somebody needs. I mean if they had a little pamphlet on hormone replacement therapy or even just the primary mental health aspect, because a lot of trans-people have mental health issues, specifically related to the fact that they're trans and there are longstanding issues with depression and anxiety and things like that. Just having a pamphlet that said you know, "trans mental health" on it, might be huge for somebody, because they could pick it up and actually start to work on stuff and help them progress forward... I think it would be great. Like it would give a little bit more visibility again, and more inclusivity. [It would be] representation for trans-people, because there is not a whole lot of representation for trans-people. I mean, again, it's growing. It's starting to become more of a thing, but I think that would be, it would be nice for me to see.

A few participants remarked how medical information is, in their opinion, often "gendered" and "heteronormative," aimed at "cisgender" and "straight" people. Jacob discussed how the information that was given to him during his hysterectomy was "gendered" and, in his opinion, could have been "easily" retyped to make transgender individuals feel more "included." Jacob said:

I think a lot of [information] is quite often pretty gendered… When I went to have

a hysterectomy, they had all these brochures and stuff for like after surgery care

and whatever… They looked like they were printed, like someone had typed them,

and then printed them. So to me, it felt like they could edit these quite easily by

just retyping them with different words. All of the things that I had said "woman"

and… that kind of thing. And they knew, like they know that they have trans-

patients now, for sure. Especially now since [some gender-confirming surgeries

are] getting covered [by insurance]. It seems to me like that could have been an

easy edit to make people feel a little more included in that kind of thing.

Noah commented that there is "never anything visible – nothing" that is geared towards "trans-folks or LGBTQ [people] in general." Noah remarked that it would be "welcoming," "inviting," and "comfortable" to see resources that he identified with. Noah remarked:

I mean if you're going in [to a health care environment] thinking worst case

scenario every time and you're ecstatic when the worst case didn't happen, if

that's where we're at, if that's our standard, then seeing something that's

welcoming, inviting, or comfortable is just going to be incredible, right? It's

going to, at least, make you feel like "okay. This is a good start."

Some participants spoke about not expecting much in the way of trans-health information since they are "a very small minority." Claire commented that she had seen a

poster for "some transgender event or pride like event" in a health care setting. However, she also remarked that transgender adults make up a small part of the general population and because of this, she does not expect to see a "ten square foot billboard" regarding trans-health in health care environments. Claire did not comment on what her expectations were in regards to resource and information for transgender persons. However, most participants expressed a clear desire for information and resources that they would feel included in. Most participants had not seen trans-specific information in the physical environment of the health care setting. All of the participants felt that having such information would be beneficial.

Indications of a "safe space." Noah indicated that having posters and information geared towards transgender individuals could indicate that the environment was a "safe space." Other participants spoke about how having a physical symbol indicating a "safe space," such as a "rainbow pride flag" or "sign," could lead to "relief" and would make them feel more "safe." Many participants discussed the benefits of having an indication of a "safe space" in the health care environment. They said that they would appreciate seeing these types of symbols in health care settings, as it would signify that "these people are actually making an effort of some sort." As Ben said:

> *All you have to do really is put a rainbow sticker on your door, type thing. The little things like that, it just gives such a huge wave of relief for me. Because that's all it takes to let me know that you're fine. And really, it's such a small thing. If they have that, then I know that everybody there is good and I don't have to worry about it. Right? It just tells me that when I'm getting something done, like a shot,*

that nobody is going to ask me all these questions that they don't need to ask or

that they should know the answer to already.

Lily mentioned how she would access health care more often if she saw "any sign or anything that indicated that I'm welcomed." She said that she would "single [that health care setting] out as a place that I would want to access health care." Lily discussed how a "stealthy" sign could "open the door" for transgender clients. She said:

Like some sort of sign that has a statement that wouldn't mean anything to anyone except transgender people. So like "people of all genders." That means absolutely nothing to a random cisgender person who knows nothing about transgender people. But, a trans-person sees that, and is like "wait. All genders? Do they? Are they on board? Are they on board!?" And it's nice and stealthy. It opens the door. It doesn't have to be this big thing like "hey look! Streamers! A pride parade! Look at all the gay people!" No. It's just enough to start putting the barriers down, breaking down the walls, and be like "okay, I feel safer already."

In Lily's opinion, she feels that the "number one reason" why health care environments do not post signs of "safe space," is because it is "political." Other participants seemed to be a bit more hesitant about signs indicating a "safe space," because they believe that these symbols are "never a guarantee to say that a space is actually safe." For instance, Emerson wondered what these places do "to make sure that your queer clients are feeling safe here?" They said:

It's like "okay, you have [a symbol indicating 'safe space'], but what are you

doing to actively make sure that your queer clients are feeling safe here?" So you

know, you can put a poster on there that has a queer person on it, but are you

actively making sure that queer people are safe? And are you educated? Is all of

your staff educated? Not just the doctors, but like receptionists and service

people?

Thus, it appeared that markers of "safe space" are important and perceived as positive by participants. However, they also indicated that these signs do not ensure safety. They expressed a desire to see some evidence that work is done within the health care setting to ensure that the environment is actually safe.

The physical organization of health care environments: Waiting rooms, ***changing rooms, and emergency departments.*** Some participants mentioned the design of the health care environment as a physical characteristic that influences their care. For instance, participants spoke about how waiting rooms, changing rooms, and emergency departments are organized and how their design can sometimes jeopardize their "privacy" as a client. When discussing waiting rooms, participants mentioned how "the [reception] desk" is often "right there in the waiting room" and that this means that there is "nowhere to privately tell someone" that they are transgender or to call attention to their preferred names or pronouns. A few participants acknowledged that this privacy issue can pose a problem for all clients, not just transgender clients. However, they believed that most cisgender clients would likely not fear "violence" in the waiting room setting.

Noah spoke about being "physically" taken to the "female change room" while at the hospital for an exam. Noah, who feels most comfortable when wearing a lot of "layers," was wearing only a "gown" "in the middle of an open space" and felt that "there was no protection whatsoever." He said:

[The staff] would not let me change in the guy's change room. They had no gender-neutral change room. They physically took me into the female change room, refused to acknowledge me, which made everybody else uncomfortable. And then I had to go upstairs and wait in the gown thing. So I was without my layers, which is not, for me, a good thing, and in the middle of an open space. There was no protection whatsoever.

In Noah's opinion, having to sit in only a "gown" left people "able to judge" and "make all kinds of assumptions." When asked if being able to wait in a different area would have helped him, he replied: "Yeah. A huge difference. Then you're not parading half way through the hospital." Noah spoke about the feelings he had when he was told that he could not wear his layers and that he had to sit a public waiting room wearing a garment that made him uncomfortable. Noah remarked:

People were able to judge, you know, my body and make all kinds of assumptions. And then the nurses, who just met you, and aren't looking at your gender marker, guess what? It makes an awful big difference when they can see your body without the layers. People take notice. You see people who were only making eye

contact with you suddenly look down and check out what parts you have. It's not

okay.

Some participants did not have issues with health care waiting rooms. For instance, Claire said that "the doctor's office is fine, even if it's more wide open." It appeared that her feeling towards waiting rooms stemmed from her not having "any fear of being in public." A few participants spoke about accommodations that had been made for them so that they could avoid an "awkward" situation. Both Emerson and Jacob discussed being "scooted" into a separate waiting room before their gynecological surgeries. This accommodation appeared to be appreciated as, in their opinions, it showed that the staff "did try to make [the experience] better."

Some participants discussed issues with emergency department infrastructure. For example, a few participants commented on having to share a room with another client. One participant noted that discussing their transgender status in this environment could be a "huge problem" because it is a "very sensitive thing." Another participant said that they would be very "weary" to have to "discuss anything specific to trans-health" with another client in the room. One participant acknowledged that people, in general, are probably not "super stoked" to have to discuss their medical emergency with another client in the room. However, he commented that in his opinion, cisgender individuals' "concerns" are probably more related to "privacy" and not "safety." Noah expressed concerns over "curtain dividers" and "privacy" in the emergency department. He also discussed what would cross his mind if he were told that he had to stay overnight in the

hospital. He stated that he worries about "where would they put me?" and "who would they room with me?" He said:

> *There is no privacy. You have curtains there which people can see or peak through. The gowns that you wear. Guess what? They're practically see through. You know? Gender-neutral change rooms would be amazing. Places with doors? Great... So like when a doctor is seeing you in emergency or something, there's a bed and a curtain, but sometimes they don't close the door. Usually the door is left open and that's kind of a big issue. Because if I'm talking about something specific, you know, that may or may not have anything to do with being trans or transition, I'd still like there to be privacy. If I thought for a minute that I would have to stay overnight in a hospital and share a room with somebody, I don't know if I could do it. And then it comes down to "where would they put me? Who would they room with me? Would they even ask me who I would be comfortable rooming with? Or would they just make assumptions?"*

Waiting room, changing room, and emergency department infrastructure were discussed by all of the participants. For some, the layout of these environments was not overly significant and did not seem to bother them. Others though, were left fearing for their safety and feeling very uncomfortable due to the physical organization of these environments.

Intake forms. Another aspect of the physical environment that participants commented on was intake forms. Participants commented that it is "great" when forms

have a "preferred name section" and an "other" option for gender. Others liked "a blank line" so that people can "write [their gender/pronouns] themselves." Participants remarked that intake forms with designated spots for people to write in their names and gender should be a "standard thing."

Some participants expressed confusion when having to fill out forms. One participant mentioned that they often question "what do you mean by gender? Or sex? Because they're always used interchangeably." They also wanted to know "why are you asking me this? The person filing this [form] doesn't really need to know anything." Hayden spoke about forms that "only have the options of male and female." They remarked that these forms make them "extremely uncomfortable" and in the past, "self-conscious." Hayden said:

> *Oh my God. The fact that there are still only the options of male and female boggles my mind…. Just why? Half the time it doesn't matter. If I'm going in there for a sore throat, you don't need to know what's in my pants. So that always makes me extremely uncomfortable. I used to be really self-conscious about it and would always mark female in fear that they would like double check my official records and like get angry about it. But now, I don't even care, I just check male. Like I don't bother. If they want to fight me on it, I don't really see what they're going to do.*

Isabelle suggested that there should be changes to medical "documentation" to allow "people an opportunity to represent themselves." She said that these changes would

"make it easier" as she would not have to explain "yes, I'm a woman, but this is what's going on, this is my issue." She said that these kind of changes, such as allowing people to write in their gender on intake and medical forms, would "give trans-people a better experience in the health community."

Almost all of the participants suggested that changing intake forms and medical paperwork to be more inclusive would improve their experience and would make them feel more comfortable. Participants remarked that it is an "easy" change and would contribute to a positive health care experience.

Theme 2 summary. This theme touched upon the importance that the geographical place of care, site of care, and physical environment have on transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia. In regards to place of care, some participants suggested that rural health care locations often produced more negative experiences than urban locations. Many participants agreed that receiving continuous care, such as having a consistent site of care in which they felt comfortable, contributed to positive experiences. Many participants felt most uncomfortable in occasional places of care.

The participants discussed many aspects of the physical environment that contribute to their perception of a positive experience. Participants spoke about the importance of having gender-neutral or single-stall washrooms, having access to information and resources regarding trans-health in the form of posters, brochures, etc., seeing indications that an environment is a "safe space," having the environment

organized in such a way that promotes privacy and confidentiality, and having medical paperwork and intake forms that are inclusive.

The next theme details the aspects of the social environment that contribute to transgender adults' experiences with health care. These facets of the social environment work to include or exclude transgender individuals and thus, influence how they perceive the environment or encounter.

Theme 3: Beyond the Office: Experiences of Social Inclusion and Exclusion

Prominent social discourses. Participants discussed many different perceptions that they believe society has about transgender individuals, such as believing that their identity is a "choice" and that transgender identity is "uncommon" and "niche." Participants commented on the many negative perceptions of transgender persons such as them being a "threat," and the opinion that non-binary gender identity is illegitimate. Participants discussed the ways that they feel transgender people are depicted and discussed in society, and how these perceptions can impact health care encounters. Some participants spoke about the progress that has been made in regards to social discourses and suggested ways to continue the progress.

Being transgender is a "choice." Some participants discussed how they feel as though society treats them like they have "willfully jumped into a minority." One participant compared the transgender "minority" group to those of individuals in minority racial or sexual orientation groups. The participant felt as though society understands that "you are born into" a race or sexual orientation, but believed that transgender individuals are treated like their gender identity is something they have "chosen." The participant

said that "as soon as we start exploring our identity," the "negative world" tells them that "things are going to get a lot more difficult for you because you've made this choice."

A few participants felt as though some health care providers believe these discourses and are thus reluctant to treat them because they feel as though being transgender is a "choice" or a "cosmetic thing." They commented: "[Providers think] 'well you chose this life.' And it's like, as opposed to what? This is who I am and yes, this is the path that I decided on. But, it's best for me." Isabelle commented that "there is a lot of prejudice in our culture that is pretty much engrained." Lily added that "we are so trained by ourselves and by other people and by society to be fearful of the fact that we are different." It was clear from these types of sentiments that many participants felt affected by these negative social discourses. In their opinions, these types of social discourses influenced their providers, which manifested in providers being hesitant to deliver health care.

Transgender health is "so niche." Some participants believed that health care providers "don't really feel like they have to know [about trans-health] because trans-health is so niche" or they think "there are specific doctors for trans-people." A few participants believed that providers did not realize the true size of the transgender population. These participants felt that providers did not spend the time to learn about trans-health issues because they assumed that the population was smaller than it actually is. Isabelle believes though, that this type of thinking will change due to "visibility increasing." Isabelle said:

[Health care providers] don't really feel like they have to know [about trans-health] because trans-health is so niche. There are so few people who are trans so they think, "okay I might have one or two clients, so this is not stuff that I'm going to have to keep in my head." ... But I think that's really going to change with visibility increasing and a lot more people actually coming out as trans because it seems to be more safe to do so now.

Negative perceptions of transgender persons. Claire discussed her role in trying to "dispel" the "negative look towards trans-people." She believes that society often thinks of transgender women as "drag queens" or "RuPaul" look-alikes. She says that by making "personal connections" with people, in health care settings and beyond, she helps to show society that she, and other transgender individuals, are "normal" people. She said that she does her "best" to "leave a positive impression" on people and implied that these positive impressions and connections may help to slowly shape social discourses.

Noah commented about society's portrayals of transgender people as "a threat." However, he believes that "a lot of the time it's the other way around." Noah discussed being made to change in the female changing room at the hospital, even though he does not identify as female. He acknowledged that being in the female changing room likely caused the women in the room "discomfort" and possibly made them "scared for their safety, because someone who looks like a guy is coming in." However, Noah believes that society's prominent discourse of transgender people as "a threat" could have left him vulnerable to "verbal harassment" or other "dangerous" situations.

Non-binary gender identity: "Not a legitimate identity." A few participants

recognized that while "visibility" and acceptance may be increasing for transgender

persons, non-binary identified people are still being excluded from social discourse. Lily

said she feels that there is a need for "a movement recognizing gender-neutral people and

people who fall outside the spectrum of the two boxes." She said that these people

"deserve the same respect" and that they are being left out of "all the advances and all of

the great things that have happened." As people who do not identify with a binary gender,

Hayden and Emerson both remarked that their identities are "not really seen as a

legitimate identity." They said that they feel as though people believe they are "doing it

for attention." Hayden discussed, what they believed to be, the social perceptions of their

gender identity, commenting that they have to portray a "default" "masculine gender"

that acts as a "shield," because they feel as though people will not understand their non-

binary identity. They said that it is "easier to say 'I'm a guy,' and that be respected, than

it is to say, 'I'm kind of a guy and I'm kind of a girl and I'm kind of a lot in between.'"

When asked if Hayden feels as though social discourses towards non-binary individuals

are even more negative than the discourses about transgender individuals who fit into a

more binary gender category, they said:

> *I think that there are a lot of shared problems with all of the trans-community.*
>
> *Anyone who is not cis. Because regardless of how the outside world perceives us,*
>
> *whether we pass or not, whether or not we choose to identify with male or female*
>
> *in those boxes – it's all about how the media perpetuates certain stereotypes and*
>
> *things against us… Obviously everyone's experience is different, but in general*

there is a message from the time we're born to just about now, when things are

just slightly starting to change, but only just so. There is the message that trans is

not welcome. Trans is not normal. But as specifically someone who doesn't

identify as male or female, I can't claim to have it worse because I do have

certain areas of privilege and I have certain areas that put me at a disadvantage

in the sense that people are less likely to understand. Yes, because "they" is very

rarely used as a pronoun.

Noah commented that "we, as a society, are not at a place where we recognize trans-people and the variety of identities that exist." Noah also remarked:

…As a society, we're still working within those [binary] constraints. We have to

break away from that before we can even get to the level of accepting trans-

people in their various paths and identities. So there has to be a whole shift and I

don't know how to change that. But I do know that a lot of times it starts with

education and listening to what people have to say.

Societal progress and suggestions for improving social discourses. Participants acknowledged that there has been some improvement in social discourses in recent years. Participants noted that it is "empowering" and "awesome" when they think of the "progress" that has already been made. Some discussed the "giant societal shift" in the prominence of the transgender community in recent years. They acknowledged that the "train is moving so fast" and that it is easy for "people providing care" to fall behind. In

order to prevent this from happening, Noah suggested having "open conversations" between the transgender community and the health care professional community:

> *We need to have open conversations and leave the egos at the door. Leave the expertise at the door and just be willing to work with people without judgments or assumptions. That's all it boils down to… There's lots to be done. We're not there yet. I'm hopeful, though… Even with all of the changes that have been taking place in the last year, there is definitely room to grow and room for improvement… All of the little changes can really make a big difference to people and their well-being… Ultimately it shouldn't be this difficult to be who you are.*

Noah suggested that health care providers may be "burying their heads in the sand" and not acknowledging the "reality" of the negative social discourses and how they can impact one's health care experiences. He suggested that some providers may think that "we're making so much progress" and that "we're already doing a lot." However, Noah felt as though these types of attitudes were ultimately harmful. He remarked that "people are hurting. People aren't taking care of themselves because of this." He suggested that these types of social discourses could be mitigated if providers interacted with transgender clients with "honesty and openness and without judgment." Noah says that he operates from a "harm reduction standpoint" and suggested that providers meet "people where they're at… regardless of their situation or who they are." He believes that "the health care system would be a lot better if we operated from that standpoint as a whole."

It appears that there are many social discourses that impact the lives of transgender individuals. Many of these discourses influence how participants interact with the health care system. Participants appeared to be hopeful that social discourses regarding transgender identity will improve as "visibility" for trans-people increases.

The potential social ramifications of being "out in public" in the health care environment. Some participants spoke about their perceptions of being "out in public" and how their "feelings" about being in public affect their experiences with public health care environments, such as waiting rooms. Some felt that it was "uncomfortable" to be in public health care spaces. One participant commented that "if I'm out in public… I have to have a charged phone and I need to have some form of protection on me. Because like, I just don't trust my surroundings. I want to make sure that I'm safe." Other participants expressed concern over whether or not other individuals in the public setting would get "ignorant" with them. Participants mentioned that they feel they need to be able to "adapt to anything" in order to protect their "personal safety." One participant reflected upon the stories that they have heard about transgender individuals being "flogged and harassed" in "public places all the time." They remarked that just because these spaces are "public," does not mean that they are "safe."

Noah commented on his thought process when he enters a public social environment, such as a waiting room, in a health care environment. He says he tries to arrive "early" when there "isn't going to be many people there" so as to avoid a "public spectacle event." He contemplates "where would be the safest place for me to sit?" He says he always has a "plan B" because it is "not a friendly environment, necessarily."

When asked if the social environment within the public health care setting impacts his visit, Noah responded:

> *Big time. I try to go as early, if I absolutely have to go, I try to go at times when there isn't going to be very many people there. Because again, if I'm misgendered, if I'm going to be called out, if there's going to be an issue, I'd rather not have it be a public spectacle event. I'm always watching my surroundings. It goes back to that always being prepared. So I walk into a space and I'm automatically eyeing everything to figure out where would be the safest place for me to sit? Should I sit close to a bathroom? Or hey, I know the triage is over there, and the door is here, so should I sit in the back corner? Should I sit super close so that I can just beeline it to where I need to be? I always have a plan B. I always have a backup route. You had to adjust to that, because it's not a friendly environment, necessarily.*

Noah also discussed the potential consequences of having trans-health related information in the waiting room. Although Noah expressed positive attitudes towards trans-health information, he was concerned about the social aspects of such resources. He worried what if "somebody sees me reading this? Are they going to then judge you based on what you're reading?... Could this be a safety issue?" He expressed concern that there could potentially be harassment or violence from another client in the waiting room, even in environments that advertise themselves as a "safe space." Participants noted that even when "all of your staff is educated," it does not prevent another client from expressing

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discriminatory behaviours. Noah said that "safe spaces" are "hard to enforce." He wondered "are [staff] going to take time out of their busy schedule… to go and talk to one individual who has an issue [with me]?" He worried that the blame for the altercation may ultimately be placed on him. He wondered if staff would ask "why did you have to go and upset this person? Did you have to flaunt it?"

Some participants were not as concerned with the social environment of public health care spaces. Lily remarked that she is not worried about the other "people who are in the waiting room. They are just trying to deal with their own thing." She said that she is "comfortable enough with myself where I'm not feeling uncomfortable walking around in the environment. So the waiting room is just another environment to me."

Participants had differing opinions regarding being out in "public." Some individuals felt as though settings such as waiting rooms, were just extensions of the public and appeared to feel comfortable navigating these environments. Other individuals did not feel comfortable about being in public health care settings and discussed the preparation that they take in order to tolerate these settings. Some of these participants discussed being fearful of discrimination and having concern for their safety while in public health care environments. This concept of discrimination will be discussed next.

Discrimination. Participants discussed varying situations in which they appeared to be socially excluded. Some participants discussed feeling discriminated against, or fearing that they would be discriminated against, in health care settings. Ben recalled the time that the walk-in-clinic physician told him that she was "not comfortable" giving him his testosterone shot. Ben said that, in his opinion, the physician made him feel like she was "justified" in not wanting to provide him care. He said that he thought to himself: "Is

that a thing? I guess [physicians] don't have to treat everybody." He now realizes that she "can't be picky" and that she "chose to be a doctor to treat people." He commented that if he ever saw that physician again and "the same sort of thing happened," he would "definitely be doing something more proactive, so that wouldn't happen to anybody else in the future."

Participants remarked that they have "received different health care then I would have before I transitioned or then other people do who are not trans. In terms of willingness to help or… I've had people be colder or shorter with me." Some commented that they have felt "ignored" by health care providers and staff. They mentioned that "people are very distant; they don't know how to have a conversation with me." Others mentioned that they thought providers were "gatekeeping" or "preventing them from moving through transition." Participants remarked that these various instances of discrimination caused them to feel "belittled" and "dehumanized." One participant talked about having "security following me around in hospitals because they feel like I'm going to cause some kind of scene, and it's like 'no, I'm here for care. I'm not here to cause trouble.'"

A few participants remarked how some providers "make non-trans-related health issues about transition." Isabelle discussed what she believed to be a discriminative theory that she says "a lot of trans-people" experience within the health care setting. This theory, called "The Trans Broken Arm Theory," attributes all health issues to the transgender individuals gender identity. She said:

I was reading an article recently that was called "The Trans Broken Arm

Theory." A lot of trans-people are going in to doctors and any medical concern

that they have or any medical issue that they have is being related back to them

being trans… "Oh you wouldn't have broken your arm if you weren't on hormone

replacement therapy." So it's like, what the hell are you people talking about?

Like you're supposed to be the medical professionals.

Other participants discussed situations that seemed to reflect this theory. For

example, Lily noted that her friend said that she was told to "see a shrink" when pursuing

health care for "stomach cramps." Some participants said that the fear of being

discriminated against extends beyond the health care setting and into everyday life. For

instance, Isabelle said that when "someone is staring at you too long," you start to

wonder if they could be "violent or aggressive." She said that even though she has not

faced "any actual physical violence," the worry that someone could be violent towards

her is "always in the back of your head." She said that she is always "on guard," whether

she is in a health care environment or not. She stated that "trans-people" often have a

"really big survival mechanism that goes through their head in trying to keep themselves

alive, because of the fact that we all face discrimination." Lily discussed how she has to

"worry" about discrimination in the health care environment, but commented that she

"can't handle constantly being afraid of everything." Lily said:

…We have to constantly be on alert. We have to worry about people being hurt

and murdered in the streets. That doctors are going to say "no" to us and

resources are going to kick us out... I think that's part of the reason why I'm

pretty okay with everything, because my psyche can't handle constantly being

afraid of everything. I need to accept that things are going to happen. I have to

mitigate them the best I can, but I'm not going to be looking over my shoulder

every five seconds.

Hayden commented that they "feel lucky" that they have not been exposed to outward displays of "violence," "violent language," or "overt transphobia" in the health care setting, but feel as though this may be because of their "privilege." Hayden said:

I feel lucky that I haven't been a victim to violence or you know, violent language

or overt transphobia, at least to my face. But I think that's because I do have a

few intersections of privilege. I mean, I'm thin. I'm white. I'm articulate. I have

been fortunate enough to have a good degree of education and people respect me

for that. Even if they don't understand my identity, they may like me.

Lily also commented on privilege and how individuals without certain privileges can be "discriminated against based on so many factors." She remarked that it can be "hard to navigate an entire new world" when "you're almost at the bottom of the ladder suddenly and for no reason." She commented that this discrimination can "throw people into depression" and that having mental health issues can then contribute to the discrimination. Hayden commented on the discrimination that they have encountered because of their transgender identity and mental health issues. Hayden discussed how

difficult it can be for transgender individuals to pursue help for their mental health issues. They said that they feel like they are being told that they "don't exist" and that they "don't matter." They remarked that they feel as though society is telling them that they are "not trying hard enough," when they feel as though they are doing "the best I can." Hayden commented:

> *Mental health is extremely important… Instead of being met with people who are used to this by now, who are compassionate, who have seen us come in and out of those doors, because I can only imagine how many trans-adults are being put in the mental health care system… We're still being told that we don't exist and that we don't matter… I guess I could say like, it'd be easy for someone without mental health problems or without trans-experience to look at things I've said and say "well just go out of your way to make an appointment. You just have to try harder"… I guess I could say to that that you would not say that to someone with a physical or fatal illness… You wouldn't tell someone in need of chemotherapy that they need to try harder to get a doctor to live. That they weren't trying hard enough. And that's something that people with mental health issues are dealt a lot. I can even… while I'm expressing my issues with the health care system, there's a voice in the back of my head, the part of me that's trained to think this way, that I'm just not trying hard enough. But, it's like, I'm doing the best I can… The most I can say is, if you care about the lives of your patients the way you would care about the life of someone with cancer – please try harder to keep us alive.*

One participant remarked that it is not an act of "violence" or something "grandiosely negative" that they fear, but "subtle discrimination." They remarked that acts of subtle discrimination can make their way through the community, and impact not only the individual who was discriminated against, but also their "family," "friends," "community," and "potentially" "every other person who is transgender." Another participant said, that in their experience, being "refused" care is often masked in an excuse. They said that a physician "got around" refusing a friend care because "they did not think they were competent or that they weren't best to handle the situation, so they should go to another hospital." They said they have heard of "different excuses" for refusal of care, but implied that the behaviour is discriminatory regardless of the excuse. Another participant worried about being in a "life threatening situation" and a physician "comes up with some excuse why they can't treat me… I'm potentially dead on the stretcher." Noah spoke about the transgender population's "need" for "care" and asked providers not to "ignore" the need. Noah said:

We're human. We exist. We're here. We're not going anywhere. We need care. Please don't ignore us or treat us like we're contagious, like if you touch us you're going to catch something.

Isabelle believes that there is a "modicum of understanding" that would "probably make [health care encounters] a lot easier." She suggested that there should be "anti-discrimination policies" within health care settings, so if a provider was "found to be discriminating, they would lose their license." She said that this kind of policy would

"take out some of the fears" because if she were to be "discriminated against," she would

have "complete and utter recourse to go against them and to complain to the proper

professional associations." Ben noted that it is unfortunate that transgender individuals

are happy when they do not face discrimination in the health care setting. He said that "it

shouldn't really have to be like that. Yay! Nothing went wrong!"

Even though participants did not report incidences of "violence" in the health care

setting, they still feared the possibility that they could experience it in the future with

some remarking that they feared for their safety while pursuing health care. Participants

spoke mainly about acts of "subtle discrimination," which appeared to be very

detrimental and frequent.

"Passing" in social environments. Some participants discussed how their ability

or inability to "pass" as cisgender or be "read" as the gender that they identify with,

influenced their health care encounters and whether or not they feared or experienced

discrimination. A few participants discussed how they are more "comfortable" to pursue

health care now that they are able to "pass" or be "read" as the gender they identify with.

For instance, Jacob talked about the "privilege" that he experiences as a transgender

person who is "read" as a man. Because of this, he does not have to disclose his

transgender identity during health care encounters "unless it's a situation where

somebody is going to be seeing" his gender-confirming surgery scars:

> *[Having to disclose my transgender identity] depends on the time in my*
>
> *transition, I would say… Earlier in my transition [having to disclose my*
>
> *transgender identity] was the case, because it was pretty likely that I would be*

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read the wrong way anyways, so you know, I'd have to say something in order to

just interact as the gender that I wanted to be. Later in my transition, I find I

don't do that, because unless it's a situation where somebody is going to be

seeing like my surgery scars or that kind of thing, they won't really know. Which

again, is a privilege of mine that I don't have to disclose all the time.

Jacob commented on the "two main reasons" why he thinks his health care experiences are different now than they were in the past. He believes that "other people's perceptions" of him are now "different" because people are no longer "confused" when they see him, which he says, puts him at "ease." He said that earlier in his transition, when he was more "androgynous looking," people "didn't necessarily know how to classify" him and that it created "a difference in the interaction." He also commented on his increased "confidence level." He said that in the past, even when he was read as a man, he still "wasn't confident that that's what was happening and so that also affected the interaction." He commented that being read as a woman or not feeling confident in being read as a man made him "feel really uneasy," "not personable," "stand-offish," "defensive," and "ill at ease," which he says "affected the [health care] interaction" "quite a bit." Jacob also remarked, that not having to explain his gender allows him to have "the energy" to educate health care providers if need be. He spoke about how he does not have to "talk about" his transition often, unlike friends of his, who are earlier in their transition or unable to "pass" as well as he does. He said:

Right now, my life is pretty easy in terms of transition. It's not relevant to most of

my day-to-day interactions. And it's a huge privilege to have. It's like, I don't

have to think about it, or talk about it, or be on the defense about it, most of the

time. So when I go into a health care setting, I have the energy to do the

educating about it. The energy to defend myself about it if I have the need too. I

have all that. If I were doing that every day, which I see some of my friends doing,

you know, they don't have the energy left. Especially when they're already in the

vulnerable state of being sick.

Hayden said they "would be extremely reluctant to go into any sort of medical health care system or mental health care system" because they do not pass as cisgender. A few participants spoke about not having "any issues" when they portrayed the gender corresponding to their sex assigned at birth. Isabelle stated that she was at a place in "her transition" where she was not "super visible." She said that she would "toss on a polo shirt" to go to the doctor and downplay her feminine gender expression to avoid "issues." Emerson said that they sometimes choose not to correct health care providers and staff when they use the incorrect names and pronouns because they can still pass as the gender corresponding to their biological sex. They say that doing this is likely why their experiences with walk-in-clinics have mostly been "good."

Claire discussed how she is "not afraid" of being identified as trans. She said:

I'm not afraid of someone saying "oh you're trans." I'm not concerned about

that. I think that makes a huge difference, because I'm not suspicious. I'm not

walking into a situation already defeated.

Claire said that "there may never be that day that I am accepted as a cis-woman." But, as she looks "down the road" into the future of her transition, she says that she will not "care if somebody still recognizes me as transgender, as long as I'm treated like a person."

Thus, it appears that participants having differing opinions on how "passing" or being "read" can affect their health care encounters. Some feel "privileged" to be able to be read as their chosen gender. Some are "reluctant" to pursue care because they feel as though they will not be read the way they wish to be. Some choose to play the role of their biological sex to avoid "issues." And one participant, Claire, remarked that she is "not afraid" of not passing and being identified as "trans," as long as she is treated respectfully.

Exclusion of trans-health from health care provider education and the importance of inclusion. Some participants mentioned that they feel as though the topic of transgender health is excluded from health care providers school curriculum and continuing education opportunities. These participants remarked that, in their opinions, health care providers did not seem to think the topic of transgender health was "important." These participants argued that transgender health is an important topic for providers to receive education about and provided reasons to support their opinion.

Some participants commented on the small amount of education that they believe providers receive while in school. One participant heard that physicians "get like five hours of training on how to deal with transgenders [sic] in the medical field." They commented: "What do you do when you've only had five hours of training?" Some participants remarked that they "feel for [providers]" because they "don't have anywhere" to find information on trans-health issues. One participant felt that providers and staff do not "seem to know how to find out anything about trans-people." Hayden said that they "wish there was other resources" for providers to gain knowledge about trans-health, as opposed to relying on clients to educate them. They suggested that a basic training for all providers could alleviate the pressure on clients to do the educating. Lily spoke about how some providers' perceived lack of knowledge may be due to a "two pronged effect:" Some providers are not "knowledgeable" and "maybe they aren't aware that they need to be knowledgeable" due to limited education on the topic in their schooling.

All of the participants made recommendations for how providers could increase their knowledge through education and training. Participants felt that trans-health issues should be a staple in medical/nursing schools. Participants suggested having "mock doctor's room situations" with transgender persons in order to improve the students' knowledge and sensitivity. A few participants mentioned the need for "conferences" and updated "textbook material." They also stressed the importance of "continued and evolving education," so as to keep up with changes in the health care system and in the transgender community. Participants felt that it was very important "that there are people

from the community that are involved so that people that are transgender or gender-neutral…have a voice so that they can get adequate health care."

Participants also made suggestions for education and training beyond medical/nursing schools. They suggested that individuals at the health policy level should have "continued dialogue with transgender people and LGBTQ people in general." One participant suggested that there should be a "general trans-health knowledge run-down for all doctors and primary practitioners who work across the province. Just like 'okay, read this tiny little book. It will give you some understanding of what's going on.'" Another suggested that all providers should be aware of the "international standards [for treating transgender clients] like the WPATH or CPATH standards of care." Some participants remarked that learning about trans-health should not be "personal responsibility." Rather, the "health care system itself should be taking some responsibility for that." One participant commented that "somebody at the top" should "spark the initiative." Participants suggested "courses," "workshops," or "certifications" that providers could take in order to increase their knowledge.

Some participants were hesitant about the idea of implementing a "course" or "certification" program. One participant was concerned that providers would have a "three-hour presentation" and then feel as though they "know everything." They remarked that this would not be the case and that "learning doesn't stop there. That's the baseline." Another participant feared that if a provider were to become "certified" in trans-health, that they may feel as though their "work is done."

Noah discussed how his rural family physician is very interested in learning more about trans-health issues. But, that even as a physician, he has experienced "gatekeeping"

from other doctors and resources. Thus, it seems that some physicians are actively trying to pursue education but do not have the proper means to receive such training. In Noah's physicians case, this may be due to a lack of educational opportunities offered in their rural location. Noah said:

> *…Other doctors are gatekeeping him. He was trying to navigate the system to get me where I needed to be for my assessments, my appointments, my endocrinology, and he would call and leave message after message after message after message for people and no one would return his calls. So anytime that there is a small milestone, he's super excited for me because he's been kind of left out of the system too. He's not trained. He would love to get training. But everything is so focused in Halifax that it's hard for anyone on the outside to actually take part in anything.*

Participants also spoke about the importance of providers receiving education beyond the medical needs of transgender persons. Participants recommended that providers receive education about "respecting pronouns" and avoiding "inappropriate questioning," as well as just a general "awareness" about transgender individuals. Noah spoke about a situation in which a paramedic acted in an "inappropriate" manner. According to Noah, the paramedic "thought they were doing something nice." Participants implied that a baseline of education or awareness on trans-health and trans-identity in general could help providers to understand what is and is not appropriate when

dealing with this population. Noah described this "horrible incident" that took place in a coffee shop within a health care facility:

> *I walked in [to the coffee shop] and [the paramedic] gave me a head nod and they said, out loud, in front of everybody, "you're really pulling it off." In other words, they recognized that I was in transition and they thought I was passing well, so they thought it would be great to make a public declaration of this, because they honestly thought they were doing a good thing by saying this… They thought they were being nice. But it escalated…Because the people that this person was with said "what? Why?" And then they out me. They said "no he's not really a guy."… And I'm standing there and I'm like "what do I do next?" Sometimes you get paralyzed…And then it escalated a little further because they tried to get my attention for the third time and they say "so what do you got going on down there? Are you going to get anything rearranged?" … This is in a health care facility, in the [coffee shop], in public. Asking me about really, really, really inappropriate things that are super personal that nobody should be asking. And after all of that, then says, "well I'm a paramedic and you know, I'm really cool with trans-people"… And I'm thinking to myself, "really? Because you have done pretty much everything you could to make this a really horrible incident for me. So if I am at a point where I might need emergency health services, do you really think I am now going to call you?"*

Jacob spoke about health care providers not being adequately aware of transgender identities. He implied that further education could have corrected these situations. In one encounter, Jacob was undergoing a CT scan and was answering the technician's questions. The technician asked Jacob "is there any chance you might be pregnant?" Jacob said "no" and the scan continued. When she came back in the room, she said "did I ask you if you might be pregnant?... Oh my goodness! I'm so sorry. I just get in the routine of asking the questions… Of course you're not pregnant! You're a man!" Jacob suggested that had she known more about trans-health, she would have realized that it is possible for a man to be pregnant and that it may be beneficial to "ask everybody" that question. Jacob also recalled his experience trying to locate his gynecological surgery appointment. He said that many nurses questioned him about whether or not the appointment was actually for him. Jacob said that they "didn't know that it was even a possibility" that "someone who looked like me" would be looking for the gynecology clinic. He said that someone should be educating "the entire building's worth of people: 'Hey, you might see dudes in here looking for gyno. Just send them up!"

Hayden commented on the fact that providers need to be aware of how their actions can negatively affect transgender individuals. They spoke about individuals who may be "mentally ill," "suicidal," and/or "falling into addiction or homelessness." They said that although being "surrounded by people who don't respect you or your identity" is not a "direct link" to mental health deterioration; it "definitely doesn't help." Hayden suggested that providers need to be more cognizant of the reasons why transgender individuals often experience mental health issues. They said they should learn about the

"huge factors behind the problems in your mental health" and try to "understand why you're mentally ill."

Overall, participants did not feel that all providers needed to be trans-health "experts." However, they felt that they should have "just enough [knowledge] so that they can serve their customers." Participants argued that it is important for all providers to have "baseline knowledge" on trans-health topics. One participant remarked that it is not like providers "just specialized in the rest of the population…No matter where you are, this is a type of person that you're going to get, so you might as well be familiar with it." Claire commented that providers should have a responsibility to learn about trans-health if "it's a percentage of their clientele." She remarked that if you have a client who is "diabetic, then you make sure you know about diabetes" and that the same type of education should be available for providers on trans-health issues. Isabelle remarked that providers should be aware of trans-health issues, because they may already have clients who are doing "everything humanly possible not to disclose their assignment at birth." She suggested that providers do not have a "fair perception of how many people actually are trans." She said that it is "difficult to obtain really good demographics about the trans-community because there are trans-people who want to be stealth." She suggested that providers likely already have some trans-clients, but may be unaware of them. Another participant remarked that they "laugh" when providers tell them that they "are the first transgender person that they've met." They said that "there is no way that I am." Claire suggested that a "little bit of knowledge" could go a long way to mitigate the knowledge-based issues. She said she would like providers to have a basic level of knowledge on trans-health issues, because "knowledge is power and understanding comes from that."

Thus, participants felt that trans-health issues were, for the most part, excluded from the curriculum in health care professional programs. Participants suggested many ways in which providers could increase their knowledge on the topic. Participants also argued for the inclusion of trans-health issues within education and training and provided reasons why they believe it to be an important matter. As one participant noted, "…please set up a workshop and make your employees educated on trans-health care, because with trans-health care, it is very much life or death."

Social barriers to care. Many participants discussed social barriers that hinder their utilization of, or access to, primary and emergency care. Participants discussed accessibility issues, as well as difficulties that they have experienced in trying to legally change their names and/or gender markers. They commented on how these barriers can lead to negative health care encounters. They also spoke about the positive and negative aspects of the trans-friendly resources that are available to them in the province.

Accessibility issues. Participants discussed a variety of social barriers that would be classified as accessibility issues. These barriers included wait times, the inability to find a trans-friendly family doctor, limited access to trans-knowledgeable endocrinologists which complicates one's accessibility to means of medical transition (e.g. HRT, gender-confirming surgeries, etc.), and access issues in rural communities where health care locations may be sparse.

Some participants commented on the wait times that they experience when they try to visit their family doctors. Participants remarked that this issue is "a general health care issue, not just a trans-health care issue." However, transgender clients have unique needs and thus, there are often only a handful of physicians that they feel comfortable

visiting. As was discussed in the "continuity of care" section of this chapter, participants sometimes commented that their family doctors, with whom they had a positive relationship, were not always accessible due to long wait times. This wait time barrier was a "serious problem" for some participants and occasionally left them needing to pursue other clinics or physicians if they were not able to wait to see the physician with whom they felt comfortable.

Individuals who have to seek out a physician – either because their family physician is too busy or because they do not have a family physician – also experience some accessibility barriers. One participant remarked that they do not know where to "start looking" to find a trans-friendly and/or trans-knowledge physician. They wondered what the "indication" is that a certain physician or clinic is trans-friendly and/or trans-knowledgeable. Another participant commented, "there's no one and it's so awful because so many people need family doctors." One participant remarked that "it is difficult for everyone" to find a family physician in Nova Scotia and for transgender individuals there is an "extra level of care needed in choosing a family doctor." Participants spoke about how some transgender people try to find recommendations for trans-friendly physicians on social media groups. One participant said that they frequently see posts asking "is there anybody accepting new patients?" But that the answers are always "not really" or "I don't know of anybody who is good at working with trans-people" or "my doctor is good for trans-people, but isn't accepting new patients." It also appeared that the perceived lack of family doctors discouraged some participants from leaving their current family doctor even if they had a negative

relationship with them. One participant remarked: "I don't have a great relationship with my doctor right now, but she's kind of all I have."

Lily spoke about being aware of "lists" of trans-friendly doctors, but remarked that in a "crisis" she would not seek out those resources. She said that visiting a new physician is always a "gamble." Lily said:

> *I can recall in my memory that there are lists [of trans-friendly providers] and all that stuff, but I mean, if I go to a place, to me it's taking a gamble. As opposed to me researching and seeking it out. In the middle of a crisis, nobody's got time for that. It's just sort of a roll of the dice and hope that the doctor that I have won't be a flaming transphobic asshole.*

Some participants commented on the "narrow selection" of trans-friendly doctors. One participant remarked that there are "maybe a handful of GP's (general practitioners) who really have any experience" with trans-health issues. Isabelle spoke about how she only knows of "one or two doctors" in the HRM that are "versed and knowledgeable about trans-health issues." She spoke about the sacrifices she would make in order to see a trans-friendly physician. She remarked:

> *It's a really, really narrow selection. And I mean, be that as it is, if I could find a doctor even outside of the HRM, like an hour drive away, that I knew hit all the other criteria, I would be willing to put in that time. I'd be willing to drive an hour out [of town] just to get to a doctor that I know is friendly and who has*

knowledge of trans-issues. You know, they may not be accessible, but if I can get

there and take off work – that's the extent that I would have to go to.

A few participants commented on how it can be difficult to find a place of care when they may be "avoiding" certain physicians or clinics. For example, Ben said that the physician who often resorted to Googling information in front of him, worked on a certain day of the week each week. He was worried that "there could be four other people just like her and they could occupy every other day of the week" and that he would have to try "a different place" if this was the case. He spoke about how this kind of worry was an accessibility issue. He said:

Like, if I were in [my rural hometown], and maybe there was something that I

needed to get checked out, I might wait until I got back to [the city]. And then I

would hope that it was not a Friday.

Noah spoke about how the lack of trans-friendly and trans-knowledgeable physicians in his rural location is an accessibility issue. He spoke about how he is a part of a support group where most members "don't have a family physician" or they have one who is "not safe" or "not friendly for trans-people." He said that these individuals "have to rely on themselves" or look "to people who might have navigated" the system before, because they are not able to access physicians who they feel comfortable with. He said:

We have a support group… and everybody…they either don't have a family physician or they have them and they're not safe or they're not friendly for trans-people…We don't have the doctors, we don't have the resources, and we don't have the knowledge, so people are left kind of in this limbo where they either have to rely on themselves or they're looking to people who might have navigated [the system] and sometimes, guess what? They're getting a lot of misinformation and that's scary too.

Some participants commented specifically on the accessibility issues that hinder their ability to see an endocrinologist, which can delay their access to HRT. Numerous participants discussed how there is "only one endocrinologist" that deals with "trans-issues." Participants commented that this "one doctor" is the only one that they have heard about who has "worked for years with trans-people and has a deep understanding of what our needs are." The participants discussed how having only one endocrinologist who they feel is knowledgeable about trans-health issues puts a "huge backlog in the trans-community in terms of accessibility." Another participant commented how they have been waiting "to see [the endocrinologist] for almost two years now because [they] are the only who is doing all this stuff for the trans-people here and in PEI."

Some participants were aware that other physicians and clinics are able to assist transgender individuals in their access to HRT. Jacob discussed how he encountered one physician who seemed to be willing to help him start HRT. However, when the physician contacted the endocrinologist for some support, the endocrinologist told him that the

HRT "should go through me." Jacob believed that this "tipped" his doctor "to the other side" of "discomfort." Jacob said:

> *[The doctor] contacted the endocrinologist who does transition related hormones for like, I would say, most of the people in Nova Scotia and [they] had sent him back something saying like, "well, it should really go through me. So maybe you shouldn't do it." And [they] had said like, "you can [start the HRT process], but if you're uncomfortable with it, don't do it." So I think that was what tipped him to the other side of, like, discomfort. Anyway, that was pretty disheartening because then I had to start over with another doctor.*

Another participant commented that they were unaware that there were other ways to access HRT besides going through the endocrinologist. They said that they "happened to have a physician who was from [a trans-friendly clinic]" when they were at a walk-in-clinic. The physician told them that their clinic could help them to get started on HRT, but that this encounter was "totally by chance." They expressed some frustration because no health care professional had been able to direct them to that clinic earlier. The participant commented that they had been looking for help with starting HRT, but that no one had been able to tell them where they should or could go. They said "you have to do all of the work just to find out what's going on." They felt as though the system was "really disconnected."

Some participants discussed how there are barriers to receiving HRT beyond finding a willing provider to initiate treatment. For example, Hayden discussed how their

"mental state," "financial position," and lack of answers from health care providers, have

caused them to feel like they are being "tossed around like a pinball." Hayden said:

> *I have been trying to gain access to hormones for the past year-ish. And whether*
> *or not it's because of the intersection of my anxiousness slash mental health*
> *issues and being trans, it's been difficult. I've been doing a lot of it through my*
> *family physician and I've also been trying through external resources like the*
> *[trans-friendly clinic]. I've been trying to gain therapy. But like, because of my*
> *financial position and just in general, my mental state, it's been very difficult for*
> *me to try and go out there and get there. I feel like I'm being tossed around like a*
> *pinball. It's very hard to get a firm answer. It's always "oh you have to see this*
> *person at this place, so you have to do this and go there. You can't actually do*
> *that here. You have to wait six months. You have to wait eight months. You have*
> *to wait ten months. You have to see an endocrinologist. You have to see a*
> *therapist." And none of that is free if you want it as soon as possible.*

Isabelle remarked that "access to hormones" should be an easier process. She

commented that "the implementation of access to hormones under informed consent" and

without so many barriers would allow people to get "what they need." This would allow

individuals to "be able to proceed in a medically supervised environment if they want

too." She spoke about a "model in California" that she has read about where individuals

receive a prescription for HRT after a much shorter "initial intake" period than what is

currently the standard in Nova Scotia. She said that "it should be as simple as saying,

'this is who I am, this is what I feel I need. I understand all the risks and consequences that come with it.'" She believes that "people can make their own choices about their body and their own choices about their health."

Hayden said that they were under the impression that "all I would need to do is to go to my local health care practitioner, give informed consent, sign the form, and then I would have hormones dispensed to me." However, they remarked that it has "been a year" and they "can't get a hold of anyone to give me an answer" as to when they will actually be able to start HRT. They expressed concern that "more trans-people are coming out" and that this means the "wait lists are just going to get longer and there won't necessarily be more health care practitioners being kept up to date…or the necessary amount of resources."

Noah spoke about the "assessments and letters" that are currently required in order to access HRT and gender-confirming surgeries. He acknowledged that these steps are in place to ensure that individuals are sure of their decisions and that their "safety" is maintained. However, he felt as though these steps can sometimes just act as "red tape" that hinders them from accessing care. He feels as though "priorities are a little backwards." He said:

> *You've already done a lot of suffering. You've already been through so much. It's*
> *not an easy transition. There's no such thing as an easy transition. It doesn't*
> *matter how privileged you are, because the social aspect is just so difficult. So*
> *why are we so concerned with all the red tape? I mean if you're concerned with*
> *safety for trans-folks and making sure all of these assessments and letters are in*

place, then why are we still having barriers to accessing primary care?... You

want to make sure that we're not making some kind of mistake and that we

understand, you know, what we're doing. But, you're going to reject somebody or

you're going to make it difficult for us to navigate care? Priorities are a little

backwards right now, as far as I'm concerned.

Numerous participants spoke about how "devastating" the wait times and/or barriers that impede them from accessing means of medically transitioning can be. One participant said that the time between "when you decide to transition and when you actually get to access [HRT]" can be a "difficult mental health period for a lot of trans-people. Waiting around. Sort of not really being in control." Some participants spoke about how they have heard of other transgender individuals pursuing non-supervised means of HRT because they are not able to access it easily. These methods, such as ordering unregulated hormones online, were described by one participant as "dangerous."

Hayden discussed the cycle-like situation that they are in with regards to wanting to access HRT, while having compromised mental and financial states. They said that they "want to feel accepted and being on testosterone would help that," yet they feel as though they are "being tossed around the system without answers." Hayden commented on the anxiety they have when they call the doctor's office because "I'm going to talk to a receptionist who is going to misgender me." They said that often times the phones are too busy to get through so they "actually have to go to the place to book an appointment." This means that they "have to be available during a certain part of the day" which does not necessarily fit with their work schedule. They remarked that each of these "hurdles"

makes pursuing care "extremely difficult." Hayden further commented that "once I'm there, it's not something that I'm going to look forward to because I know that [my physician] has no answers for what I actually need help with." They said that although "hormones would help," the barriers that are in place to gaining HRT causes them to feel as though they are "too anxious and poor to try and access them." Noah also spoke about the "harm" that not being able to access HRT can have on a transgender individual. Noah suggested that the "health care system is supposed to help," but that in some cases, it causes "harm." Noah commented:

> *…Our health care system is supposed to help, but it's doing harm to people. Whether or not it's physical [harm]. You might take care of their physical issues, but if somebody is coming out with a lot more mental health instability because of the treatment that you're getting while trying to access health care – that's a serious problem that we have to look at.*

Noah also commented on an accessibility issue that was unique to his rural location. He spoke about emergency rooms being "closed" and how the location of the next nearest hospital may not be accessible. He also spoke about what would happen if a physician told him that they were not "comfortable" treating him, which would mean he would have to try to access another location. Noah said:

> *Access is a huge issue. There are a lot of barriers to access in just trying to get there. Like I said, a lot of the times our emergency rooms are closed. I rely on*

public transportation, so if our emergency room is closed, I'm not going to be

able to get to the next nearest hospital. So there's a lot of different issues around

that, whether or not you're trans, you know, it all plays a part. Like okay, what

happens if my emergency room is closed and I go in and this doctor is telling me

"nope, I'm not really comfortable." And then what?

A few participants spoke about the accessibility issues that hinder their access to mental health providers. They discussed how the provincially funded mental health resource is inaccessible due to a minimum six month waiting period. One participant stated that they avoid the "mental health care system" because there are no "trans-friendly resources" that they know of. They said that they have not known where to turn when they experienced a "mental health crisis" because of the lack of trans-friendly locations, wait times, and financial barriers. Hayden commented that they are able to "get pills for my mental health" through their family doctor, but are not able to access "therapy to keep up with my mental health." They stated that this has caused them to feel that they are "not at an ideal point in my life. I'm doing as well as I can. But I could be doing a lot better."

Numerous participants spoke about access issues surrounding gender-confirming surgeries. Some participants commented on how more and more surgeries are being offered within Nova Scotia, but expressed concern that the individuals providing the surgeries may not have the "education" and "experience necessary." One participant commented on a gender-confirming surgery that they had done outside of Nova Scotia. They said it was "awesome" because the provider "does a lot of trans-health care, so like

he knows what he's doing." The participant was concerned that providers in the "public system" "don't know what they're doing as much with trans-people."

The participants expressed gratitude that the province now covers some types of gender-confirming surgeries. However, a few commented that they would like more of these surgeries to be done "in province" so as to avoid having to travel. Isabelle brought up an issue surrounding the coverage for gender-confirming surgeries. She said that "Nova Scotia has been great about" providing coverage for some surgeries. However, she believes that there are still access issues which can lead to "mental health" issues because only portions of the surgeries are covered provincially. She said:

> There's other issues surrounding access to surgeries and things like that, which Nova Scotia has been great about, in starting to provide and cover for that. A lot more needs to be done in province. I think they are trying to go in that direction. But, they also need to examine some of the surgeries that they offer. Like, for transmen, they offer mastectomies, but they don't offer chest contouring, which gives it a more masculine appearance. And what they're thinking, of course, is "well that's aesthetic. That's not a requirement." But, it is as part of the mental health of the person. Because you can get your boobs cut off, but if you still have a feminine contouring to your chest, it's still going to be an issue, right?

Participants commented on many accessibility issues that act as barriers to them receiving primary and emergency care. Some of these barriers, such as wait times to see a general practitioner, are issues for the general population. Other barriers, such as limited

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access to HRT and assessments for gender-confirming surgeries, are more specific

obstacles that prevent the transgender population from being able to access care.

Participants commented that there is a definite need for "more physicians who are willing

to get up to speed and treat people" in order to help to reduce accessibility issues.

 Medical documentation as a barrier to care. Many participants spoke about

wanting to change their medical records to reflect the name and sex that they identify

with. Participants thought that their health care encounters would be better if their

medical records aligned with their identity. However, they discussed the numerous

barriers that prevent them from changing their medical records. A few participants spoke

about how they are reluctant to pursue primary and emergency care because their medical

records still display the sex that they were assigned at birth and their legal name. Some

participants remarked that their health care experiences are "a little bit constrained, like

pulled back" because "my health card still has my former name on it." Some participants

discussed the barriers that prevent them from being able to change their names and sex

designations. Some remarked that they "don't have the money to get a name change."

Hayden spoke about the financial obstacles that prevent them from being able to legally

change their name and sex. They remarked that it is "ridiculous" that they have to "prove

that you're trans" in order to get their name changed. They said:

> *For myself personally, when it came to going to the doctor's office, I'm*
>
> *misgendered because I don't have the money to get a name change… And they've*
>
> *just recently come out saying that you can change your gender on official*
>
> *government identification, but you need to prove that you're trans. And in order*

to do that, that means you have to go to a therapist, a social worker, and you have

to get them to write a letter confirming that you're transgender. Which, I find to

be ridiculous. You don't have to get a therapist to sign off on the fact that you're

gay if you're about to enter a gay marriage. But, there's not anything that I can

do about that right now. I don't have $300 to spare in disposable income, so I

can't afford a legal name change.

A few participants remarked that they feel as though they are being judged "based off of their files" when they "aren't necessarily in a place where" they can "legally change their name or [begin a] medical transition." Despite asking receptionists and providers to respect their names and gender identities, many participants remarked that it "still doesn't matter. It only matters when your documents are legally changed." Noah commented:

…It still doesn't matter. It only matters when your documents are legally

changed. And even when my documents were legally changed, but I still didn't

have the card in my hand, guess what? Doesn't count. It's almost like you're

completely discredited. It doesn't matter. Until you have that card and we can

change it in our system, we're going to ignore everything you say regardless of

how inappropriate you feel it is or why you've explained it's disrespectful and

triggering. They don't care.

Noah also discussed an altercation with a receptionist that transpired after the receptionist noticed the female sex designation on Noah's health card. He said that he feels as though he is being "told all of the time" that he "can't be" who he is because his medical documents and his gender expression do not "match." He commented:

I am told all of the time "you can't be who you say you are because [your sex designation] doesn't match your name." So I had an argument about two weeks ago when I went to get blood work at [the clinic] with somebody doing the administration work for the lab. She was getting very visibly upset and angry with me, saying "you can't be this person, because there's an 'F' on here." Even though my name is changed to represent who I am.

Some participants spoke about how having their birth sex on their health card and medical records causes them worry and distress. For example, Lily commented that her sex designation has gone "unchanged" because she "can't access the resources to change it." She expressed concern over the incongruence between how she presents and what her medical records state. However, she also expressed concern about the potential consequences of having a health card with a female designation while still having biologically male genitalia. She stated that this could put her "at risk." Lily said:

It also puts me at risk if I'm on a stretcher and my health card says female and something happened to my torso and they have to rip my pants off in order to do whatever… And they see my junk because I haven't had bottom surgery. What's

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the situation there? I'm passed out, I'm bleeding possibly, and now the EMT's are

like "what the hell is this?"

One participant spoke about numerous encounters in which receptionists had misgendered them and called them by their former name. The participant wondered if the receptionist was "legally required" or if it was an "actual legal necessity" for the receptionist to refer to them by their prior identity since their medical documentation had not be changed.

Jacob described the hassle that ensued when a pharmacist entered his sex into the system without checking his health card first. The pharmacist "had put me into the system as male based on, I guess, what they saw of me. But hadn't actually checked my health card." Jacob spent "three months" trying to understand why his prescriptions "wouldn't go through." This resulted in him "paying for drugs that I didn't need to be paying for because they wouldn't go through in the system, because somebody didn't check [my sex designation]." He said that this experience was "frustrating," but that he also understood why the mistake had been made. He seemed to feel as though having updated medical records, with the sex that he identifies as, would have prevented this situation.

Another participant commented on an unfortunate event wherein medical records were "reset" throughout the hospital medical records system in the HRM. They said that all of the medical records were "reset," so "even if you've legally changed your name and it's been changed in the system," it was erased. They remarked that many transgender

individuals were asked if they had ever visited the hospital under their "old name." The participant remarked that this was "stressful" and "really awful for a lot of reasons."

Participants commented on the numerous issues that they face when they "can't access the resources to change" their name and/or sex designation. Some felt that their health care experiences were "constrained" because of the fact that they could not change their medical records. Others spoke about feeling judged when health care providers noticed an incongruence between their gender expression and sex designation on their medical records. However, one participant noted that they could potentially be at "risk" if their sex designation was changed to match their gender expression, but was incongruent with their genitalia. Yet, most participants felt as though having their medical records and gender expression match would benefit their health care experiences, but reported that there are numerous barriers to changing their medical documentation.

Resources or connectors? All of the participants mentioned resources that have been helpful to them in their pursuit of health care. Some participants spoke about trans-friendly clinics or divisions within larger health care systems, and others commented on social support organizations. All of the participants commented on the positive influences that these types of resources have had on their health care experiences.

Some participants were more critical of these resources than others. For example, Hayden felt that these resources are more like "connectors" because "there's only so much that they can do." Hayden commented:

> *…Unfortunately, [resources] are just more or less connectors… There's only so much that they can do. They may refer me to [a social support resource], they*

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may refer me to a trans-friendly therapist, they may refer me to [a trans-friendly

clinic], but that still involves that six month waiting list and money at the end of

the line that I don't have… Resources to me are just connectors. Instead of

hearing resources, all I'm hearing is connectors. Because that's all they're kind

of doing. They connect you to a place that I can't actually get too.

All of the participants spoke about resources that have provided them health care

information or allowed them to access trans-friendly care. However, a few participants

expressed concern that these resources were really just "connectors" to other sectors of

health care and that they were not overly helpful in assisting the individual to overcome

accessibility issues.

Behaviours resulting from social exclusion. Participants commented on the

behaviours that result from social exclusion and negative health care encounters. These

behaviours included avoidance of health care, increased reluctance to utilize health care,

and non-disclosure or reluctance to disclose their transgender status. For some, these

behaviours began after a negative experience during a health care encounter. For others,

the fear of possibly experiencing a negative encounter was enough for these behaviours

to commence. Participants discussed the consequences of these behaviours.

Avoidance of primary and emergency care. Some participants mentioned that

they tended to avoid health care encounters in which their transgender status would

inevitably have to be discussed. For example, one participant commented that they

avoided going to the doctor to get "the ball rolling" with their medical transition. Another

participant said that they needed to get a letter from their physician stating their readiness

for a gender-confirming surgery. This participant remarked that they avoided their family physician because they did not want the doctor to "give them a hard time." Others spoke about gendered care and their avoidance of procedures or exams that are traditionally considered "for men" or "for women." One participant remarked that "gynecology is never going to happen." Another commented, "I tend not to get exams, like pelvic exams and that kind of thing."

Some participants spoke about avoiding health care because of fear of interacting with new staff or providers. One participant remarked that they avoided going to their family doctor "because the reception person who I'd built up a kind of respect with would be on vacation, and I would have to then go through and explain everything over and over to whoever was taking over the position." The same participant remarked that they "avoided going to hospitals for many reasons" including a lack of gender-neutral washrooms and changing rooms and perceived insensitivity from providers and staff.

Hayden and Noah both commented on their avoidance of mental health care. Hayden spoke about times where they "probably needed" mental health services but they "definitely avoided seeking out help" because of their "reluctance" to trust that providers would be trans-knowledgeable, trans-friendly, etc. Hayden mentioned that encountering such a provider would cause further "deterioration" of their mental state. Noah said that he tries to avoid the "stigma" and "discrimination" that he feels he will face in these types of environments. He said that he has "needed somebody to talk to" but that he "didn't go" because there was not a "safe space for me to talk." He said:

We don't talk about the mental health component and there have been times when I am sure I needed somebody to talk to and guess what? I didn't go because I knew that there wasn't going to be a safe space for me to talk. There's not even a mental health professional that I can speak to around trans-issues without it being turned into a negative thing or again, something that is up for debate. So yeah, there has been a lot of avoiding the health care system.

Many participants discussed how they avoid accessing care for non-critical health concerns. They mentioned that for minor sicknesses and ailments they are likely to "wait things out" or to avoid care for a longer period of time than they would have before they changed their gender expression. One participant remarked that they "don't go unless you really need to." Another remarked that "I have waited maybe a little longer" to pursue care as an out transgender individual than they would have before, but said that they have "never all together avoided" care. Although many participants shared times when they avoided pursuing health care, the majority agreed that if they are very sick they will pursue care. For example, Lily said that she accesses health care when she is "sick enough" that she knows she needs "actual medical attention."

However, a few participants spoke about avoiding care all together, even during emergency situations. Noah said that he has even informed his co-workers that should he be in an emergency situation, he does not want to be taken to the emergency department. He commented that if he ever gets "to the point where I need to go to the hospital – I have told my co-workers, do not take me there. It wouldn't be a safe space for me." Noah said that he avoids the "emergency stuff as much as possible" and "likely would not go"

to the emergency department for any urgent issue. He said that the only situation in which he would utilize the emergency department is if he knew "for certain that there is somebody there that is safe." He commented:

> *I avoid the emergency stuff as much as possible. I haven't had any injuries; I haven't really had a lot of incidents where I needed that service. But there are definitely times, even now, where I say "if I need this service. Guess what? Don't." It's not going to happen. Unless I know for certain that there is somebody there that is safe… And you never know that.*

Noah also spoke about an incident where he was "deathly sick" and "refused to go to the hospital." He said that he was "turning gray" and that something was "seriously wrong" with him. He commented that "people were actually worried that I wasn't going to make it." He said that he avoided the emergency room until someone "picked me up and carried me to the car." He said that part of the reason why he avoided care was because "I just didn't have the energy in me to try to have to explain all of this to people." He discussed having to consider "what's more important?" – pursuing health care for his illness and potentially having a negative experience, or avoiding an environment where he would be "constantly misgendered," but leaving his illness untreated. He said that "I couldn't make that call when I was that sick." He said that it is "easier" to think "this [health issue] will fix itself" and "avoid all of that," referring to misgendering and other insensitive behaviours expressed by providers and staff. He further commented:

If something sets off an alarm, red flag, danger – you're not going to do it again if you can help it. And it's sad that that's the way that I have to think of our health care system… You're always trying to…be as preventable as possible to your own triggers. And sometimes that means cutting out the health care system altogether, or as much as you can, until you can't ignore it anymore.

When asked if Noah feels as though his avoidance of care could be negatively affecting his health, he said "absolutely." He also spoke about the "guilt" that he feels when he avoids care, as part of him says "should I just do it and get it over with?" He remarked that part of the responsibility for making him feel comfortable to pursue care should be "on the health care system." Noah remarked:

Absolutely [avoiding care might negatively affect my health]. I mean how can it not? Anytime, you know, there's a thing that you probably should be doing and then you're avoiding it because of stigma and lack of information and all of these things, of course it's impacting your health in one way or another. Again, maybe it's not causing a serious physical issue right now, but it might. And I'd never know. But again, there's also all of that mental health stuff that's weighing on top of that. There's a lot of guilt there. There's a lot of "should I just do it and get it over with?" And then it's a lot of pressure then added on me. And again, shouldn't it be on the health care system to say "hey, we're actually going to welcome you and accept you. We'll have this be as painless as possible."

Many participants recalled times when they have avoided primary or emergency care. Although many of the participants spoke about avoiding health care for small or minor ailments, the majority agreed that they would seek out care for emergency situations. However, some participants felt that they would even avoid emergency care because of barriers and fear of how the encounter would unfold.

Reluctance to utilize primary and emergency care. Some participants who did not completely avoid care, still spoke about being feeling reluctant to pursue primary and emergency care. For example, Lily stated that she is hesitant to utilize care because she feels as though she will either be "discriminated against" or she will have to spend "so much time explaining details about my personal life." She commented that she has to ask herself: "Do I access health care or do I not? Do I accept that something could happen and that I'll have to go into the war zone or can I wait it out?" She commented that these types of questions contribute to her "reluctance" to pursue care.

Hayden stated that after accompanying their friend to an emergency room visit, they would be "extremely, extremely reluctant to admit myself to any of the local hospitals." They said that they could not see themselves being "comfortable" in the hospital environment and thought that the experience would be "hellish." Emerson spoke about feeling reluctant to search for a family physician. He said that he did not want to have to say: "Hi, I'm not here for trans-related care, but I'm trans and that's going to affect how you treat me."

Most participants reported feeling reluctant, at some point in time, to pursue care. Thus, even when individuals decide not to avoid care, they may still experience some hesitation about following through with their decision to seek medical attention.

Non-disclosure of gender identity in the health care setting. Some participants discussed how they disclose their transgender status during a health care encounter. Some participants remarked that they "have to" disclose their transgender identity so that they feel as though they are in control of the situation. Others felt it was best to not disclose their transgender status, but remarked that this could potentially jeopardize the care that they receive. Regardless of whether or not they chose to disclose their gender identity, most agreed that the decision of whether or not to disclose is stressful.

A few participants spoke about feeling as though they had to disclose their gender identity, even when they did not feel comfortable doing so. Lily said she feels like she has to "declare that I am [transgender]" so that any sort of "issue that may be coming up can be dealt with immediately." She said that by "declaring what I am," she becomes in control of the situation and can use her declaration "almost like a weapon" and as a "defense mechanism." She said that feeling as though she has to disclose her gender identity in order to feel safe does not "give me confidence in the system." She commented that she feels as though "she has to champion the fact that I'm transgender," even when she's trying "to deal with something completely unrelated." Isabelle spoke about how she feels as though she needs to disclose her identity in "the interest" of her "best care." She said that she "wants them to be aware of the issues that I might have, because I put down that I'm a woman, but I have a prostate." She feels as though medical concerns may be overlooked if she chose to not disclose. Noah said that "I feel like if I bring it up first, then at least I've done my part." He said he often feels as though he needs to "put this out front right away" to avoid any issues. He commented:

Sometimes I go in there going "I have to put this out front right away." I have to

actually make that statement when I first walk in, otherwise it's going to get really

awkward, because I just know that something will inevitably come up… I feel like

if I bring it up first, then at least I've done my part.

Other participants said that they often choose not to disclose their transgender identity. Some said that they purposely did not disclose because they did not "want to have to explain things to people." One participant believed that the benefits of not disclosing, such as not having to educate providers, outweighed the potential health consequences that could accompany non-disclosure. Other participants remarked that they "don't bring it up unless I have to." Jacob said that he has "experimented" with disclosure and non-disclosure and has found it "less awkward to not disclose." He said:

Usually the time that I consider whether I'm going to bring [my transgender

identity] up or not is when I have to give a like medical history and like a surgical

history. Because then, they are pretty much going to find out. But I have

personally opted not to do that. So I just list the surgeries that I've had and if they

ask me about it, I tell them. But if they don't, I don't. So I'll say like "I've had a

double mastectomy. I had a hysterectomy" and if they don't ask me about it, I

don't tell them. But I find disclosing it is awkward and it makes it a thing and it

opens up the possibility of discussions about it that I don't necessarily want to

have. So I've sort of experimented while like going to the doctor, with disclosing it

and non-disclosing it, and I've actually found it less awkward to not disclose and just sort of list those incongruent surgeries and medical procedures.

Many participants spoke about trying to decide if disclosing their identity would be beneficial for the encounter or not. Noah commented that sometimes when he discloses his transgender status, providers "try to debate" him or they "make assumptions" about him. He remarked that although he "can be open and disclose it," he "can only handle so much before I shut down and I stop trying." One participant commented that they have to decide if disclosure would be "relevant" to the reason that they are pursuing care. They said that if disclosing their identity is not relevant, then they do not "bring it up." One participant remarked that "most of male bodies and female bodies are the same, so I don't usually worry about it." Ben said that he hopes his transgender status will get "overlooked" when he is pursuing care for non-transition related concerns, such as a "chest cold." He wishes that disclosure could be a "non-issue." He remarked:

> *It would be great if I could navigate the whole thing without anybody – with it just being a non-issue. Like if I'm there because…I have like a chest cold or something, I don't really think that part of my identity is going to be pertinent to the appointment or whatever. So like, if we can go through that whole thing without them looking at my chart and seeing it and then getting really awkward, then that's great. So basically, every time I go in for something like that, I'm really hoping it just gets overlooked.*

Many participants touched on the hassle that comes with having to disclose. Hayden remarked that "coming out isn't a single event. It's every single day." Emerson remarked that disclosure is "a scary thing." It appeared that choosing whether or not to disclose one's transgender status was often a difficult decision. Many participants seemed to put a lot of thought into whether or not they would disclose and appeared to weigh the risks and benefits of disclosure versus non-disclosure.

Theme 3 summary. This theme highlighted how social factors can influence individuals' perceptions of, and experiences with, primary and emergency care in Nova Scotia. Participants commented on their perceptions of the prominent social discourses regarding transgender identity. Some participants spoke about what it is like to be "out in public," and how these experiences can translate into being in public health care settings. Individuals discussed their experiences with, or fear of, discrimination and some commented on how their ability or inability to "pass" or be "read" as their preferred gender affects their encounters. The participants also commented on the many social barriers to utilizing care, such as accessibility issues, medical documentation issues, and the pros and cons of trans-specific resources. Finally, they commented on the behaviours that can result from a combination of these social factors and the resulting feelings of social exclusion. Some participants have avoided care, some have felt reluctant to utilize care, and some have struggled with whether or not to disclose their transgender identity.

Chapter 5 Summary

This chapter provided a detailed explanation of the second and third major themes that emerged from the participant's accounts of their perceptions and/or experiences with primary and emergency care in Nova Scotia. These themes underscore the importance of the physical and social environments within the health care system. These environments are often overlooked in the literature exploring transgender individuals' experiences with health care. Participants discussed the numerous physical and social factors that play a role in how they perceive their health care experiences. Within their discussions of these environments, participants provided tangible suggestions for how providers, staff persons, and policy makers could implement changes to make transgender individuals feel more welcomed and comfortable. The implementation of these suggestions would likely cause transgender individuals to utilize care more often and may provide them with better experiences.

Chapter 6: Discussion

The findings indicate that transgender adults experience varying degrees and frequencies of discrimination while pursuing primary and emergency care in Nova Scotia. This chapter highlights the impact of this continuum of discrimination by discussing its significance and consequences. Also, this chapter emphasizes the navigation issues that hinder transgender adults from pursuing care or from easily accessing care. The impacts and ramifications of these barriers will be discussed. Based on participant suggestions, this chapter also discusses the lessons that can be learned by health care providers and health policy makers. This chapter will conclude with some recommendations for future research in this area.
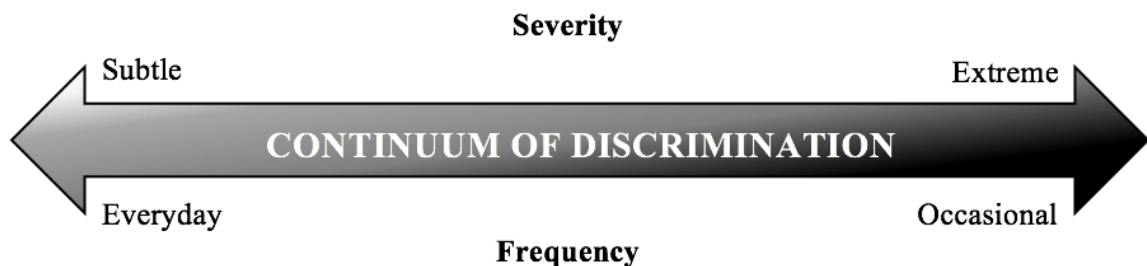
Experiences of Discrimination and Stigmatization

Overt versus covert: Discrimination as a continuum. In order to understand the continuum of discrimination that transgender people encounter in health care settings, it is important to understand the difference between stigmatization and discrimination. Although sometimes used interchangeably, stigmatization and discrimination do possess differing meanings. In the context of gender identity, stigma refers to the devaluing of individuals who are not cisgender (Logie, James, Tharao, & Loutfy, 2012). Goffman (1963) argued that stigmatized individuals possess an attribute that causes their identity to become "spoiled." This then causes individuals with this attribute to be barred from social acceptance. Under this definition of stigma, one's transgender identity "marks" them as a member of a "discredited" group (Stevens & Hall, 1988). Discrimination refers to members of a group being treated as though they are inferior or lesser than non-group

members (Hausmann, Jeong, Bost, & Ibrahim, 2008). Discrimination, in the context of gender identity, is often the result of stigmatizing or transphobic perceptions or beliefs (Logie et al., 2012; Shires & Jaffee, 2015). Thus, stigma is the negative perception that individuals may have about transgender persons, whereas discrimination is the inequitable treatment and behaviours targeted towards transgender persons (Logie et al., 2012; Shires & Jaffee, 2015). Therefore, stigma is the negative perceptions that can lead to a range, or continuum of, discriminatory behaviours (Canadian Mental Health Association, 2016).

Most studies on the topic of transgender health discuss how discrimination can serve as a significant hurdle to accessing or utilizing health care services (Bradford et al., 2013; Grant et al., 2010). However, most of these studies emphasize only the overt acts of discrimination such as outward displays of violence, verbal harassment, sexual assault, and refusal of care (Grant et al., 2010; Kenagy, 2005). Although some of the present study's participants had experienced situations where they were overtly discriminated against, most of the participants recounted frequent experiences of subtle or covert displays of discrimination. Being disrespected by having their preferred names and pronouns ignored or feeling as though a provider's attitude was negatively influenced by one's transgender identity are prime examples of discriminatory behaviours that are relatively covert. In the context of racial discrimination, Sue and colleagues (2008) refer to these acts of subtle discrimination as "microaggressions." They define microaggressions as "brief and common place daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of colour" (p. 271).

Expressions of "microaggressions" are commonly directed towards members of marginalized groups. Sue and colleagues state that covert discrimination is somewhat "old fashioned" and that expressions of hatred and bigotry are now commonly disguised as ambiguous and nebulous forms of discrimination that are difficult to isolate. Although this subtle type of discrimination is not as dramatic as being physically or verbally abused in the health care setting, it was clear from participants' accounts of their experiences that subtle discrimination was experienced more often than extreme discrimination and was perceived as harmful. Figure 2 illustrates discrimination as a continuum of severity and frequency ranging from subtle and frequent discrimination, to extreme and occasional discrimination. For some individuals, experiences of subtle discrimination occur every day in health care settings and beyond. Extreme acts of discrimination, in health care settings and in one's everyday life, appear to occur less frequently.

Figure 2. Continuum of discrimination. A depiction of how discrimination can vary in both severity and frequency. Individuals appear to experience subtle discrimination frequently or every day, whereas extreme displays of discrimination happen more occasionally.

The Ontario Human Rights Commission (2014) states that discrimination based on gender identity and gender expression "can be direct and obvious or subtle and hidden, but harmful just the same" (p. 3). Thus, this definition acknowledges a range of

discriminatory behaviours and under this definition, "subtle" and "hidden" discriminatory actions are recognized as damaging and detrimental. Yet, the references to such types of discrimination in the literature appear to be sparse. It seems that most studies regarding transgender individuals being discriminated against in the health care setting fail to acknowledge discrimination as a continuum ranging from subtle to explicit behaviours. Even when subtle discriminatory acts are discussed, the harmful consequences of these types of behaviours for transgender persons are overlooked.

Although the acknowledgement of a discrimination continuum does not appear to exist in the transgender health literature, the concept exists within literature relating to other marginalized populations such as racial minorities (Beagan, 2013; Dovidio et al., 2008; Hausmann et al., 2008), gay and lesbian communities (Hong, Woodford, Long, & Renn, 2016), and obese health care users (Magallares, de Valle, Irles, & Jauregui-Lobera, 2014). Research on overt versus covert discrimination with these populations seem to have produced similar results. The findings show that harmful consequences stem from both hidden and blatant forms of discrimination. Hong and colleagues (2016) investigated the experiences of varying degrees of discrimination in a sample of LGBQ college students. The authors note that there was very little research investigating subtle types of discrimination in this population and noted that such covert acts of discrimination are much more frequent than the blatant forms. They contend that subtle discriminatory acts are often excused as unintentional and are thought to be insignificant. Yet, they found that students were negatively affected by such displays of discrimination, even when indirect and vicarious. They called for more attention to be placed on subtle discrimination in the forms of programs and policies, so as to help validate and mitigate

these harmful experiences (Hong et al., 2016). In a study with racially diverse medical students, Beagan (2013) concluded that subtle acts of racism have additive effects over time and serve as a reminder of a group's perceived low status and unworthiness. These acts are easily minimized and deemed unproblematic by others. Some participants felt that such acts were not worth "getting into a big fuss over," especially when a power differential existed between the discriminatory individual and the individual being discriminated against (e.g. between educator and student) (Beagan, 2013, p. 859). However, the accumulation of every day, subtle incidents can cause significant distress for the individual and may even be more detrimental than a few acts of extreme discrimination.

Furthermore, other studies with racially diverse samples have concluded that subtle and ambiguous racial encounters are more detrimental on an individual's health than covert discriminatory experiences (Merritt, Bennett, Williams, Edwards, & Sollers, 2006; Williams & Mohammed, 2009). For example, one study found that subtle discriminatory experiences led to higher increases in blood pressure and cardiovascular reactivity than individuals who had experienced a blatant form of discrimination (Merritt et al., 2006). Such subtle behaviours are experienced more frequently than blatant displays of discrimination and are often deemed inconsequential by others and are subsequently ignored (Hong et al., 2016; Magallares et al., 2014). Therefore, support for individuals who endure covert discrimination is likely lacking as well, especially since these individuals have the burden of proving that the subtle discriminatory act took place.

Another reason why subtle discrimination may be perceived as more harmful, is because individuals may be able to attribute extreme experiences of discrimination to the

individual who expressed the behaviour. In other words, some participants spoke about assuming that the overtly discriminatory individual was a rude person in general, rather than them actually having a problem with transgender people. On the other hand, subtle discrimination almost seems to be a normalized response to transgender individuals and may cause transgender persons to feel as though that is how most people view them.

Although it can be understood why research may focus on the more dramatic types of discrimination, the neglect of covert discriminatory experiences from the literature may work to reinforce these behaviours as such inattention essentially negates the harmful impacts of these experiences. In other words, providers and policy makers may not realize that their intentional or unintentional "slights" towards transgender persons are detrimental. Providers and policy makers may feel as though their actions are not harmful as they are not demonstrating extreme discrimination towards this group and the ramifications of such subtle discriminatory behaviours are often not discussed in the literature.

Figure 3 illustrates how, for some individuals, the impacts of constant and continuous subtle discrimination over time may outweigh the impact of a few occurrences of extreme discrimination. The circles represent the weight of a discriminatory experience. The extreme experiences may be individually "heavy," but the additive effect of the many subtle discriminatory experiences may be even more burdensome. Although it is tremendously important to ensure that transgender individuals do not experience violence and harassment in the health care setting, this concept of a "discrimination continuum" also highlights the importance of ensuring that subtle acts of

discrimination and disrespect are mitigated so as to prevent the damaging cumulative impact of these everyday occurrences.
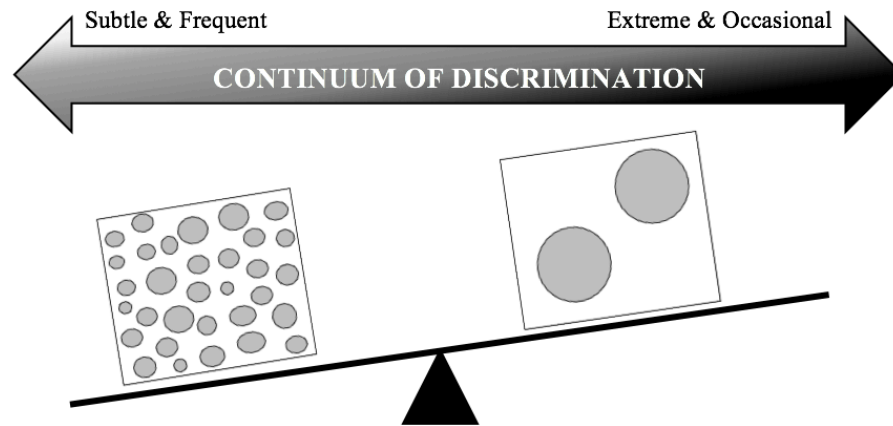
Figure 3. The impact of varying degrees of discrimination. A depiction of how the cumulative impact of frequent experiences of subtle discrimination can, for some, be more detrimental than a few extreme discriminatory experiences.

Levels of discrimination: Interpersonal and institutional. It was clear from the participants' remarks that they experienced stigmatization and discrimination at multiple levels. Participants discussed being discriminated against on an interpersonal level, as well as through the physical and social environments at an institutional level. Whereas interpersonal discrimination refers to the discriminating behaviour of individuals, institutional discrimination refers to the policies and discourses regarding the stigmatized group (Pincus, 1996).

Many articles call for research to further study the impacts of institutional discrimination within health care settings as it is often overlooked. One study, which investigated how societal deprivation of rights for LGB individuals affects mental health, argued that institutional discrimination is especially important as it includes "fateful

experiences" or experiences that are out of the individual's control (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). Unlike interpersonal discrimination, which occurs through one-on-one interactions, institutional discrimination is engrained at the institutional and societal levels and cannot be easily contested by the person experiencing it. Studies have demonstrated the harmful effects of institutional discrimination on marginalized communities, such as racial and sexual minority groups (Gee, 2002; Hatzenbuehler et al., 2010).

However, in the context of this study, the institutional discrimination that participants discussed appears to be more along the lines of institutional and informational "erasure" (Bauer et al., 2009). The participants rarely spoke about discriminatory policies, but more so about transgender identity being neglected at the institutional level. In other words, some participants felt as though there was a lack of thought regarding transgender identity at the institutional level all together. The majority of their concerns with the physical and social environments seemed to stem from a feeling of social exclusion or invisibility, such as a lack of trans-specific information in health care settings and the omission of transgender health curriculum from many health care professional programs.

Bauer and colleagues' (2009) article discussing transgender "erasure" nicely summarizes the varying levels of social exclusion that participants in this study commented upon. Informational erasure is a lack of knowledge regarding transgender identity often due to the assumption that such information is not necessary or does not exist. Transgender identity is informationally erased in some health care professional program curriculum, textbooks, and in research studies as historically, transgender

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identity has been understudied or conflated with other groups (Bauer et al., 2009). The authors contend that informational erasure essentially renders transgender identity invisible. They suggest that the social exclusion that stems from such erasure has a profound affect as the transgender experience is silenced. In relation to health care encounters, the authors argue that the:

> *Pervasive absence of information, along with stunted knowledge production and dissemination, greatly affect the ability of trans people to access health care services. It manifests in an unwillingness on the part of providers to transcend obstacles to gain access to information or to use the information that has been provided* (p. 353).

Institutional erasure ensues due to a lack of policies that aim to accommodate transgender persons, or due to ignorance that such policies are necessary. The authors discuss how, in the health care system, transgender individuals must often choose whether they will access services according to their sex assigned at birth or abstain from health care services all together due to institutional erasure (Bauer et al., 2009). The authors suggest that the physical and social environments of the health care system assume that health care users are cisgender and that cissexist infrastructure works to exclude transgender persons from utilizing care.

The authors allude to a cycle of informational and institutional erasure. When transgender identities, health issues, and needs are denied by research, educational materials, curriculum, health care setting infrastructure, policies, etc., the invisibility is

furthered. The neglect of transgender identity from these contexts essentially signifies to health care providers and institutions that this population's needs are unimportant. Thus, significant challenges are in place for individuals and institutions who wish to design accommodating protocols and policies, as they may be unsure where to turn to gain information and would likely feel as though they would not have the necessary societal supports to enable positive change. Bauer and colleagues (2009) summarize the impact of this cycle by stating that:

> *All of these instances of institutional erasure are interwoven, with texts and forms, protocols and policies, and institutional infrastructure set up in ways that assume cissexuality and are thus often inappropriate for trans identities, trans bodies, and trans lives. The erasure of trans people in institutional contexts functions with information erasure to form a mutually reinforcing system…The lack of information, along with the failure to synthesize existing information into curricula and texts, contributes to the impression of research scarcity and, by extension, minimizes the importance of trans-related research. This information gap creates significant challenges for institutions and individuals in designing care protocols or developing policies. Lack of consideration of trans people in protocols and policies provides for continued erasure of trans people's needs and does not signal their importance or even existence to staff and providers* (p. 356).

They contend that this cycle of erasure underestimates the size and strength of the transgender community and distorts the need for research on the topic of trans-health.

Ultimately, this erasure creates a health care system that may be inaccessible to transgender individuals and can affect the quality of care that individuals receive when they do access the health care system (Bauer et al., 2009).

Although institutional-level erasure and discrimination is undoubtedly harmful, it appeared as though participants in this study were more concerned with, and affected by, interpersonal discrimination. In particular, participants seemed to be most negatively impacted by perceived provider discrimination. However, it is important to note that these levels are interconnected and that individuals may feel as though they are most affected by interpersonal discrimination as that is the level most immediate to them.

Other studies have investigated the consequences of perceived provider discrimination in the health care setting. For example, Lee, Ayers, and Kronenfeld (2009) found that racial and ethnic minorities who felt as though they had been discriminated against by their health care provider were more likely to report that they were in poor health than those who were not discriminated against. Furthermore, those who believed that they had been discriminated against were more likely to delay seeking health care, which in turn, may promote their poor health. The authors contend that interpersonal discrimination on the part of the health care provider generates a mechanism that creates and sustains health inequities within marginalized groups (Lee et al., 2009).

Although it is not explicitly stated in their article, this mechanism appears to be cyclical in nature. Individuals who feel as though they have been discriminated against are less likely to pursue health care and have higher rates of poor health. The authors also found that racial and ethnic minority groups perceived more provider discrimination, lower health care utilization, and higher poor health outcomes than white individuals

(Lee et al., 2009). Thus, it can be assumed that Crenshaw's (1989) concept of "intersectionality" is present within these interactions. For example, Lee and colleagues (2009) state that providers may intentionally or unintentionally treat marginalized groups differently than non-marginalized groups due to their various social determinants of health (e.g. income, education, etc.). Thus, individuals who experience intersections of marginalization in the social determinants of health likely perceive more discrimination and utilize health care less for fear of experiencing more discrimination. Their health may suffer from not utilizing care and they may feel as though being ill will further contribute to the discrimination they receive. Lee and colleagues (2009) found that those who perceived discrimination often still did not utilize health care services even when they knew that they needed to. Thus, there is an evident cycle whereas discrimination leads to lower service utilization, which leads to poor health outcomes, resulting in either an avoidance of care or a health care encounter with likely higher rates of perceived discrimination.

Similar results were found in a study of low-income, HIV-positive individuals. Kinsler, Wong, Sayles, Davis, and Cunningham (2007) examined how perceived "stigma" from a health care provider impacted individuals. The authors asked participants for their perceptions regarding their provider's level of comfort treating them, attitude towards them, and incidences of refusal of service, among other measures to quantify "perceived stigma." The findings indicated that those who perceived stigma from a health care provider reported significantly lower access to care (Kinsler et al., 2007). The results highlight the potential detrimental consequences of stigma and discrimination within the health care setting. When an individual perceives their provider to be uncomfortable with

them, or feels as though they are being treated in an inferior manner, they are likely less often to pursue care. The authors suggest that such avoidance could be generalized to all health care providers, not just the individual who was discriminatory (Kinsler et al., 2007).

Research has indicated that stigmatized individuals who experience persistent rejection may enter a state of deprivation which affects their emotions, thoughts, behaviours, health, and adjustment. These individuals' perceptions regarding others may be shaped by, and can lead to, hesitation to encounter any experience in which rejection, devaluation, or discrimination may occur (Baumeister & Leary, 1995; Shelton & Richeson, 2006). Thus, the client may develop trust issues with providers that colour any and all health care experiences. It was clear that some participants in the current study were hesitant or reluctant to pursue health care in new settings and with new providers due to the effects of past negative experiences. Some participants seemed to feel as though future encounters could trigger the negative emotions attached to prior adverse experiences. These individuals may be putting themselves at risk for poor health by underutilizing health care services.

In summary, the participants in the present study discussed feelings of discrimination and erasure from multiple levels within the health care setting. All acts of discrimination appeared to be harmful to varying degrees. However, participants seemed to be able to better navigate the obstacles and barriers within the physical and social environments if they had a non-discriminatory health care provider. Similar to existing research, it appeared that being the recipient of interpersonal discrimination from a health care provider was very detrimental (Kinsler et al., 2007; Lee et al., 2009). When

participants had good relationships with their providers, the negative effects of the social and physical environments appeared to be lessened.

The expectations and responsibilities of family physicians. There is no doubt that some participants had their rights as clients violated by providers. The Legal Information Society of Nova Scotia (2001) states that clients have the right to "receive competent medical treatment," "give informed consent to the treatment," "have your wishes about treatment respected," and "have information about your health and treatment kept confidential." In regards to consent, they state not only must consent be given, but that the consent must be informed. Therefore, proceeding with an exam or procedure without having the informed consent of the patient is against the law. In regards to confidentiality, all information given to physicians and staff must be kept confidential unless the information is shared with another health care professional for the benefit of the patient, regards a communicable disease, or is in relation to a crime or abuse (The Legal Information Society of Nova Scotia, 2001). Therefore, having one's transgender status revealed by a health care provider or staff person to other individuals in the community is a violation of the law. Thus, some individuals who participated in this study may have been subject to illegal acts in addition to the outright discrimination that they experienced.

Acts of covert discrimination, such as physicians being unwilling to increase their knowledge regarding trans-health or exhibiting negative and disrespectful attitudes, are not illegal behaviours. However, listed within the Canadian Medical Association's (2015) Code of Ethics are six "fundamental responsibilities." These responsibilities include prioritizing the well-being of the client, treating clients with dignity and respect,

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providing care for a client even when a cure is not possible, considering how matters of health could influence society, practicing medicine with integrity and without impairment, and engaging in lifelong learning with the intention of consistently improving one's knowledge, skills, and attitudes (Canadian Medical Association, 2015).

When participants discussed their expectations of care providers, they mentioned that providers should have a baseline level of knowledge on trans-health issues or should at least be willing to improve their knowledge. They also felt that providers should know how to respectfully interact with transgender persons in terms of their sensitivity and attitude. None of the participants expected that all providers should be trans-health experts. Based on the duties of family physicians outlined by The College of Family Physicians of Canada (2016), it is clear that these expectations are within the scope of practice for general practitioners. They state that family physicians "specialize in breadth rather than depth of knowledge." They contend that generalists need to feel comfortable managing any health issue that arises and that there is a need to continuously increase and strengthen their knowledge in order to do so. They also stress the importance of establishing deep connections with the clients and communities they care for, which presumably would require one to act in a respectful and courteous manner (The College of Family Physicians of Canada, 2016). The wishes and expectations of this study's participants are clearly reasonable. It was evident that some of the participants felt as though their provider not only disregarded the fundamental tenets of their job, but also acted in ways which breached their ethical code of conduct.

Internalized oppression. Transgender individuals are often interrogated about their identities by providers and blamed for their negative health issues (Collier, 2015;

Poteat et al., 2013). Although previous research has correlated experiences of discrimination with mental health issues, few articles have investigated the concept of internalized oppression within the transgender population. Internalized oppression can affect stigmatized members of marginalized groups. Affected individuals come to internalize the dominant, discriminatory views of their group and may come to accept their subordinate status. Some individuals may start to believe that behaviour that they once perceived as discriminatory is now deserved (Krieger, 1999). Internalized oppression can lead to feelings of self-hatred, inferiority, powerlessness, and fears of violence (Pheterson, 1986). Some of the participants in this study alluded to feelings of hopelessness and resignation in regards to pursuing health care. However, it should be noted that none of the participants were complacent to discriminatory behaviours and all appeared to be strong advocates for their health and for fair and equitable treatment. Even still, a few participants commented on their feelings of gratitude or gratefulness for somewhat positive health care experiences, even if they felt that these experiences were less than stellar. Research with other marginalized populations has determined that "gratefulness for being allowed to survive" is a characteristic of internalized oppression (Pheterson, 1986, p. 35).

In the book "Internalized Oppression: The Psychology of Marginalized Groups," an example is given regarding an individual in a wheelchair (Watermeyer & Gorgens, 2014). The author states that they became habituated to living in an environment that was unaccommodating. They discuss the constant hostility they encountered when trying to cross roads, enter public buildings, and so on. They remarked that living with such inaccessibility became part of their normalized everyday life. They commented on others'

indignant and annoyed attitudes when they requested assistance. They also described how some individuals boasted with pride whenever they were able to assist the disabled person. The author noted that although this response may be instinctual for some, it reinforces the notion that disabled individuals should feel grateful for the access to certain spaces – even though these spaces should be accessible for all. Describing how the feeling of gratefulness is complex, the author remarks (Watermeyer & Gorgens, 2014):

The implication is that under different circumstances you may well not be so lucky, and that you and your needs remain an anomaly that require "extra effort" for the rest of society to satisfy. The possible result is a toxic emotional cocktail, where one is grateful to individuals for making the effort to ensure you are included, but undercut by an awareness of not being welcome in the same way that everyone else is (p. 263).

The author goes on to discuss that they also feel lucky in comparison to other disabled individuals who may not be granted access to a certain space, even though the way in which they were personally granted access still made them feel socially excluded (Watermeyer & Gorgens, 2014).

Thus, in regards to the individuals in this study, it may be that their feelings of gratefulness stem from varying degrees of internalized oppression. This concept could account for why some individuals feel lucky in comparison to transgender friends and peers, even when they know that the care they are receiving is sub-par. Transgender

individuals may subconsciously come to believe that their health care requires superfluous effort on the part of the provider and in turn, feel grateful when they do not experience blatant oppression. Thus, the discrimination that is entrenched within all levels of the health care system may become internalized by transgender individuals, which could cause them to feel grateful for any experience in which they are not overtly discriminated against.

Barriers to Navigating Health Care

In addition to discrimination, participants discussed many obstacles that they endure when trying to pursue primary and emergency care. It appeared as though participants were often responsible for navigating through hostile health care environments. Participants discussed having to educate their providers, having to stay positive, feeling as though they needed to protect one another in the form of social support, etc. Some participants did not seem bothered by some of these obstacles, but rather enjoyed their active client role. Others seemed to feel as though navigating through these environments was an unwanted responsibility. Regardless of one's personal feelings towards these obstacles, it is clear that these obstacles are present within health care settings.

Having to be an active participant in one's care. It was evident from the participants' descriptions of their experiences that they often felt as though they had to be active participants in their care. Whether they were educating providers, staying positive, deciding when and how to disclose their transgender identity, etc. – it was obvious that being a passive client really is not an option. Some individuals seemed to enjoy taking an

active role in their care, whereas others did not. Either way, there are various dimensions in which transgender clients have to be active participants in their care. These responsibilities are not expected of cisgender clients – at least not in regards to their gender.

   Educating providers. Literature on clients educating their providers is very limited. Even more limited is literature examining clients who feel as though they have to offer education to their provider, even though they would rather not take on this responsibility. There appears to be some similarities between the transgender community and early HIV/AIDS patients in regards to having to educate providers. In the 1980's, HIV/AIDS patients were often discriminated against by individuals working in the health care system. Many providers did not have adequate knowledge regarding HIV/AIDS, with some believing that HIV/AIDS could be transferred by shaking hands or by being in the same room as an infected individual (Wertz, Sorenson, Liebling, Kessler, & Heeren, 1987). These stigmatizing beliefs and discriminatory behaviours, coupled with a general lack of acceptance and understanding for individuals with HIV/AIDS, meant that infected individuals often had to educate others (DeMarco, Miller, Patsdaughter, Chisholm, & Grindel, 1998; Reeves, 2001). This comparison is not at all meant to equate transgender identity with a disease state. Rather, it is meant to compare two populations that each experience marginalization and a lack of understanding within the health care system. The perspectives of HIV/AIDS clients who provided education to their providers are neglected in the literature. However, it can be assumed that many of these clients, like the participants in the present study, found the responsibility of educating to be onerous.

Of the studies that do examine the perspectives of individuals who educate their providers, the majority seem to focus around the positive effects that patient advocacy or agency can have for health care users. For example, one study examined the experiences of women living with an autoimmune connective tissue disease (Mendelson & Poole, 2007). These women desired a collaborative relationship with their physicians and felt empowered by "taking control of their illness." The participants felt that advocating for one's health "was a necessary component of maintaining the highest quality of life possible" (Mendelson & Poole, 2007, p. 1495).

A few critical differences exist between Mendelson and Poole's (2007) sample and the present study's sample. Firstly, there seems to be a difference in the responsibilities of the two groups. In the present study, participants often felt that they had to provide education not only on trans-health issues, but also in regards to transgender identity in general, as providers often had very minimal knowledge in both areas. In Mendelson and Poole's (2007) study, the clients were seeking a partnership-type relationship, which implies that the physicians already possessed some knowledge regarding the participants condition. In this case, the clients were able to become self-advocates as opposed to educators. Thus, it appears as though Mendelson and Poole's (2007) sample was advocating for better health care, whereas the present study's participants were often educating so that they could receive health care at all. This study's participants often felt like they did not have a choice over whether or not they would educate their providers. Although some of the participants felt empowered by providing education, many felt as though being an educator was an unwanted burden. Thus, the present study highlights how clients providing education can be a double-edged

sword. Some individuals bask in the responsibility, whereas others would prefer to not be used as a teaching tool.

Another article discussed the "goldfish bowl model," in which clients are used as educational tools (Foster, 2015). The author, who is a nurse, states that a client came to her to discuss some of the negative behaviours and attitudes he had encountered during a brief stay in the hospital. The client did not have any complaints about his health care and for the most part, felt as though his stay had been a positive experience. The author asked the client to participate in a "goldfish bowl" meeting in which he discussed his experiences with a trained staff person. The health care team who cared for the patient observed the interaction from a seated circle around the patient. The author states that "the key aim of the goldfish bowl is to be an interactive session with a trained facilitator designed to encourage staff to learn from patient stories and convert that learning into attitudes and behaviours that serve to improve the quality of the care provided" (Foster, 2015, p. 903).

This method of using clients as educators was recommended as a means of learning patients' perspectives and thoughts (Foster, 2015). Although implementing a model such as this could help to improve health care providers' knowledge regarding trans-health, there may be some issues with its execution. Firstly, someone within the health care environment would have to take the initiative of getting this type of meeting established. Secondly, transgender individuals may feel as though taking part in this type of meeting is burdensome. Some individuals may even be fearful of such an interaction as the power differential between the client and the physician can be overwhelming (Goodyear-Smith & Buetow, 2001).

Even though some individuals may enjoy taking the opportunity to educate providers, it should not be assumed that transgender individuals will want to be scrutinized in the "goldfish bowl." Due to the small size of the transgender population in Nova Scotia, it may be difficult to find individuals who would want to participate in this kind of education. Furthermore, these meetings would have a relatively small range of impact as only a few health care providers would be present. Finally, unlike the client in Foster's (2015) article who had a few small complaints, the participants in this study often had multiple negative experiences to discuss. Reliving these types of experiences for the purposes of educating a few providers could become exhausting and distressing.

These articles, as well as the findings of the present study, underscore the importance of following the client's lead. Those who enjoy educating, collaborating, and advocating should have room within the relationship to do so. Those who do not enjoy these responsibilities, should not feel pressured to have to assume these roles. There is a clear need for providers to receive education regarding transgender identity and health issues. As many clients find the educational responsibility to be a navigational barrier, this education should be supplied by the governing body of the health care setting. This way, individuals can choose whether or not they would like to supplement their provider's learning, but would not feel as though they were responsible for it entirely.

Keeping a positive attitude. Some participants seemed to pride themselves on their ability to keep a positive attitude. Others found it challenging to keep high spirits when navigating the sometimes hostile health care environment. It seemed important to all of the participants to try to stay as positive as possible, and to not let experiences of discrimination stop them from accessing health services when they really needed them.

Participants often faced negative encounters, yet most appeared to be able to move on and not dwell on these negative experiences. This is not at all to say that these experiences did not impact the individuals. Rather, it highlights the resiliency of the participants.

Resiliency "refers to positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversity" (Herrman et al., 2011, p. 259). Resilience should not only be thought of as an absence of adverse outcomes in the face of adversity, but also as the presence of protective factors that help to lessen the effects of adverse experiences (Dyer, Patsdaughter, McGuinness, O'Connor, & DeSantis, 2004). The factors that contribute to one's resilience have been studied in numerous populations to understand why some individuals are able to be more resilient than others. Research has shown that there are numerous domains contributing to resiliency. For example, certain personality traits (e.g. openness and agreeableness), biological factors (e.g. sensitivity of receptors, neural networks, etc.), environmental factors (e.g. supportive relationships with family and friends), and systemic factors (e.g. community connectedness, a desire to be free from discrimination, etc.) have been identified as key components of resiliency (Dyer et al., 2004; Herrman et al., 2011).

Research regarding transgender individuals' ability to be resilient in the face of negative health care encounters does not seem to exist. However, the resiliency of other marginalized populations, such as individuals living with HIV/AIDS, have been studied. These studies have found that there are multiple factors that contribute to one's resiliency. Individuals who have strong relationships with their health care providers and who possess the other domains, such as social supports and community empowerment,

appear to be the most resilient (Dyer et al., 2004; Earnshaw, Bogart, Dovidio, & Williams, 2013). For some individuals, actively being resilient may be an exhaustive and burdensome task. Especially for those populations, like the transgender community, who often experience disparities in many of the social determinants of health (Bauer et al., 2009; Bauer et al., 2010; Travers et al., 2013). These individuals may have to work extra hard at keeping a positive attitude if they do not possess the factors that contribute to resiliency in the face of adversity.

One study describes a "model of patient complexity," in which they discuss a balance between a client's "workload" and "capacity" (Shippee, Shah, May, Mair, & Montori, 2012). The authors state that the "workload" includes "the demands on the patient's time and energy, including demands of treatment, self-care, and life in general" (Shippee et al., 2012, p. 1041). "Capacity" refers to one's ability to handle the workload. The authors contend that a workload-capacity imbalance can compromise the patient leading to illness burdens and further imbalances, which can increase the complexity of the patient over time (Shippee et al., 2012). When using this model with the transgender community, it is easy to see how resiliency is important. Transgender individuals often bear a heavy "workload" with experiences of discrimination, accessibility and utilization barriers, negative health outcomes, etc. Transgender individuals may have trouble developing their "capacity" through external means, as there are limited resources relating to transgender health. Thus, one's internal capacity, including one's ability to be resilient, are necessary in order to create a workload-capacity balance.

The participants in the present study seemed to strive to keep positive attitudes. For some participants, resiliency seemed to come naturally, while others had to take a

more active role in order to achieve it. Resiliency and the ability to keep a positive attitude seem to be important personal characteristics when navigating the health care system, as without these factors, individuals could easily become defeated by their negative experiences.

Paving the way and safety in numbers. In regards to overcoming navigational barriers, two interesting concepts emerged from the data regarding social supports. Firstly, some participants discussed how they endured inappropriate questioning or took the time to educate physicians because they felt as though they were paving the way for other transgender clients who would encounter that provider in the future. Secondly, many participants spoke about accompanying transgender friends to their doctor's appointments, or having friends accompany them. Both of these concepts appeared to help mitigate the negative impacts of the hostile health care environment.

Some individuals seemed to enjoy "paving the way" for others, whereas others felt it was an added responsibility. Research regarding these specific types of social supports in relation to the transgender community seems to be nonexistent. However, "peer navigators" or "patient navigators," are discussed in relation to other populations, such as individuals in need of cancer screenings or individuals living with severe mental illness (Corrigan, Pickett, Batia, & Michaels, 2014; Freeman, 2006). Harold Freeman established the first patient navigator program in 1990, with the goal of increasing cancer screening and timely treatment in racially diverse groups (Freeman, 2006). Patient navigators are usually members of the community who have lived experience with the condition or who have overcome similar navigational barriers in their pursuit of care. These navigators usually share common characteristics with the community members and

can therefore help the community to mitigate barriers to care. Freeman (2006) states that the role of the patient navigator is to "assure that any barrier a patient encounters in seeking screening, diagnosis and treatment is eliminated. Patients most frequently encounter financial, communication, medical system, and emotional/fear barriers. The patient navigator identifies, anticipates, and helps to alleviate barriers that patients encounter" (p. 140). This program has been effective in improving early screening, diagnosis, and treatment of cancer, as well as helping clients make sense of the complicated health care environment. The reduction of these prominent barriers has resulted in improved health outcomes for many groups (Corrigan et al., 2014; Freeman, 2006).

Research has suggested that there are two fundamental components of patient navigation: navigator interactions and navigator tasks (Parker et al., 2010). Successful navigators serve as a liaison in the interpersonal interactions between clients and physicians, nurses, other health care workers, and staff persons. The tasks of a patient navigator are to assist with coordinating health services, facilitating the involvement of community resources that could assist with the client's care, anticipating and assisting the client in overcoming barriers, and continuously engaging with the community in order to assist as many individuals as possible (Corrigan et al., 2014).

It appears as though many of the participants in this study have taken on the role of an informal patient navigator at some point throughout their lives. However, it is important to note that in official patient navigator programs, navigators receive specialized training. Research has shown that patient navigator training is an important factor in the success of the program as it allows for patient navigators to be sure that they

are passing on accurate information. In addition, many articles state that patient navigators are trained in effective coping strategies for dealing with stress and anxiety that they can teach their clients to implement (Fillion et al., 2009; Jandorf et al., 2013). However, it is likely that such training programs also equip the navigator with personal coping strategies that they can use to ensure that they do not carry the weight of all of their clients' experiences. It was evident that some of the informal navigators in this study held on to the negative experiences that they had witnessed and heard about, likely because they are not trained in how to work through the negative emotional impacts of such encounters. Furthermore, standardized training allows for senior health care workers with extensive knowledge on the health care system to assist with the navigator's instruction (Corrigan et al., 2014), and may help to establish a collaborative relationship between navigators, community members, and health care providers.

It is important to consider that many individuals in the present study felt as though they were obligated to take on a navigator role. Sometimes it was assumed by others in the community that the participant knew all of the strategies for navigating the health care system, even though the participant felt uncomfortable being viewed as an expert. One participant even expressed concern that individuals taking on this informal peer navigator role may accidentally be spreading inaccurate information. Some participants felt that the responsibility associated with this role was burdensome. Yet, many individuals took on this active role and acquired the necessary information to assist their peers. There does not seem to be any formal patient navigator programs geared toward this population in Nova Scotia.

In addition to navigating with peers, the participants often spoke about attending medical appointments with friends. It appeared as though participants felt that there was "safety in numbers." Participants discussed the benefits of having a friend with them who could help to defend them if need be. Accompanying friends to doctor's appointments, or vice versa, helps to manage the uncertainty in the encounter and is thought to be an effective health promotion strategy as peer support often leads to improved experiences, treatment compliance, and positive outcomes (Brashers, Neidig, & Goldsmith, 2004; Dennis, 2003; DiMatteo, 2004).

Depending on the source, the categories of social support may differ. However, they are often organized similarly. The description below provides a brief overview of four commonly referred to types of social support, all of which would likely be demonstrated when being accompanied by, or accompanying a friend, to a medical appointment. Emotional support includes expressions of encouragement, trust, acceptance, and empathy. Informational support involves the receiving of information, advice, and suggestions (Dennis, 2003). Appraisal support includes information that is intended for self-evaluation (Dennis, 2003; Malecki & Demaray, 2003). For instance, when individuals have a friend with them at their appointment, they can receive informational support regarding the treatment of their illness. In addition, they may also receive appraisal support from their peer regarding the peer's perception of how the client was spoken to and cared for by the health care professional. Appraisal support may be used to assist with problem solving and encouraging of optimism. Finally, instrumental support refers to tangible gestures of aid and service, such as the act of spending time with someone (Malecki & Demaray, 2003). It is clear why individuals may choose to

take friends with them to their appointments. These types of interactions provide varying types of social support and likely help individuals to better cope with navigational barriers. Giving and receiving interpersonal social support in order to improve health care encounters underscores the apparent need for transgender individuals to be active participants in their care and in the care of their transgender peers.

Burdens of disclosure and "passing." Participants briefly touched on two more interconnected barriers that hinder their navigation throughout the health care system: disclosing their gender identity and "passing" or being read as their preferred gender. "Passing" is a sociological term used to describe one's ability to be regarded as a member of a certain group (Berger, 1990; Renfrow, 2004). Much of the literature around passing describes "racial passing," which is the idea that individuals are able to pass as white and consequently enjoy the privileges attributed to white people (Futty, 2010). In the context of gender identity, literature often refers to the ability of transgender men to pass as cisgender men or transgender women to pass as cisgender women. For a transgender person, passing is the experience of being read as the gender that they understand themselves to be (Futty, 2010). "Passing" is a term used in the literature and was used by some of the participants in the present study. However, "being read" is a more accurate and appropriate term. For example, transmen should not have to "pass" as men, because they are men regardless of whether or not they are "read" as men by others.

The concept of "passing" is connected with the concept of "Othering." Othering refers to the socially constructed framework which holds the dominant group (e.g. white, cisgender, heterosexual, etc.) as superior, and labels all "others" as inferior and deviant (Ahmed, 1999; Futty, 2010). Othering supports unjust hierarchies and power relations as

some groups are viewed as better than others. The concept also supports the notion of dichotomous identities, such as white or non-white, cisgender or non-cisgender, etc. (Futty, 2010). Ahmed (1999) discusses a paradoxical facet of passing in relation to Othering. The author states that the concept of passing threatens the notion of Othering by indicating that it is not always possible to tell the difference between the superior and inferior groups. However, the concept of passing also reinforces the power relations between the superior and inferior groups, as the whole idea is that a member from the "Other" group is able to assume a position in the "superior" group (Ahmed, 1999).

Individuals who are read in the way they wish to be read likely experience the privilege that comes with fitting into the so-called superior group (Berger, 1990; Renfrow, 2004), whereas individuals who do not "pass" are seen as "Others." However, being read in the way that one wishes to be, can pose problems for disclosure of gender identity because doing so would cause one to have to "out" themselves. Even for individuals who do not "pass," disclosure can be difficult. In order to receive informed health care, individuals must be open and honest with their health care providers (Eliason & Schope, 2001). However, some individuals are hesitant to disclose their transgender identity for fear of a negative reaction (Roberts & Fantz, 2014). One research study found that lesbian, gay, and bisexual individuals felt more comfortable disclosing their homosexual identity to their parents, which is often regarded as the most stressful event in the disclosure process, than to their health care provider. The same study found that, during health care encounters, individuals tried to avoid questions regarding their sexuality. Furthermore, the majority of individuals never explicitly disclosed their sexual orientation to their provider (Eliason & Schope, 2001). Transgender individuals

experience reluctance to disclose their identity, as well as the stress of how they are being read. Furthermore, the ability to be read as one's preferred gender and the challenge of whether or not to disclose are dynamic processes, as one's outward gender expression may change over time. Individuals may experience times when they do not "pass" well, meaning that their transgender status is relatively obvious. The same individual may proceed through their transition and find themselves in encounters in which they "pass," but are then left with the decision of whether or not they disclose. One's gender identity and expression is not static and neither are their experiences of passing and disclosing. Thus, passing and disclosing are interrelated navigational barriers to care, as the burden often falls on the client to worry about how others are perceiving them and to decide how, when, and if they will disclose their transgender status.

   Maintaining a balance between active participant and too active. To summarize, transgender individuals seem to face many barriers to navigating through the health care system. In order to overcome these barriers, transgender persons are forced to take an active role in their care. Some individuals enjoy this responsibility, whereas others do not. Some participants spoke about the consequences of being a relatively passive client. In these cases, acts of discrimination went unopposed and the client often seemed to feel defeated. However, there were also consequences for seemingly being on the other end of the extreme and being too active. When participants appeared to overstep the doctor's comfort zone by educating too much or challenging them on sensitivity issues, the provider sometimes got defensive and became intolerant of the client's active role. Thus, it seems as though clients must maintain a careful balance between being active in their care and resilient to adversity, but not being too active or resilient that they threaten their

provider's sense of authority. The power dynamic between physician and client is inescapable and necessary in order for each to serve their role in the relationship. Yet, when one individual in the dyad feels as though their power and agency is endangered, challenges may ensue (Goodyear-Smith & Buetow, 2001).

      In the context of Nova Scotia. It is necessary to briefly situate these navigational barriers in the context in which they take place: Nova Scotia. Many of the barriers and accessibility issues discussed within this study can be linked to some current challenges within Nova Scotia's health care system. In 2013, Doctors Nova Scotia stated that there is a "shortage of general practitioners in the province, recruitment and retention challenges in rural areas, and increased demands on the health care system due to chronic disease and an aging population" (p. 1). These general health care issues mean that many Nova Scotians are waiting too long for necessary health care services (Doctors Nova Scotia, 2013). Even though there seems to be some useful resources for transgender adults, these places also seem to experience health care issues, such as staffing shortages and long wait times, and are therefore not able to be as effective as they would likely want to be. These general health care issues, coupled with an apparent lack of trans-health knowledgeable providers, can cause a delay in transgender individuals' access to a medical transition. The time between an individual deciding that they want to pursue a medical transition and the commencement of such procedures is known to be a particularly challenging time in regards to some transgender persons' mental health. Bauer, Scheim, Pyne, Travers, and Hammond (2015b) found that suicidal ideation was much higher for individuals who wanted to transition but had not yet begun, than it was in individuals who were in the process of transitioning or who had fully transitioned. The authors expressed concern

over the amount of time that individuals sometimes must wait in order to begin their

transition (Bauer et al., 2015b). The startling statistics regarding the high prevalence of

mental health issues during the time that transgender adults are in limbo, waiting for their

transition to begin, highlights the need for gender transition to be treated as urgent and

important.

It appears that navigational barriers are quite common within the health care

system in Nova Scotia. Transgender individuals face additional barriers, acts of

discrimination, and adversity that compound these obstacles. For some individuals, the

impacts of these navigational barriers are devastating.

Lessons Learned for Health Care Providers and Policy Makers

Through the participants' accounts of their experiences, some thoughtful

suggestions for health care providers and policy makers were unveiled. Some participants

were explicit with their recommendations, whereas other suggestions could be inferred

from the positive, as well as the negative experiences, that individuals commented on.

This section will describe the modification to service delivery that providers and policy

makers could undertake to ensure best practice and social inclusion for transgender

clients.

In relation to knowledge. Participants appreciated when their provider had a

basic level of knowledge regarding transgender health. They also appreciated when a

provider was upfront about their lack of knowledge and was willing to take responsibility

to increase their knowledge base. This study, as well as others, have found that

transgender persons often feel as though they need to educate their provider on trans-

health issues (Williams & Freeman, 2008; Xavier et al., 2007). Although some individuals took pride in educating providers, others did not. Therefore, the provider should follow the lead of the client and should not expect that an individual will want to provide education, as it is not the responsibility of the client to have the knowledge base of a health care provider.

Furthermore, participants appreciated when providers knew about reputable sources that they could turn to in order to improve their knowledge. Numerous participants were irritated by providers turning to Google to look up, what they perceived to be, basic trans-health concepts. Lifelong learning and adequately serving the population are characteristics required of health care providers (The College of Family Physicians of Canada, 2016). The suggestions that participants provided in regards to providers' knowledge base are reasonable. Previous research has shown that transgender individuals are less likely to pursue health care when they perceive their provider's knowledge base to be inadequate (Bauer et al., 2009; Bauer et al., 2015a; Poteat et al., 2013). Thus, is likely that transgender individuals' access to, and utilization of, health services would improve if more providers took the time and responsibility to learn briefly about the topic at hand.

From the participants' accounts, there seemed to be three key components for the physician to establish an acceptable knowledge level and therefore, an improved physician-client relationship: acknowledging that they need to increase their knowledge of trans-health issues, taking the responsibility to improve their knowledge, and having a continuous and lasting relationship with their client in order to show improvement over time. These components highlight how continuous care is an important concept. When

individuals are able to utilize continuous places of care with continuous care providers, their relationships are able to develop and progress over time. When individuals' encounters are more static and exist in isolation (e.g. they use a different place of care or different provider for each health care encounter), they do not have the opportunity to positively grow their relationship. Continuous relationships can be difficult to establish in locations like Nova Scotia, where many family physicians are not accepting new patients (Province of Nova Scotia, 2012).

Although participants' wanted individual health care providers to take responsibility to further their knowledge on trans-health issues; many participants also discussed the need for higher-level institutions to educate providers. Thus, there is a need for policy makers involved in organizations such as Doctors Nova Scotia, The College of Physicians and Surgeons of Nova Scotia, The College of Registered Nurses of Nova Scotia, and health care provider education programs to incorporate such education and opportunities into their programming.

In relation to cultural competency. Many of the suggestions relating to providers' sensitivity towards transgender clients falls within the category of "cultural competency." Cultural competency has been defined as "the ability to understand, communicate with, and effectively interact with diverse populations, and it can be measured by awareness, attitude, knowledge, skills, behaviors, policies, procedures, and organizational systems" (Wilkinson, 2014, p. 68). Cultural competency acknowledges that the "one-size-fits-all" method, that is prevalent within many health care systems, is not sufficient in meeting the needs of all persons who each have diverse racial backgrounds, sexual orientations, genders, etc. (Baker & Beagan, 2014; Carpenter-Song,

Nordquest Schwallie, & Longhofer, 2007). Based on the participants' remarks, it appears as though some providers lack the cultural competency necessary to appropriately care for transgender clients.

The participants provided many recommendations for providers that are related to improving their cultural competency. For example, participants suggested that providers respect one's chosen name and preferred pronouns regardless of whether these characteristics have been legally changed. They recommended that providers politely ask clients what their preferred pronouns are, rather than assuming. Even those with the best intentions may make a mistake in which they call the transgender client by the wrong name or pronoun. In such a situation, an apology and a correction of the mistake are helpful for overcoming the error. Making excuses for one's mistake can be frustrating or triggering for the transgender client (Bryn Mawr College, 2016).

Participants also expressed disdain for the use of gendered terms within health care. For example, when a health care professional is providing gynecological care to a transman, there is no reason for the provider to refer to such care as "women's care." Participants appreciated when providers asked the client how they would like certain parts of their bodies to be referred to. When discussing sexual anatomy, many transgender persons may prefer for providers to use phrases such as "persons with penises" or "bodies with vaginas," rather than "males" and "females" (Aramburu Alegria, 2011; Bockting, Knudson, & Goldberg, 2008b).

Some of the participants encountered providers who asked inappropriate questions regarding their transgender identity or bodies and participants felt as though providers should know not to ask questions that are irrelevant to why they were pursuing

care. A participant in Hussey's (2006) study suggested that providers should think about how they would feel if they were asked that question by a health care professional. Providers must remember that a client's purpose is not to satisfy one's curiosity and even if a question is relevant to one's care, it must be asked with dignity and appropriateness.

A few participants spoke about undergoing, or having the fear that they would undergo, an inappropriate or unnecessary physical examination. In these cases, the privacy and dignity of the clients is violated. The participants' suggestions regarding how to improve transgender clients' comfort with physical examinations are supported by current literature (Booth, Whicker, Wyman, & Moaney-Wright, 2010). They suggested that providers explain to the client what is going to happen during their examination and why it is necessary. They suggested that the provider ensure that the client is comfortable and understands the procedure before it begins. Once the examination has begun, it is necessary for the client to be adequately draped, so as to protect their privacy and modesty. Only the area of their body that is currently being examined should be uncovered. The participants recommended that the provider inform the client before touching them in a new location. They suggested that clients are made to feel comfortable to ask questions throughout the procedure (Booth et al., 2010). As with most issues of cultural competency, participants suggested that providers should "follow the lead" of the client. If the client appears uncomfortable with an examination, then perhaps a more thorough explanation of the importance of the procedure and insurance that the procedure will be conducted respectfully, is required. In addition, providing accommodations when appropriate can also comfort transgender clients. For example, one participant was made to feel much more comfortable when they were allowed to insert the external ultrasound

wand themselves. Utilizing these strategies during physical examinations will likely make transgender clients more comfortable, but may also improve the experience for all clients in general, as most individuals appreciate feeling respected and in control of their bodies (Bickley, 2013).

Many participants commented on their provider's attitude. Participants were pleased when providers were supportive, compassionate, and understanding. Sobralske (2005) states that providers must demonstrate non-judgmental attitudes and show a genuine concern for their clients regardless of their gender identity. Providers who exhibited negative or uncomfortable attitudes appeared to contribute to the participant's perception of a negative experience. Studies have found that as one's knowledge of, and experience with, transgender health improves, their attitudes usually follow suit (Kelley, Chou, Dibble, & Robertson, 2008; Shaffer, 2005). Thus, if providers take the time to learn about trans-health and cultural competency, they may develop more positive attitudes towards transgender clients.

In relation to the physical environment. The participants made suggestions regarding the physical environment that could be employed by providers in private practice, as well as by policy makers who oversee the physical organization or infrastructure of health care environments. The implementation of these suggestions would assist the participants in feeling more comfortable during their health care encounters. The first suggestion was that individuals should have access to a unisex or single-stall washroom. Many articles have recommended that health care settings have at least one unisex washroom so as to accommodate the needs of transgender clients (Beagan et al., 2013; Cobos & Jones, 2009).

Participants also suggested that health care settings display information, such as posters and brochures, targeted towards transgender persons. Some participants discussed how they did not expect to see a lot of information geared specifically towards the transgender community as they represent a small percentage of the general population. However, these participants said that it would be nice to see an indication that they were welcomed. This sentiment ties into the third recommendation for the physical environment – a tangible indication of a "safe space." Participants said that if they saw a transgender flag or pride flag displayed, they would feel more comfortable to pursue care. Beagan and colleagues (2013) suggest that health care environments display a declaration of nondiscrimination, in which they commit to providing equal care to all clients. Bockting and colleagues (2008b) suggest that visible signs of inclusion such as indications of a safe space, or transgender posters and books, indicate to clients that the clinic/hospital is aware of transgender identities and supportive of transgender clients. However, this study's participants stressed that in order for a symbol of a safe space to truly be effective, it has to be backed up by the actions of everyone who works in the environment. Health care policy makers should provide training initiatives for all health care professionals and staff persons to educate them on the basic knowledge and cultural competency issues affecting the transgender population. Providing this kind of training is critical in ensuring that environments are actually safe spaces and would allow for individuals to feel more comfortable pursuing care as there would be a sense of consistency across health care settings (MacDonnell & Daley, 2015).

Individuals discussed how intake forms are often very binary and can cause them to feel excluded. Participants praised health care environments with medical forms that

have a blank line for them to write their gender in. Beagan and colleagues (2013) contend that a blank line allows transgender clients to self-identify their gender and communicates the environment's inclusiveness of transgender persons. The authors state that intake forms that list potential gender identities such as, "male," "female," "transgender," "MTF," "FTM," etc., while still possessing a blank line for individuals to self-identify, expresses an even more inclusive environment as trans-identities are explicitly acknowledged.

Participants also discussed the issue of privacy and how they often felt as though their privacy was violated due to the physical layout of the health care setting. For example, participants remarked that they often felt that they were declaring their transgender status to the entire waiting room due to the positioning of the receptionist's desk. Similarly, some participants thought that discussing their transgender identity or having to change in a shared emergency department room could potentially put them at risk for harassment from other clients. Although it cannot be expected that health care environments will restructure their physical organization, there are accommodations that can be undertaken to lessen these anxieties. Providers and policy makers should establish protocols for dealing with such situations. For example, receptionists who have desks within the waiting room could invite the individual to come into the actual clinic to discuss their identity. In the emergency room, transgender clients should be roomed with others according to their identified gender. If possible, the client should be given a private room (Polly & Nicole, 2011). If a private room is unavailable, the provider should make every effort to protect the client's privacy and confidentiality by talking in a low voice or by having the client step into another room to discuss trans-specific matters. Some

participants mentioned the distress that stemmed from having to sit in a waiting room wearing a revealing hospital gown. In situations like these, providers could make accommodations for these clients, such as allowing them to sit in a different room or allowing them to wait to change into the required ensemble until they were called in for their appointment. It is likely that these accommodations to increase clients' privacy would also be appreciated by cisgender clients who do not feel comfortable discussing their medical issues in front of others or who would prefer to not wear revealing hospital gowns in public settings.

The implementation of these suggestions by policy makers would likely assist many transgender individuals in their utilization of primary and emergency care. Some of these suggestions, such as having a unisex washroom or inclusive intake forms, would likely not cause harm to any clients and therefore, should be employed. Some of these suggestions though, could be equally as discriminating if employed fully as they are when not employed at all. For example, some transgender persons may be extremely relieved that they are allowed to wait until they are called in for their appointment before changing into a hospital gown. However, if this suggestion was taken as all or none, it could be seen as very discriminatory if all trans-persons were told to wait in their clothes in the waiting room. Such an act could send the message that staff and other clients do not want trans-bodies visible in the health care setting. Thus, the critical point is that providers and staff should always follow the lead of each specific patient to ensure that their actions are appropriate for that individual. It is important that there is flexibility within the health care system to offer the option of accommodations and inclusivity protocols for those who wish to take advantage of them.

In relation to the social environment. The participants also made recommendations for bettering the social environments of health care settings for transgender clients. Firstly, they suggested that providers and policy makers make an effort to understand transgender identity. A few participants felt as though their providers believed some untrue social discourses including that transgender individuals are threats to others, that they chose to be transgender, and that transgender health is so niche that they did not need to learn about it. Participants felt that the social environment of the health care setting would be improved by providers and policy makers being more informed about, and more compassionate towards, transgender identity. Furthermore, participants implied that providers and policy makers should realize that although some specialization is needed in order to holistically care for trans-clients, the majority of the primary and emergency care needs of this population are similar to those of the general population (JSI Research and Training Institute, 2000; Snelgrove et al., 2012). Beagan and colleagues (2015) note that acknowledgement and recognition of one's transgender identity is necessary in order to mitigate dominant and normative assumptions. However, they contend that "when someone sees a physician, their LGBTQ identity should both always matter, and not ever really matter. After all, a sore throat is a sore throat is a sore throat" (p. 19).

Participants also remarked that there seems to be a limited understanding of the complexity of gender identity within the health care setting. Individuals stressed the importance of comprehending gender as a fluid continuum. Kuper, Nussbaum, and Muustanski (2012) state that the term transgender has "expanded to become an umbrella term applied to a diverse group of individuals whose gender identity or expression

diverges from culturally defined categories of sex and gender" (p. 244). They state that even individuals who identify with the term "transgender" may experience and express their identity in a great number of ways. For providers and policy makers to truly be able to care for transgender clients, they must come to understand the complexity and multiplicity of gender identities, embodiments, and expressions. The concept of gender is diverse and fluid, differing between and even within individuals (Kuper et al., 2012). Health care providers and policy makers should help in validating the legitimacy of these various gender identities by treating these individuals as they would any other client and not making one's gender expression grounds for delivering insufficient health care. Validation of one's gender identity may help to reduce one's anxiety and increase their health seeking behaviours (Kreiss & Patterson, 1997). The traditional binary structure of health care must be rejected in order to include the many individuals who do not feel as though this organization adequately includes them.

In addition to an understanding of transgender identities, providers and policy makers must have an awareness that transgender clients exist within health care. The assumption that all health care users are cisgender, socially excludes those whose gender identity does not match their sex assigned at birth. One participant discussed his experience trying to locate the gynecological unit of the hospital so that he could undergo a hysterectomy. He was questioned by numerous health care professionals and staff members who were in disbelief that this individual, who appears very masculine, would be in need of gynecological services. Policy makers should instill an awareness of transgender identity in health care professionals and staff persons so as to prevent frustrating and humiliating experiences such as this.

As previously stated, research shows that the more experience a health care provider has with transgender persons, the more comfortable they are providing care for them (Kelley et al., 2008; Shaffer, 2005). Thus, it can be assumed that when medical and nursing students receive education on the topic, their attitudes towards serving this population may improve. It would appear that many of the barriers that transgender persons currently face when trying to pursue care could be mitigated by having trans-health included in curriculum and educational materials. For example, participants discussed the long wait times that they encounter when trying to book appointments to see one of the few trans-friendly or trans-knowledgeable physicians in the province. If more providers become trans-friendly and trans-knowledgeable, these wait times may decrease. Having more providers who are able to treat transgender clients will help to eliminate the wait time barriers, may assist in reducing anxiety for clients who need to pursue health care, and may allow for resources to be able to adequately help trans-clients and not just connect them to other settings that are also riddled with barriers.

A final recommendation for providers and policy members is the importance of continuous care. Continuity of care is important in interpersonal relationships, as well as at the higher policy level. Haggerty and colleagues (2013) describe the three types of continuity that are important in the health care system – relational, informational, and management continuity. In the primary care literature, continuity in personal relationships is defined as "relational continuity" and refers to the sense of loyalty, familiarity, and trust shared between a client and their provider (Gulliford, Naithani, & Morgan, 2006). It was clear from the participants' accounts that they valued having a consistent provider,

often in the form of a family physician, when that provider was trans-friendly and trans-knowledgeable.

Informational continuity refers to the "common thread linking care from one provider to another and from one healthcare event to another" (Haggerty et al., 2013, p. 1220). A few participants in this study commented on the positive effect of having their gender identity and preferred names and pronouns passed on from person to person within the health care setting so that they did not have to "out" themselves each time they pursued care. Management continuity can be employed by health policy makers, as the goal of this type of continuity is to provide a consistent approach to the managing of care (Haggerty et al., 2013). Thus, policy makers should instill a consistent and continuous set of protocols for the treatment of transgender clients, so that this care is constant across health care locations and environments.

Continuity of care, in general, contributes to positive physician-client interactions, improved communication, and better overall care (Haggerty et al., 2013; van Servellen, Fongwa, & D'Errico, 2006). Thus, it is important for providers and staff to demonstrate continuity in their relationships with transgender clients, and for policy makers to create continuous care protocols at the managerial and informational levels.

Recommendations for Future Studies

Throughout this study's exploratory examination of transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia, a number of possible avenues for future research endeavors were revealed. Based on the

terrific response from members of the Nova Scotia transgender community, it is clear that individuals are willing and ready to share their experiences with researchers.

Although one of the strengths of this study was its novel approach to holistically viewing the health care encounter, this approach limited the depth at which each topic could be investigated. Numerous concepts arose in this study that could be pursued as a more singular focus in future research. For example, exploring individuals' experiences in rural versus urban places of care, or delving deeper into the current state of transgender inclusivity in medical school curricula, could be fruitful topics for future projects.

Future studies could also investigate the differences between those who report positive health care experiences and those who do not. Although this study's participants did provide a range of experiences, it is difficult to understand why these experiences differ due to the small sample size. Investigating other within-group differences could help to pinpoint more specific health care barriers. For example, how do health care experiences differ by gender identity? Do transmen have experiences that are unique to their sub-group? What about transwomen and gender non-binary individuals? Other characteristics could further be explored to see if there are any discernable patterns linking socio-demographic information to individuals' perceptions and experiences. Characteristics such as the effects of age, education level, social supports, etc. could be interesting topics of study. For instance, the participant in this study who reported the most positive experiences happened to be the oldest participant. Does life experience and maturity help individuals in overcoming health care barriers? Due to the small sample size and the vast array of topics covered in this study, it would be unreasonable to assume that one's experience was because of certain socio-demographic characteristics.

Furthermore, by investigating specific socio-demographic characteristics in relation to health care experiences, research could help to highlight the intersections of marginalization that individuals face when they are disadvantaged in one or more of the social determinants of health.

Finally, it would be of value to explore this topic of study from the perspective of the health care providers, staff persons, and policy makers. Understanding the views of these key persons could help to identify specific deficiencies in the relationships between providers/staff/policy makers and transgender clients. Having an understanding of both "sides" of the relationship would likely lead to the identification of modifiable factors within these interactions.

Conclusion

The transgender community is growing and general acceptance towards this population is improving. Yet, there still seems to be a lack of understanding and acknowledgement of this group within health care settings. The findings of this exploratory study have unveiled many questions and suggestions for future research on the topic of transgender health. The findings of this study underscore the need for more research with this population so as to delve deeper into the many important concepts discussed within this project. It is important to recognize that although individuals' negative encounters may stand out the most, there were descriptions of health care providers and staff who were inclusive, caring, and effective. These individuals should be as positive examples.

Through a discussion of this study's results, numerous suggestions were made for health care providers and policy makers. This study strengthens the notion that there is a need for more trans-knowledgeable, sensitive, and compassionate health care workers. The rich and nuanced data that this study produced is due to the strength and eloquence of the participants' stories. These individuals are experts of their experiences and their suggestions for health care providers and policy makers are very valuable.

The overarching themes of this study indicate that although there are positive aspects of health care, there are many instances of stigmatization and discrimination, both subtle and overt. Furthermore, there are many navigational barriers that individuals must face in order to utilize health care services. The findings highlight the importance of educating health care providers and policy makers about transgender identity, so that transgender individuals can feel included in the interpersonal, physical, and social health care environments. It is hoped that the findings from this study will provide understanding of the experiences of some transgender adults in Nova Scotia, which may raise awareness of their health care needs. Furthermore, it is hoped that acceptance and integration of the transgender community into health care settings will improve with findings such as those presented in this study.

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Interview Guide

<u>Introduction</u>

Thank you for agreeing to participate in this interview. During the interview today, I will be asking you questions about your perceptions of, and experiences with, primary and emergency care in Nova Scotia. For the purposes of this project, primary care is defined as a setting with a family practitioner or nurse practitioner. This can be your family doctor's office, a walk-in clinic, a University health clinic, etc. Emergency care is care you would receive in an emergency department or from a paramedic or emergency medical technician (EMT). I am interested in hearing about your entire experience, not just your experience with the doctor. If you have not experienced these types of health care, I am interested in learning about how you perceive primary and emergency care. So please feel free to share whatever you are comfortable disclosing.

That being said, if you are uncomfortable with any of the questions that I ask, please feel free to say "pass" and we can move on. Also, if you have any questions for me during the interview, feel free to ask. Your contribution today will help me learn more about transgender adults' perceptions of, and experiences with, primary and emergency care in Halifax. These experiences do not have to be experiences related to your transition. This information will be useful for informing programs and policies. Because of the focus on transgender health, I am most interested in hearing about your perceptions of, and experiences with, primary and emergency care since you have been expressing a gender identity that is different from the sex you were assigned at birth.

There are no right or wrong answers and you are free to share as much information as you like. The interview has approximately 12 open-ended questions and will last between 1-2 hours. You can choose to stop participating at any time during the interview.

<u>Questions</u>

1. **Can you tell me a bit about yourself, as a transgender person living in Nova Scotia – like where you are from, when you first identified as transgender, and so on?**

2. **Describe any positive experiences you have had with primary and/or emergency care. What made these experiences positive?**

3. **Similarly, describe any negative experiences you've had with primary and/or emergency care. What made these experiences negative?**

4. **Can you share any times that you may have felt reluctant to disclose the fact that you are transgender in a primary and/or emergency care setting?**

- Fear of discrimination?
- Fear of violence?
- Did not think it was important/necessary?
- Previous negative experience?

5. **Can you share any times when you may have avoided primary and/or emergency care all together for fear of discrimination if you disclosed your transgender identity? If so, what were your perceptions of primary and/or emergency care at this time?**
- Perceived it as unsafe?
- Perceived it as unknowledgeable?
- Perceived it as discriminatory?

6. **Can you share any times when you may have felt that a health care providers (i.e. doctor, nurse, EMT, paramedic, technician, etc.) knowledge, understanding, or competency regarding transgender health care impacted your primary and/or emergency care experience or perceptions?**
- Experiences with doctors, nurses, nurse practitioners, EMTs, paramedics, technicians, etc.

7. **Can you share any times when you may have felt that a staff persons (i.e. receptionists, porters, etc.) knowledge, understanding, or competency regarding transgender health care impacted your primary and/or emergency care experience or perceptions?**
- Experiences with receptionists, porters, etc.

8. **Can you share any times when you may have felt that the physical environment of the health care setting (i.e. emergency room, doctor's office waiting room, etc.) impacted your primary and/or emergency care experiences or perceptions?**
- Restrooms, waiting-room, privacy for changing, privacy of doctor's office or emergency department room, curtains for separating patients, etc.

9. **Can you share any certain conditions that influence whether or not you pursue primary and/or emergency care?**
- Do you only go when you are very ill?
- Do you only go for issues that will not reveal your transgender status?
- Do you only go to clinics that you know are trans-friendly?

10. **Are there any barriers that prevent you from accessing or utilizing primary and/or emergency care?**

11. Are there any facilitators that help you to access or use primary and/or emergency care?

12. Are there any changes that you would like to see with regards to the primary and/or emergency care services offered to transgender adults in Nova Scotia?

Appendix B: Demographic Survey

Demographic Survey

Interview # _____

This information will help us learn more about the participants in this study. If you are not comfortable answering a certain question, please leave it blank.

1. What is your age group?
☐ 18-24
☐ 25-33
☐ 34-44
☐ 45-54
☐ 54-65
☐ 66 or older

2. What ethno-racial group do you most closely identify with? (e.g. Caucasian, Black Nova Scotian, etc.) _____

3. Do you currently have a family physician? ☐ Yes   ☐ No

4. If no, why not? _____

_____

5. What is the highest level of education/school that you have completed?
☐ Not completed high school
☐ High school diploma or equivalent
☐ Some college or university
☐ College diploma
☐ University bachelor's degree
☐ Graduate school or professional degree (Masters, MD, PhD)
☐ Other: _____

6. What is your current relationship status? Check all that apply.
☐ Single, never married
☐ In a relationship
☐ Married or domestic partnership
☐ Widowed
☐ Divorced
☐ Separated
☐ Other: _____

7. Are you currently living in the Halifax Regional Municipality? ☐ Yes ☐ No

8. What is your *annual household* income?
☐ Less than $20,000
☐ $20,001 - $50,000
☐ $50,001 - $80,000
☐ $80,001 - $110,000
☐ $110,001 or more

9. What is your current employment status? Check all that apply.
☐ Employed full time
☐ Employed part time
☐ Unemployed and looking for work
☐ Unemployed but not currently looking for work
☐ Student
☐ Retired
☐ Unable to work
☐ Other: _____

ARE YOU A TRANSGENDER ADULT WHO IS INTERESTED IN DISCUSSING TRANS HEALTH CARE?

Are you?

- **English speaking**
- **18+**
- **Transgender**
- **A Nova Scotia resident (for at least 2 years)**
- **Able to meet in the HRM**
- **Have experienced, or wanted to experience, health care in Nova Scotia in the last 2 years**

…WE WOULD LIKE TO TALK TO YOU!

What's involved?

- **A confidential, 1-2 hour, face-to-face interview**
- **$25 for your time**

For more information, please contact Ella!

Ella Vermeir, Masters Student, Dalhousie University
ella.vermeir@dal.ca OR (902) 800-4631

ARE YOU A TRANSGENDER ADULT WHO IS INTERESTED IN DISCUSSING TRANS HEALTH CARE?

Are you?

- **English speaking**
- **18+**
- **Transgender**
- **A Nova Scotia resident (for at least 2 years)**
- **Able to meet in the HRM**
- **Have experienced, or wanted to experience, health care in Nova Scotia in the last 2 years**

…WE WOULD LIKE TO TALK TO YOU!

What's involved?

- **A confidential, 1-2 hour, face-to-face interview**
- **$25 for your time**

For more information, please contact Ella!

Ella Vermeir, Masters Student, Dalhousie University
ella.vermeir@dal.ca OR (902) 800-4631
*For your own privacy, please DO NOT comment on this post.

Appendix E: Email/Phone Inclusion Criteria Letter

Hello,

Thank you for expressing interest in participating in my research study: *"Exploring transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia."* To participate you must:

- Be able to comprehend English
- Be at least 18-years-old
- Be transgender
- Currently live in Nova Scotia (for at least the last two years)
- Have experienced, have tried to experience, or have wanted to experience, primary* and/or emergency** care in the last two years
- Be able to meet me for a face-to-face, confidential, 1-2 hour interview in the HRM

If you meet all of these criteria, please let me know if you may be interested in participating and I will send you more details and perhaps we can set a time and place for an interview.

Thank you,

Ella Vermeir
MA Health Promotion Student
Dalhousie University

For the purposes of this project, primary care is defined as a setting with a family practitioner or nurse practitioner. This can be your family doctor's office, a walk-in clinic, a University health clinic, etc.

**Emergency care is care you would receive in an emergency department or from a paramedic or emergency medical technician (EMT).*

Appendix F: Consent Form

**EXPLORING TRANSGENDER ADULTS' PERCEPTIONS OF, AND
EXPERIENCES WITH, PRIMARY AND EMERGENCY CARE IN NOVA
SCOTIA**

LEAD RESEARCHER:

Ella Vermeir, BSc, MA (candidate)
School of Health and Human Performance
Dalhousie University
6230 South Street
Halifax, NS B3H 4R2
CANADA

Phone: (902) 800-4631
Fax: (902) 494-5120

RESEARCH SUPERVISOR:

Dr. Lois Jackson, Professor
School of Health and Human Performance
Dalhousie University
6230 South Street
Halifax, NS B3H 4R2
CANADA

Phone: (902) 494-1341
Fax: (902) 494-5120

INTRODUCTION

You are invited to take part in a research study being conducted by Ella Vermeir, who is a Masters student in the Health Promotion program at Dalhousie University. Dr. Lois Jackson, a professor in the School of Health and Human Performance, is supervising the research. Your participation in this study is entirely your choice and you may decide to end the interview at any time. You may also contact Ella within 7 days of the interview to tell her that you do not want your interview used in the study.

The information below tells you about what is involved in the research, what you will be asked to do and about any risks or benefits that you might experience. Please ask as many questions as you like. If you have any questions later, please contact Ella Vermeir, the lead researcher, (902) 800-4631 or ella.vermeir@dal.ca

PURPOSE AND OUTLINE OF THE RESEARCH STUDY

The purpose of this study is to better understand transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia. The results will be used to help inform health care providers and policy makers about what it is currently working, as well as what needs to be improved.

WHO CAN PARTICIPATE IN THIS STUDY?

You may participate in this study if you: are English speaking, are at least 18 years old, are transgender, currently live in Nova Scotia and have lived in Nova Scotia for at least two years, are able to meet in the Halifax Regional Municipality for your interview, and if you have experienced, have tried to experience, or have wanted to experience primary and/or emergency care in Nova Scotia within the last two years.

HOW MANY PEOPLE ARE TAKING PART IN THE STUDY?

Approximately 6-10 individuals will be interviewed for this study.

WHAT WILL YOU BE ASKED TO DO?

If you choose to participate in this study, you will be asked to meet face-to-face with the lead researcher in a one-on-one interview to talk about your perceptions of, and experiences with, primary and emergency care. Before starting the interview, you will be asked to orally consent to participating and to having the interview audio recorded. If you do not wish to have the interview audio recorded, the interviewer will take detailed notes. You will also be asked to provide oral consent for the lead researcher to use your direct quotations from the interview in presentations, publications, and papers. This consent is your choice.

Instead of using your actual name, a fake name will be assigned to you. You will have the option to choose a masculine, feminine, androgynous, or 'other' name. You will also be assigned a participant number.

You will be asked to orally consent to having the researcher contact you by phone within 14 days of the interview if she has any questions about something you said. You do not need to give this consent if you are not comfortable doing so.

If you are comfortable doing so, the researcher will have a blank piece of paper for you to give your contact information. This information will be shredded after 14 days.

The interview will last 1-2 hours in a location and time that works for both you and the researcher, and that is quiet and safe (such as a private room in a public library).

During the interview, you will be asked questions about your experiences with, or desire to experience, primary and emergency care in Nova Scotia. You do not need to answer any questions that make you feel uncomfortable.

Once the interview is complete, you will be asked to fill out a form indicating your age range (i.e. 18-24), ethnoracial group, whether or not you have a family doctor, your highest level of education, relationship status, annual household income, employment status, and whether or not you live in the HRM. The results of this information will be used to gain a better understanding of the participants. You do not need to answer any questions that make you feel uncomfortable.

POSSIBLE RISKS AND DISCOMFORTS

There are very few risks attached to participating in this research study. It is likely that you will not experience any significant discomfort or distress during your participation. However, it is possible that the interview may bring up past experiences that are upsetting to you. You always have the option not to answer a question and you can stop the interview at any time. The researcher will have a list of counselors in the HRM who have identified themselves to prideHealth as having had experience with transgender clients. If you feel that you would like to talk with a professional, the researcher will provide you with this list.

POSSILE BENEFITS

Taking part in this research project will not have any direct benefits for you. However, there are some indirect benefits to participating. The information that you share will help us gain a better understanding of the experiences of transgender adults pursuing health care in Nova Scotia. This information may be used to inform service delivery and policy in the future.

WHAT WILL YOU RECEIVE FOR TAKING PART?

To thank you for your time, you will receive $25 cash for participating. If you choose to discontinue your participation during the interview, you will still receive this compensation. You will be asked to orally acknowledge that you have received the $25 and the researcher will make note of this acknowledgement.

HOW WILL YOUR INFORMATION BE PROTECTED?

It is not possible to keep participants' identities anonymous because of the face-to-face interviews, but all of the information that you share will be kept confidential. However, information will not be kept confidential if is related to the neglect or abuse of a child or adult in need of protection.

As a researcher, Ella must report this information on to the proper authorities (i.e. Child Welfare Services and/or the Halifax Regional Police). She will also notify her research supervisor.

After each interview, the audio recordings will be listened to and typed word for word by the researcher. At this time, any identifying information (such as the names of people or specific places) will be removed. Once the audio recordings have been transcribed and checked for accuracy, they will be deleted. The principal investigator, Ella Vermeir, is the only one that will have access to the audio-recordings. Ella's thesis supervisor, Dr. Lois Jackson, and her thesis committee members (Dr. Brenda Beagan and Dr. Emily Gard Marshall) will have access to the data once all of your personally identifying information has been removed.

All data will be kept on two password-protected USB drives in a locked security box at the researcher's home office. Once the research and analysis is finished, the data will be stored in a locked filing cabinet in Dr. Lois Jackson's office for a minimum of 5 years, at which time they will be destroyed. All paper copies of the data will be kept in a locked security box at the researcher's home office and shredded after she has finished her thesis. If you provide a mailing or email address for a summary of the results, this information will be kept in a locked security box and shredded once you have been sent the results.

It is possible that the researcher will want to use quotes from the information you share in her thesis, other publications, or in presentations. In order to do so, all your personally identifying information will be removed (such as the names of people or specific places). The researcher may mention your age range, relationship status, whether or not you have a family physician, and whether or not you live in the HRM, only if it is relevant to the quotation. If using these demographics would make you easily identifiable, they will not be used. It is important to note that despite our best efforts, it is possible that you might be identifiable as having said a quotation, so please only share what you feel comfortable sharing.

IF YOU DECIDE TO STOP PARTICIPATING
You are free to leave at any time during the interview. You are always able to skip a question if it makes you uncomfortable. You will also have 7 days from the day of your interview to contact the researcher to tell her that you do not want her to use your interview in the study. After 7 days, the data will become a part of the study.

HOW TO OBTAIN RESULTS
If you would like to obtain a summary of the completed study, please leave a mailing or email address with the researcher. The researcher will have blank pieces of paper for you to do this. Please note there will be no individual findings. Results will be made available in approximately one year.

QUESTIONS

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Ella Vermeir at (902) 800-4631 or ella.vermeir@dal.ca or Dr. Lois Jackson at (902) 494-1341 or lois.jackson@dal.ca at any time with questions, comments, or concerns about the research study.

If you have any ethical concerns about your participation in this research, you may also contact the Director of Research Ethics at Dalhousie University, Catherine Connors, at (902) 494-1462 or email: ethics@dal.ca.

Appendix G: Receipt of Honorarium

Receipt of Honorarium

Interview # _____

☐ I have **orally acknowledged** that I have **received** a sum of $25 cash from Ella Vermeir for my participation in the research titled: *Exploring transgender adult's perceptions of, and experiences with, primary and emergency care in Nova Scotia.*

Interviewer signature: _____   Date: _____

Appendix H: Signature Page

EXPLORING TRANSGENDER ADULTS' PERCEPTIONS OF, AND EXPERIENCES WITH, PRIMARY AND EMERGENCY CARE IN NOVA SCOTIA

Interview # _____

LEAD RESEARCHER:
Ella Vermeir, BSc, MA (candidate)
School of Health and Human Performance
Dalhousie University
6230 South Street
Halifax, NS B3H 4R2
CANADA
Phone: (902) 800-4631
Fax: (902) 494-5120

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered. I agree to take part in this study. I realize that my participation is voluntary and that I am free to leave the study at any time during the interview and for up to 7 days following the interview.

Please check the following **only** if you agree with the statement.

☐ I have read and understood the consent form.

☐ I understand that my participation is voluntary and that I may withdraw at any time during the interview and up to 7 days following the interview without consequence.

☐ I have given my **oral consent** to be audio-recorded.
   OR

☐ I have given my **oral consent** for the researcher to take detailed notes.

☐ I have given my **oral consent** for the researcher to contact me within 14 days of this interview if she has a question regarding something that I said during the interview.

☐ I would like to receive a copy of the results of this study.

Interviewer name: _____

Interviewer signature: _____   Date: _____

Please provide a mailing address or email address on a separate piece of paper provided by the researcher if you would like to receive a copy of the study results.

Appendix I: Consent for Direct Quotations

CONSENT FOR DIRECT QUOTATIONS
Use of Direct Quotations Approval Form

Interview # _____

☐ I have given my **oral consent** to confirm that I give permission for the use of direct quotations from my participation in a one-on-one interview as part of the research study: *Exploring transgender adults' perceptions of, and experiences with, primary and emergency care in Nova Scotia.*

☐ I understand that my true name will not be associated or linked to the direct quotations, and that a pseudonym will be used in its place.

☐ I acknowledge that all personally identifying information, such as names of people or specific places, will be removed.

☐ I acknowledge that my age range, relationship status, whether or not I have a family doctor, or whether or not I live in the HRM may be identified along with my quotation.

☐ I understand that these quotations may be used in papers, presentations, and publications.

I would like my pseudonym to be:
☐ A masculine name ☐ An androgynous name (such Alex, Morgan, etc.)
☐ A feminine name ☐ Other: _____

My preferred pronoun is:
☐ He/him ☐ They/them
☐ She/her ☐ Other: _____

Interviewer signature: _____ Date: _____

Appendix J: Dalhousie Research Ethics Board Approval Letter

DALHOUSIE UNIVERSITY
Research Services

Health Sciences Research Ethics Board
Letter of Approval

June 25, 2015

Ms. Ella Vermeir
Health Professions\Health & Human Performance

Dear Ella,

REB #:   2015-3580
Project Title: Exploring Transgender Adults' Perceptions of, and Experiences with, Primary and Emergency Care in Nova Scotia

Effective Date: June 25, 2015
Expiry Date: June 25, 2016

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans.* This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

Dr. Brenda Beagan, Chair

Post REB Approval: On-going Responsibilities of Researchers

After receiving ethical approval for the conduct of research involving humans, there are several ongoing responsibilities that researchers must meet to remain in compliance with University and Tri-Council policies.

1. Additional Research Ethics approval
Prior to conducting any research, researchers must ensure that all required research ethics approvals are secured (in addition to this one). This includes, but is not limited to, securing appropriate research ethics approvals from: other institutions with whom the PI is affiliated; the research institutions of research team members; the institution at which participants may be recruited or from which data may be collected; organizations or groups (e.g. school boards, Aboriginal communities, correctional services, long-term care facilities, service agencies and community groups) and from any other responsible review body or bodies at the research site.

2. Reporting adverse events
Any significant adverse events experienced by research participants must be reported **in writing** to Research Ethics **within 24 hours** of their occurrence. Examples of what might be considered "significant" include: an emotional breakdown of a participant during an interview, a negative physical reaction by a participant (e.g. fainting, nausea, unexpected pain, allergic reaction), report by a participant of some sort of negative repercussion from their participation (e.g. reaction of spouse or employer) or complaint by a participant with respect to their participation. The above list is indicative but not all-inclusive. The written report must include details of the adverse event and actions taken by the researcher in response to the incident.

3. Seeking approval for protocol / consent form changes Prior to implementing any changes to your research plan, whether to the protocol or consent form, researchers must submit them to the Research Ethics Board for review and approval. This is done by completing a Request for Ethics Approval of Amendment to an Approved Project form (available on the website) and submitting three copies of the form and any documents related to the change. Please note that no reviews are conducted in August.

4. Submitting annual reports
Ethics approvals are valid for up to 12 months. Prior to the end of the project's approval deadline, the researcher must complete an Annual Report (available on the website) and return it to Research Ethics for review and approval before the approval end date in order to prevent a lapse of ethics approval for the research. Researchers should note that no research involving humans may be conducted in the absence of a valid ethical approval and that allowing REB approval to lapse is a violation of University policy, inconsistent with the TCPS (article 6.14) and may result in suspension of research and research funding, as required by the funding agency.

5. Submitting final reports
When the researcher is confident that no further data collection or analysis will be required, a Final Report (available on the website) must be submitted to Research Ethics. This often happens at the time when a manuscript is submitted for publication or a thesis is submitted for defence. After review and approval of the Final Report, the Research Ethics file will be closed.

6. Retaining records in a secure manner Researchers must ensure that both during and after the research project, data is securely retained and/or disposed of in such a manner as to comply with confidentiality provisions specified in the protocol and consent forms. This may involve destruction of the data, or continued arrangements for secure storage. Casual storage of old data is not acceptable.

It is the Principal Investigator's responsibility to keep a copy of the REB approval letters. This can be important to demonstrate that research was undertaken with Board approval, which can be a requirement to publish (and is required by the Faculty of Graduate Studies if you are using this research for your thesis).

Please note that the University will securely store your REB project file for 5 years after the study closure date at which point the file records may be permanently destroyed.

7. Current contact information and university affiliation The Principal Investigator must inform the Research Ethics office of any changes to contact information for the PI (and supervisor, if appropriate), especially the electronic mail address, for the duration of the REB approval. The PI must inform Research Ethics if there is a termination or interruption of his or her affiliation with Dalhousie University.

8. Legal Counsel The Principal Investigator agrees to comply with all legislative and regulatory requirements that apply to the project. The Principal Investigator agrees to notify the University Legal Counsel office in the event that he or she receives a notice of non-compliance, complaint or other proceeding relating to such requirements.

9. Supervision of students Faculty must ensure that students conducting research under their supervision are aware of their responsibilities as described above, and have adequate support to conduct their research in a safe and ethical manner.

Appendix K: List of LGBTQ+-Positive Counselors in Halifax

List of LGBTQ+-Positive Counselors from prideHealth

It is important to note that the individual and organizations listed have chosen to participate in this directory and are responsible for the accuracy of their information. prideHealth does not screen the service providers listed in this directory and cannot make guarantees about the quality of their service. All service providers and organizations in this directory have listed themselves as LGBTQ+-positive. This list only includes those who have experience with trans individuals.

Family Service Association
Contact Name: Valerie Bobyk
2069-6960 Mumford Rd.
Halifax NS B3L 4P1
Phone: (902) 420-1980
Email: valerieb@fshalifax.com
Website: www.fshalifax.com

Halifax Sexual Health Centre
201-6009 Quinpool Rd.
Halifax NS B3K 5J7
Phone: (902) 455-9656
Email: admin@hshc.ca
Website: www.hshc.ca

Jennifer van Kessel
2176 Windsor St.
Halifax NS B3K 5B6
Phone: (902) 406-1503
Email: info@jennifervankessel.ca
Website: wwww.jennifervankessel.ca

Jessica Wine
5687 West St.
Halifax NS B3K 1H6
Phone: (902) 880-2262
Email: jessicawine@gmail.com
Website: www.halifaxtherapist.com

Radiant Health Counseling and Consulting
Contact Name: Elizabeth Shein
5533 Columbus Place
Halifax NS B3K 2G7
Phone: (902) 497-3735
Email: melizabethshein@gmail.com

Sara Lamb Psychotherapy & Counselling
201-6156 Quinpool Rd.
Halifax NS B3L 1A3
Phone: (902) 473-0813
Email: sara@saralamb.ca
Website: www.saralamb.ca