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# Being Transgender and Seeking Healthcare in the World's Most Liberal City

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Being Transgender and Seeking Healthcare in the World's Most Liberal City  
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## **Abstract**

The right to the highest form of healthcare is one of the most essential rights a person should have. It should be accessible to all human beings, and it appears this is not the case when it comes from the transgender population in the Netherlands and the U.S. In addition to

transitional health care needs like hormonal treatment and surgery, transgender people require the same variety of general health care needs as many other groups of individuals. When obstacles create stigma within health care providing facilities, transgender individuals may be less inclined or discouraged to seek the care they need. This research is relevant for both healthcare providers as well as those involved in public health policy. Whether it be in the United States or internationally, the stigma and micro-aggressions combined with the lack of knowledge with regard to transgender issues within the sphere of healthcare is hurting the health of transgender populations worldwide. It is important to research this issue to gain a better understanding of where these faults lie, to improve the quality of health, and the quality of life for all those involved. The objective of this study is to provide suggestions for improving accessibility to the right to the highest form of healthcare for transgender individuals and to provide a basis for further research in the Netherlands.

Key Words: Gender Studies, Health Education

## **Introduction**

Two years ago, in a class on Ethics in U.S. Healthcare, I was first exposed to the reality that healthcare providers can actually perpetuate the opposite of health, standing as a physical barrier to the right to health care themselves. I learned, even if unintentional, as discrimination via ignorance often is, institutionally and individually health care providers in the U.S. are



providing unequal treatment to transgender healthcare users as a result of lack of knowledge available via medical education or training, institutional or personal prejudice, and an emphasis on binary systems. As an aspiring physician assistant and public health policy influencer, I felt it vital to take the responsibility to ensure I will never inflict this kind of discrimination myself. In the short period of time I have taken an interest in transgender rights, I have listened to countless stories from trans-individuals in the U.S. who have personally experienced obstacles in seeking non-transition related healthcare through the healthcare system. Taking a sociological perspective, I realize this issue is multidimensional, and if we are to ever minimize the health disparities experienced by transgender populations across the globe, the issue must be approached from both inside and out: from the individual level to the institutional. I selected the research program with SIT in the Netherlands due to the progressive reputation the country has for both LGBTQ rights and their approach to health care with the intention of bringing back suggestions for how the U.S. healthcare system could improve their approach to transgender health. In turn, I found that issues of homophobia and transphobia exist in the Netherlands as well. And transitional healthcare, in many facets, is far from progressive.

While there has been research on similar topics in the U.S. context, and research on obstacles faced by trans individuals when seeking trans-specific care in the Netherlands, a major gap exists in how the care of transgender individuals in non-trans specific health settings can be improved. In this paper I investigate the following research question: How do current obstacles generated by the healthcare system in the Netherlands withhold transgender patients from the right to the highest standard of non-transition related health care due to the identity label, “transgender”? This paper begins with the historical evolution of the relationship between medicine and transgender people. It then outlines the the relationship between transgender

individuals and the healthcare system in the Dutch context today, illuminating the challenges faced when seeking transitional care. The paper then introduces two U.S. studies of similar nature to the primary research question at hand to provide a kind of theoretical framework to guide the analysis of interview findings throughout the paper. Interview findings are then presented and analyzed using this framework to theorize how various forms of discrimination faced by transgender individuals may function to form barriers for the right to the highest form of healthcare available in the Netherlands. Though no conclusions can be drawn from this research due to the circumstances of this project, this paper helps to shed light on potential holes in transgender specific cultural competency education available to health care providers, and sources of discrimination transgender healthcare users experience in non-trans specific medical settings. Patterns in the interviews are used to provide suggestions for further research and improvements to the Dutch healthcare system, and the paper concludes with a discussion of limitations.

## **Literature Review**

### **A. Explanation of the Language**

Throughout my sociological studies pertaining gender and sexuality, language and terminology have been at the very heart of understanding identities. I believe that language is essential to visibility. To display this concept, I want to share an example I once read in a text book in which a comparison was made between the way rice is perceived in the U.S. versus Taiwan. There are over 25 words for rice in the Mandarin and Taiwanese language, while on the

contrary there are only a couple words for rice in the English language. Due to this difference, when understanding the concept of rice in Mandarin , for example, you might be able to visualize rice in all 25 of its varieties, considering that in English, you would only be able to see white rice, brown rice, and quinoa. This difference in understanding of terminology becomes especially important in approaching issues of discrimination, both institutionally and individually, as language is instrumental in combination for both.

When first entering the Netherlands, sitting through some of my first classes at SIT, I came across a very interesting observation that provides a great example of how vital language is to approaching problems. Because there is no word in the Dutch language to talk about race, it is very difficult to talk about racism.

So, throughout this paper, I use the term, “transgender,” as an umbrella term to describe any individual who identifies with a gender that differs from the sex assigned at birth, whether that be male, female, non-binary, or any other gender identity identify with.

And I am careful to use the term, "healthcare user," rather than, “patient,” to describe transgender individuals seeking health care through any aspect of the healthcare system. Due to the long history of the association between the term patient with the medicalization of the state of being transgender itself, and due to the fact that both transgender and patient are both used as identity terms, representative of the individual, I want to clarify the distinction that the state of being transgender is not inherently a disease.

Though there was extensive effort dedicated to respecting the preferred pronouns of my interviewees, I made the choice to use the pronouns, “they,” “them,” “theirs,” in referring to both my interviewees so as to further protect the anonymity of their identities.

## **B. International Transgender History Outline**

## *Early History*

Karl Heinrich Ulrichs in the early 1860's was the first to hint at the idea of experiencing a form of gender incongruity when he described his attraction to men stemming from having, "a female soul enclosed within a male body," and in 1869, the earliest documented treatment of a transgender patient was treated by Carl Westphal (Beemyn, 2013).

It was not until 1886 that the concept of what is understood today as transgender began to take shape and became understood as a pathology when Richard von Krafft-Ebbing coined the term, *metamorphis sexualis paranoica*. Beemyn argues Krafft-Ebbing's spectrum framework of cross-gender identification may have been the most influential contribution to the medical field and transgender in the 19th century (Beemyn, 2013). In 1910, German physician and sexologist, Magnus Hirschfeld was the first to conceptualize what is understood today as cross-dressing when he coined the term, "transvestite," to describe individuals who experience a, "feeling of peace, security, and exaltation, happiness, and well-being...when in the clothing of the other sex,"(Beemyn, 2013). In his published work, *Transvestites*, he argued same-sex sexuality and gender differences to be inherently distinct and that not only were transvestites not masochists, fetishists, and suffering from a form of psychopathology, the experience of erotic pleasure from cross dressing was not essential to being a transvestite (Beemyn, 2013). Hirschfeld's findings that transvestites could hold any sexual orientation proved distinct differences between same sex attraction and gender variations. And they found, more often than not, transsexual individuals tended to be heterosexual from the standpoint of the gender they were assigned at birth (Beemyn, 2013). It is important to note, before Hirschfeld began studying female cross dressers, cross dressing was perceived as a behavior exclusive to men by current researchers. In 1919, Hirschfeld opened what is known as, "the world's first institute devoted to sexology,"

Hirschfeld's Institute for Sexual Science which specialized in gender affirming surgeries and hormone therapy. The institute was documented to have performed the earliest recorded genital reassignment surgeries (Beemyn, 2013). The institute's most well know health users were Dorchen Richter and Einar Wegener. The first documented case and successful example at that was Dorchen Richter. She was assigned male at birth, and living with the desire to be a woman for most of her former life, she underwent castration in 1922 and had her penis removed and vagina construction surgery in 1931. Following her surgery, she worked at the institute as an example. Portrayed by Eddie Redmayne in the 2016 motion picture, *The Danish Girl*, Einar Wegener, later known as, Lili Elbe, was the institute's most famous. Under the Hirschfeld Institute, she received several male-to-female surgeries including castration, vagina constriction, and the earliest form of hormone therapy, ovaries surgically placed in her abdomen. She died in 1931 due to heart complications following her final surgery, to construct a uterus with hopes of later bearing children. In 1933, the institute was destroyed by the Nazi's during WWII after Hitler named Hirschfeld, "the most dangerous Jew in Germany," (Stryker, 2008). As cited by Beemyn, through the 1930's hormone therapy evolved with the rise of two major research developments. One: endocrinologists discovered the possibility of cross-gender treatments with "male" hormones, or testosterone, occurring naturally in women and "female" hormones, or estrogen, in men. Two: synthetic forms of estrogen and testosterone were developed, giving those who were seeking to transition access to a more affordable and available option, as very few physicians in the U.S. and Europe were prescribing hormones for transitional purposes.

Beemyn citing Kennedy and Sharpiro, claims the first female-to-male person recorded in history to take testosterone for transformational purposes was Michael Dillon in 1939. He was a doctor and heir to a title in a British aristocratic family. His desire to learn about masculinity and

changing his body inspired his pursuit of medicine. He started hormones in 1939 and following the masculine changes in his body, he had a double mastectomy in 1942, and became the first documented female-to-male individual to receive genital construction surgery when he began a series of over twelve penile constructive surgeries in 1946. During the course of his surgeries, he attempted to tackle stigma faced by gender nonconforming individuals in health care when he published his book, *Self: A Study of Ethics and Endocrinology*. In his book, he criticized psychologists committed to changing gender nonconforming individuals through therapy. Beemyn cites that Dillon argued, “where the mind cannot be made to fit the body, the body should be made to fit, approximately, at any rate to the mind, despite the prejudices of those who have not suffered these things,”(Beemyn, 2013). Though *Self* was not written to reflect Dillon’s life in any way, after its release, Dillon was forced into exile in India in 1958 due to the heavy harassment he received when the media reported his identity(Beemyn, 2013). In the 50’s and 60’s, the term, David Cauldwell, a U.S. physician, coined the term “transsexual” to distinguish those who do not identify with their sex assigned at birth and desire to change it from the term “transvestite” to describe. Harry Benjamin, an endocrinologist in the U.S. became the leading advocate for the use of transitional hormones and surgery for gender nonconforming people and like Dillon, argued the body should be adjusted to the mind. He prescribed hormones himself and recommended american patients to surgeons abroad experienced in transitional surgeries. Beemyn cites Meyerwitz saying, Benjamin challenged beliefs held by doctors like Cauldwell including the mental pathology of transsexual people and that gender is rooted in biological sex, and conceptualized “psychological sex” as separate from biological sex, now termed, “gender identity”. Using the concept of “psychological sex,” as fixed and more essential to gender than

biological sex, Benjamin argued the ability to change the sex of their bodies was vital to the well being of transsexual individuals, (Beemyn, 2013).

### **C. Transgender Care in the Dutch Context**

This past year, the Dutch organization, Principle 17 wrote the petition, “Transgender Care Expansion rather than Contradiction!” based on a recent survey report they released released in December, “Trans Health Care in the Netherlands” dedicated to current abuses in transgender care. According to the study, it is evident though transgender healthcare has come a long way since the 1960s, issues for transgender patients are still widely misunderstood by the healthcare system and by no means has discrimination of trans individuals in healthcare settings disappeared. According to the research report, 43% of participants reported negative experiences when seeking health care through the Dutch Healthcare system. Though the focus of my research is to investigate health care in specifically non-transition related settings, I thought it imperative to review research on transgender specific care because it is possible that for transgender individuals seeking medical care, the two cannot be separated.

According to the Principle 17 petition, two gender specific clinics have a monopoly on the care of transgender individuals, the Dutch Center of Expertise on Gender Dysphoria (KZcG) of the VU University Medical Centre in Amsterdam (KZcG) and the University Medical Center Groningen (UMCG) in Groningen. For transgender youth, Leiden University Medical Center (LUMC) in Leiden is available, though, according to my advisor I have been recently informed it is in the process of closing down. These centers provide everything from the diagnosis of gender dysphoria by a psychologist/psychiatrist to endocrinologist monitored hormone therapy treatment to gender affirming surgeries. Due to these limited options, many abuses within

transcare have surfaced, some of the most important include: long waiting lists (before and during treatment); the problematic practice of pathologizing the transgender identity; a one-size fits all approach to transitional care; and the inability for transgender patients to choose their practitioner.

### *Long Waiting Lists*

According to Foundation Patient Organisation Transvisie cited by Principle 17 in their petition, “For years, transgender health care has suffered from a chronic shortage of capacity, resulting in long waiting lists and a total delay of two years (or more) between entry and medical treatment,” (Principle 17, 2016). In a report cited by VICE conducted by Transvisie, waiting lists are the biggest problem in the transgender care in the Netherlands (Hanna, 2017). One explanation for the long wait times is the standard protocol of clinics like the KZcG as Principle 17 summarizes, the health care user is placed on an often long waiting list before they even receive a diagnosis. “Once their turn is up everyone receives -regardless of individual wishes or needs- a diagnostical process lasting a minimum of six months up to a few year,” (Principle 17, 2016). According to Transgender Info Nederland, the entire transition path health care users follow when transitioning with the gender teams in the Netherlands, takes three years and includes psychological examination steps, called *real-life experience* with hormones and possibly operations (Transgender Infor Nederland, 2016). Due to the role of influential role psychologists in the gender teams, behaving as gatekeepers of who is allowed to transition and when, the length of treatment can be further extended. Principle 17 reports patients can be denied access to transitional treatments based on a variety of reasons they are expected to resolve before transitioning including depression, anxiety, heavy smoking or drinking habits, and even a high



body mass index. These issues can be difficult to resolve, especially when gender dysphoria contributes as a leading causal factor.

Not only does the literal factor of time itself stand in the way of obtaining proper care, when individuals are denied access to necessary treatments, patients will seek elsewhere to find it. In the case of denying transgender individuals the access to transitional treatments like hormones and surgeries, especially due to barriers like waiting lists, people will turn to other sources. According to a report conducted by Transvisie in the summer of 2016 including 273 transgender people who are currently transitioning or have already transitioned, 26 % of transwomen and 7% of transmen in the Netherlands order their hormones over the internet, (Transvisie, 2016).

In the report, Transvisie further detailed that there is usually no monitoring of this type of hormone usage by healthcare providers. While hormone therapy has been proven very safe when monitored closely under the supervision of a physician, hormones used in incorrect doses can cause a variety of dangerous complications. For example, when testosterone is taken by mouth or in high doses, it can cause damage to the liver. Estrogen can increase blood pressure, blood glucose levels, and increase the risk of blood clots. And anti-androgens can cause blood pressure to drop, disrupt electrolytes, and cause dehydration (Vanderbilt University Medical Center, 2012).

### *Transgender as a Pathology*

Another aspect of transgender care in the Netherlands that discourages trust in the healthcare provider is the treatment of transgender as a pathology. The research article, *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, published in 2015 evaluates stigma towards transgender people in the U.S.

Though, not specific to the Dutch context, the historical background of the medicalization of gender nonconformity applies internationally. According to the article, gender nonconformity was first medicalized in the early 1900's to distinguish gender nonconformity as a condition biologically determined, and not a choice (Hughto, Reiser, Pachankis, 2015). In 1968, the concept of identifying with or expressing a gender different from the sex assigned at birth was listed as, *gender identity disorder*, in the *Diagnostic and Statistical Manual of Mental Disorders*. Although the movement of medicalizing transgender individuals was essential to accessing transitional treatments like hormone therapy and gender aligning surgeries, Hughto, Reiser, and Pachankis argue that pathologizing gender nonconformity through the institution of healthcare, “shapes and reinforces societal perceptions of transgender people as deviant,” and maintains, “the rigid binary construction of gender, making gender conforming transgender people invisible, and further stigmatizing those who do not conform to socially sanctioned expressions of gender”(Hughto, Reisner, and Pachankis, 2015).

Although *gender identity disorder* was finally changed in the DSM to *gender dysphoria* in 2013, now describing the distress, alone, associated with gender incongruence, *gender dysphoria* is still treated, for all practical purposes, as a disease in the Netherlands that must be diagnosed by a psychologist in order to gain access to transition specific treatment. According to an interview conducted by VICE news in the article, *In the Netherlands, Transgenders Still Treated as if they have a Disease*, in March of this year, Brandenburg Hack of the Transgender Network Netherlands argues the first step to improving transgender healthcare in the Netherlands begins with the demedicalization of the transgender identity. He told VICE, "You are the only one who can determine whether you are transgender or not. Psychologists and doctors only need to check if you are bright enough to diagnose yourself,"(Hanna, 2017). Because it is currently

organized in the Netherlands that you must first obtain a diagnosis for gender dysphoria to qualify for a transition, it is experienced by many transgender people as having a disease. Gender dysphoria is still listed by the World Health Organization as a mental disorder. Next year, the term will be changed to gender inconvenience (Hanna, 2017). VICE further reported, according to the transgender people they spoke with regarding the mandatory gender dysphoria diagnosis for beginning transitional treatment negatively impacts individual's perceptions of themselves. Those who did not feel ill prior to the diagnosis, felt the burden of the label and the stigma attached to having a disease. This forces transgender patients seeking care into a very confusing role, as Brand referring to this aspect of the transition process through the Dutch healthcare system, says, "transgender people feel that they have to prove to be crazy, but not too crazy to be treated,"(Hanna, 2017).

### *One Size Fits All Approach to Health Care*

A third theme that destabilizes the relationship between a transgender patient and the transgender care system in the Netherlands is what Principle 17 refers to in their petition as a "one size fits all" protocol used by gender teams. This kind of protocol has fixed parts, entirely disregarding the transgender patient as an individual with individual needs, and forces patients to undergo medical treatments they often disagree with resulting in sometimes unnecessary expensive care (Principle 17, 2017). For example The Principle 17 Survey summarizes the standard treatment protocol enforced by the KZcG as such,

"The treatment always starts with an interrogative talk during which it is being decided whether the 'patient' is at the right desk. If the KZcG believes that gender problematics probably are at play, the care recipient is placed on an, often long, waiting list. Once their turn is up everyone receives -regardless of individual wishes or needs- a diagnostical process lasting a minimum of six months up to a few years. Throughout this process a psychologist or psychiatrist decides whether gender dysphoria truly is at play and if so, if the care recipient has sufficient capacity to endure the treatment. If the answer to both of these questions is yes, and no further complications arise (labelled

‘comorbidity’ 3 ), the care recipient may proceed with the treatment for which they came. The medical treatment commences with hormone replacement therapy and at a later phase surgery on primary and (some) secondary sex markers,” (Principle 17, 2017).

Medical treatment under the protocol includes:

- Facial laser hair removal for those who have stubble and wish to remove it
- Mastectomies for those who wish to remove their breasts
- Breast reconstructive surgery through breast implants for those who do not have them and wish to
- Hysterectomies for those who have their uterus and ovaries and wish not to
- Metoidioplasty or phalloplasty for those who wish to have a penis and scrotum
- Vaginoplasty for those who wish to have a vagina

Other treatments not included in the basic treatment protocol, but are sometimes granted upon request are facial reconstructive surgery for feminization of appearance, medical tattooing to cover scars, and hip liposuction for masculinization of the hips. Principle 17 emphasizes that these three treatments and breast reconstructive surgery are not covered by basic health insurance because they are considered “elective cosmetic operations.” And finally, it is important to point out psychotherapeutic and psychosocial guidance are excluded from the protocol because they fall out of the expertise of gender teams like the KZcG, (Principle 17, 2016).

### *Choice of Practitioner*

And finally, while the right to choice of practitioner is granted to all other residents of the Netherlands, due to the monopolization of transgender care by a limited number of facilities, in transitional care settings, health care users are not granted this privilege. As earlier mentioned, trans care facility options are already limited, the VU University Medical Center and the University Medical Center Groningen are the only two healthcare facilities in the country that provide everything from diagnosis to surgery. According to the VICE article, gender clinics like the VU assign trans-patients a psychologist and “you must be lucky with the psychologist you receive, because you may not change psychologists,”(Hanna, 2017). It is described that this is

especially problematic because many psychologists believe, in order to diagnose gender dysphoria, the trans-identity must be visible which encourages a health care provider to depend on objective protocol standards for diagnosis, and leads to the potentially reinforcement of narrow problematic stereotypes.

#### **D. Overview of the Current Research**

As of yet, there has been very little research done on the topic of obstacles transgender individuals face when seeking health care under non-transition related circumstance. In this review of the current research, I focus primarily on research done in the U.S. context due to the lack of research resources available in the Netherlands. As one of my interviewees emphasized, it is not surprising that most of the research done on trans-healthcare, and academic research in general, is congregated in the U.S. when you consider the sheer size of the U.S. and the fact that the country has the highest density of university institutions in the world. The two most relevant studies I found center around the topic of non-transitional related care and the most relevant studies I found in the dutch context center around problematic themes under transition-specific care. As one of the activists I interviewed concluded, organizations such as the one they work with is most interested in solving issues within transitional health care because that is what is needed most. Due to the fact that the VU gender clinic is a major source of information for non-trans related physicians, discrimination within general medical facilities cannot be addressed until discrimination within the gender clinic is addressed first. They added, “We are definitely interested in non-transition health, but as there are very little data known on this in the Netherlands. There’s also very little known from trans people, just from rumor, through the grapevine, we know very little. And its complicated to start digging into that. We really need

subsidy to have good research on that. And nobody is really interested in doing that at the moment.”

### **E. Obstacles to the Right to Non-Transitional Healthcare in an International Context**

Though medical education and the system of healthcare in the U.S. vary both structurally and operationally from the Netherlands, due to a fundamental similarity in the failure to address transgender topics in the education of providers, it is possible similar obstacles to health care are faced by the Dutch transgender community as in the U.S. The studies, *Discrimination and Delayed Health Care Among Transgender Women and Men: Implications for Improving Medical Education and Health Care Delivery* conducted by Kim D Jaffee, and *Managing Uncertainty: A Grounded Theory of Stigma in Transgender Health Care Encounters* by Tonia Poteat, reveal discrimination transgender patients experience when seeking health care, is rooted in ignorance with discrimination in medical settings. This discrimination they emphasize as being a leading barrier to the right to health care. In the review of these studies, I would like to highlight several themes generated by the lack of knowledge among health care providers: the patient’s need to educate their provider on transgender issues or their own care; lack of cultural competence; experiencing various forms of discrimination in healthcare offices; and the resulting theme, breaching of trust between the medical provider and patient.

*Discrimination and Delayed Health Care Among Transgender Women and Men: Implications for Improving Medical Education and Health Care Delivery* by Kim D Jaffee

In Jaffe’s study, they report previous research reveals physicians are missing knowledge on transgender issues which leads to perceived discrimination by patients who feel forced to educate their providers. They summarize the ways this kind of discrimination likely stands as

barrier to health care. And in their research, they report their findings support a significant correlation between discrimination, uneducated healthcare providers, and delayed or avoided health care among transgender patients in the U.S.

Kim Jaffee introduced their study with a review of previous research on the relationship between how lack of education produces the discrimination transgender patients experience when seeking care. As cited by Jaffee,

“Previous studies have found that physicians generally lack specific training that would provide knowledge and understanding of transgender people. Two qualitative studies found that providers report feeling uncomfortable when treating transgender patients because they lack the skills or training needed to feel competent with this population. Health care providers who lack knowledge are likely to be uncertain about their ability to provide adequate care to transgender patients, and can unwittingly create an atmosphere of disapproval for transgender patients. Although patients are increasingly collaborating with physicians in making critical medical decisions regarding their health care, giving unsolicited information to physicians about appropriate health care can be perceived as a challenge to a physician’s authority. Consequently, health care providers may, either consciously or subconsciously, manage uncertainty about their medical authority by stigmatizing their transgender patients.”(Jaffee, 2016).

Using participants from the National Transgender Discrimination Survey in 2008 and 2009, Jaffee recruited a sample of 3486 transgender people and assessed whether predisposing, enabling, and health system factors were associated with delaying needed care for transgender women and transgender men. According to the survey, Jaffee suggested, the transgender population in the U.S. is likely affected by discrimination in the healthcare field in the following ways: not having access to healthcare, having negative experiences during medical visits, being denied equal treatment in health care offices, and being less likely to have a regular healthcare provider or to have had a health check up in the last 12 months compared to non-transgender survey participants. In their assessment, Jaffee focused specifically on two major themes: “(1) the proportion of transgender individuals who delayed or did not seek care for an illness or injury

due to discrimination; and (2) the association between delayed sick/injury care and patient reports of needing to teach their providers about transgender people, controlling for both enabling and predisposing factors,” (Jaffee, 2016). During a previous study Jaffee found 40% of transgender male participants reported experiencing some form of discrimination in a doctor’s office or hospital including verbal harassment, physical assault, or denial of care. In their findings this round, due to discrimination in healthcare settings they reported, 30.8% of transgender participants delayed or did not seek needed health care at all. Of that 30.8%, “respondents who had to teach health care providers about transgender people were 4 times more likely to delay needed health care due to discrimination”( Jaffee, 2016). As cited by Jaffee, the Institute of Medicine defines access to health care as, “timely use of personal health services to achieve the best possible outcomes,” (Jaffee, 2016). And according to the Healthy People 2020 report by the Department of Health and Human Services, Jaffee says delays to necessary medical care can be detrimental to health leading to higher rates of morbidity and mortality, (Jaffee, 2016).

*Managing Uncertainty: A Grounded Theory of Stigma in Transgender Health Care Encounters  
by Tonia Poteat*

Like Kim Jaffe work, Tonia Poteat’s study is also precluded with an overview of the relationship between discrimination against transgender healthcare users and unknowledgeable health care providers. They suggest transgender care is excluded from training in medical schools due to institutional and social stigma against transgender individuals. And this lack of training leads to medical encounters in which health care providers are uncertain and ambivalent about how to care for the patient and transgender health care users anticipate health care



providers will be ill-prepared to respond to their needs. Between January and July of 2011, Poteat conducted a qualitative interview-based study of fifty-five transgender participants and twelve health care providers to investigate how stigma and discrimination are produced and function in health care interactions. In addition to health care providers ill-equipped to cater to the needs of their transgender patients, the study found , “discomfort with uncertainty leads clinicians to reinforce medical authority with stigma” (Poteat, 2013). Poteat in their findings, also shed light on the function of stigma used by physicians to produce a problematic power dynamic between provider and patient that ultimately leads to health disparities. Poteat reported,

“Findings from this study are also consistent with the attribution model of stigma (Weiner, Perry, & Magnusson, 1988). The attribution model posits that people are more likely to respond negatively to those whom they believe to be responsible for their stigmatized identities than those whose stigmatized identities are believed to be beyond their control. In this study, providers who expressed uncertainty about the nature of transgender identity were more likely to express stigmatizing attitudes toward transgender patients than those who felt that transgender people were innately compelled to express their gender identity,”(Poteat, 2013).

In other words, the less educated the medical provider is on transgender issues, the more likely they are to stigmatize or discriminate against their transgender patients. Supported by a growing body of literature that argues stigma and discrimination are at the heart of many health disparities, Poteat describes this precise form of discrimination experienced in health care then, directly influences transgender people’s utilization and access to health care.

In the conclusion of their study they go on to say, “ If the function of stigma is to reinforce existing social hierarchies, then challenges to current power structures may be the social impetus for stigma. Those who challenge this structure would be stigmatized whether it is by assuming they are inherently inferior and justifying it or by attributing their inferiority to choices they have made,”(Poteat, 2013). And if this is in fact true, this study gives further insight on the last study as to why those who challenge their providers by educating them about their

specific care and transgender issues, they might be more likely to face more discrimination and therefore delay care.

### *Medical School Curriculum in the Netherlands*

Upon review of these studies, I found it critical to take a look at the medical school curriculum in the Netherlands. There are eight accredited medical schools in the Netherlands: University of Amsterdam, University of Groningen, University of Leiden, Maastricht University, University of Nijmegen, Erasmus University Rotterdam, and University of Utrecht. In order to become a general practitioner in the Netherlands, it is required you obtain both a bachelor and masters of medicine. Both programs are three to four years long. After, if students are interested, graduates may apply to specialty programs. Each of these universities require completion of a bachelor of medicine through their university to apply to their master's programs. While there is an emphasis in some programs on communication skills, reflection on actions as a physician, and sometimes international perspectives on diverse traditions when treating patients, upon careful examination of the curriculum of both Bachelor's and Master's programs of each university, I did not find a single course description addressing topics of cultural competence of any kind, diversity of patients, or topics in gender. The University of Leiden offers lectures on sexuality but only as it pertains to reproduction.

### *Cultural Competency*

In Principle 17's petition, they argue, cultural competency training in (para) medical curricula is missing and vital to improving care for trans individuals. "In education almost no attention is paid to dealing with transgender people, while they are about 4% of the population.

In this way the knowledge gap and the lack of understanding by (para) medical professionals continue to exist, resulting in discrimination by ignorance, incorrect diagnoses, unnecessary or wrong treatments, care refusal, etc.”(Principle 17, 2016).

Willy Wilkinson, MPH, has worked with a variety of nearly three hundred different community health organizations, businesses, and educational institutions training and advising on how to provide equal access to services for LGBT people. They have also received multiple awards for their writing. A review of Willy Wilkinson’s work on cultural competency might help explain one of the most vital components of the discrimination-producing knowledge gap in transgender care help by health care providers discussed in the previous research. According to Wilkinson, “Cultural competency refers to 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, 2015). And transgender cultural competency, as well as other service providers, for healthcare professionals, entails understanding, “the complex array of identities and expressions that transgender and gender-nonconforming people represent. This includes people who identify as male or female as well as people who identify as something between or beyond male and female. It is also important to understand the various ways in which trans and gender-nonconforming people want to be addressed and to be equipped to successfully navigate appropriate name and pronoun use. Also key is the ability to respectfully obtain this information when it is unclear what is appropriate and to recover gracefully when a mistake is made,” (Wilkinson, 2015). Wilkinson also describes cultural competency of transgender individuals in the approach to health care involves an intersectional understanding of how all identity components trans individuals may experience form barriers to accessing care including for example, “ low

socioeconomic status, limited health care access, lack of family acceptance, partner and community discomfort, discrimination in employment and housing, legal challenges, and medical conditions including HIV/AIDS,”(Wilkinson, 2015).

## **Methodology**

### **A. Rationale for Conducting Oral Interviews**

The first I heard of discrimination within the healthcare field for transgender individuals was via a guest lecturer from the organization One Colorado in a course called Ethics in U.S. Healthcare back at my home institution in Boulder. According to One Colorado's website, the organization is described as "the state's leading advocacy organization dedicated to advancing equality for lesbian, gay, bisexual, transgender, and queer (LGBTQ) Coloradans and their families," (One Colorado, 2017). The guest lecturer identified as a trans-man himself and began the lecture with a story from his own experience with the healthcare system in Colorado to introduce various common modes of discrimination against the LGBTQ community in Colorado through the health care system. He said knowledge about transgender health and transgender issues among healthcare providers is very slim and more often than not, transgender individuals avoid going to the doctor's office altogether for fear of being discriminated against by their health care provider.

I took this course a year ago, and since then, I have attended several LGBTQ conferences with panels on how to improve the health of trans-individuals and repeatedly, stories of personal experiences with obstacles faced when seeking health care were brought up trans-identifying speakers. Following a lecture at SIT on this same topic with Principle 17, my advisor, Bear Silver, shared a story in which they had gone to their general practitioner in the Netherlands for a broken finger, and upon the disclosure of their trans-identity, and instead of treating Bear's broken finger, the provider redirected the entire appointment to discuss their being trans. With this story, it occurred to me that similar forms of discrimination may exist in within the Dutch healthcare system as well. And What Bear's story, the speak from One Colorado, and the countless conference speakers revealed to me, was the power of personal accounts of discrimination from the receiver, especially in the absence of data. So, given this context, I

decided the method of oral history would be the best way to approach my research question, and would be the best place to begin to approach the health disparities felt by transgender individuals. There are a few reasons why the use of oral histories would better answer my research question over qualitative research, surveys, or a case study: They leave room for shared information not planned by the interviewer; they allow for follow up questions and further clarification; they provide a platform for informative answers filled with more detail; and interviews can be catered to the individual's experience.

### **B. Interviewee Recruitment**

Those who participated in the interviews for this research were recruited through inner connections to the SIT office in Amsterdam.

### **C. Positionality**

Walking into this research project, I made sure to be hyper aware of my positionality at all times. First and foremost, I am cisgender. I am white, middle-class, heterosexual, American, and a woman. I am not unaware of the privilege I am granted when walking through public spaces presenting as binary. I pass as a woman, and I feel most myself when performing gender femininely. This means I have never walked into a health care facility and experienced any form of discrimination due to my gender identity from a healthcare provider. It also means that I do not experience micro-aggressions on a daily basis for my gender identity or experience the stresses that come with the status of identifying with a minority group. I have spent the better part of my life surrounded by those very similar to me, a city primarily white, middle to upper class, and heterosexual. I have always experienced the privilege of using my first language everywhere I go at home. I have a background working in healthcare both as a nurse's aid and as a certified medication administration person in hospitals and skilled nursing facilities. My studies

have also primarily been in pre-health. So, although I have never working with transgender patients, I understand I come into this research with more experience from the care providing side than the patient side. And I can also attest to never discussing nor receiving training on the care or the issues of potential transgender patients. In fact through my anatomy, physiology, and nurse's aid certification courses, we never discussed the topic of gender nor non-binary bodies.

All of these aspects of my identity, I knew, had the potential of creating an unequal power dynamic between the interviewee and myself. I kept this in mind when writing questions I would ask, and prior to conducting any interviews, I did my best to account for this dynamic by approving my interview guide with both the director of the SIT program, and with my advisor Bear, who identifies as trans themselves.

As a researcher, I realize I have the power to start the interview but also stop the interview at any time; I know it is my responsibility to gage the emotional distress I am causing; I must be mindful of triggers because people may have experienced a lot of trauma with the healthcare system. I also realize this is my first time doing qualitative human research, so I let them know, and reminded them the interview process could be stopped at any time.

I also took into account the power I have as a researcher when someone shares private, possibly sensitive information with me. To address this, I ensured I would protect their identity when reporting my reach through anonymity and that the interviewee could trust I would keep any information shared private.

#### **D. Ethics**

To ensure I conducted this research in an ethical manner, I approved my interview question guide with SIT staff members and my methodology was reviewed and approved by the local review board of SIT. Prior to conducting interviews, I verbally assured participants the interview could be stopped at any time. I asked if they preferred I keep their identities anonymous

in the report of my research. And while conducting interviews, I prepared myself to the best of my ability, to watch for signs of emotional distress from my interviewees via body language and verbal cues. Though this step was not needed, in the case of emotional stress, I planned to offer a break and remind the participants the interview could be stopped at any time.

## **Findings and Analysis**

### **A. Interview Participants**

The two interview participants are both involved in activism and education regarding LGBTQ topics in the Netherlands. To ensure their anonymity, I use alias names intended to be gender neutral as well as “they/them” pronouns. I refer to Participant #1 as Jesse and Participant



#2 as Alex. Both participants grew up in the Netherlands. There is an age gap between the two participants; The participant I refer to as Jesse is an older adult and the participant I refer to as Alex is younger, more middle aged. They both identify under the umbrella term “trans” or nonbinary.

## **B. Mis-gendering**

Repeatedly throughout my interview with Jesse, they shared personal stories of being mis-gendered by various members of medical teams during their non-trans related visits throughout their life: everyone from administrative personnel, to nurses, to doctors. The first story they shared was during a visit to a dentist’s office about ten years ago,

“I went to the academic center where students are trained to work with patients, dentists students of third year and later, study is five years. Because I identified as non-binary, I always got called by my insurance gender which, of course, never is the one I really inhabit, and it had been problematic for me in that sense: My paperwork being different than my expression, my presentation being really different. And it depends, every time you get someone else calling you.”

They continued,

“Sometimes it was okay and I had a good experience. I had a couple of good experiences recently, in the hospital where I told them, stop this Miss or Mr, just call me by my first name or my first name and my family name, because that gender thing just doesn’t work. ‘Okay!’ They just wrote my full name on the whiteboard...Until someone else doesn’t get it or is not involved in that part. Just calling patients because their shift started later or so and I’m not on the board or not yet on the board and they don’t try.”

On one occasion,

“In my GP’s office it was pretty easy, half a year ago, I asked is there a field for first name in your records? Yes we do, ah! Yes we do!, then in that case could you please change my name? Yes of course! And I explained my name and my GP immediately had a laughing fit, but a good one, and said that’s original! That’s a good way! ...He said that’s original! There’s no way I’m going to forget this!”

Their GP still keeps Jesse’s legal name of file, but the solution has worked thus far.

### *Educating Providers on Pronoun Usage*

When referring to the experience of being mis-gendered over and over again, Jesse says, “That’s insulting. That is painful.” Though, sometimes it is possible for the transgender patient to educate the person who mis-genders them, mis-gendering can be one of the first forms of discrimination a transgender person faces when seeking general healthcare. When responding to being mis-gendered, Jesse says,

“My answer depends. Sometimes I just say like, ‘No, you’re wrong. Yes, I am the one you are looking for, but, it is not Mr., it’s not Ms. either.’ Which confuses them. And indeed when you’re having a medical issue, you don’t always feel after educating them, like going to the assistance office window and saying ‘Hey, just wanted to advise you to warn you in advance, that if you call me this way, I may not react.’ I’ve done it a couple of times, but then also you get tired of it. Emotionally tired of it that is.”

As reported in *Discrimination and Delayed Health Care Among Transgender Women and Men*, 30.8% of transgender participants delayed or did not seek needed health care at all due to discrimination in healthcare settings. And of that 30.8%, “respondents who had to teach health care providers about transgender people were 4 times more likely to delay needed health care due to discrimination”( Jaffee, 2016). The experience of Jesse suggests this kind of education surrounding the usage of proper pronouns might reflect the findings of Jaffee’s study.

### *Discrimination Behind Improper Pronoun Usage*

Not only can the education aspect itself distract from the issue a trans-patient has come in for, but is possible upon reviewing the previously mentioned literature, that the discriminatory aspect of mis-gendering can also act as a barrier to accessing future healthcare. In *Discrimination and Delayed Health Care Among Transgender Women and Men*, Jaffee claims,

“For stigmatized minority groups, experiencing discrimination when seeking health care may be one such health system contextual factor and a contributing factor to satisfaction,

and in fact, discrimination is one of many factors significantly associated with health care utilization. Previous research has shown that those who perceived discrimination by their health care provider based on race/ethnicity were more likely to put off getting needed medical care than those who did not feel discrimination. This is also true for lesbian women. Others have found that lesbian, gay, and bisexual individuals are less likely to seek needed care compared with heterosexual individuals and are more likely to use the emergency room for medical care compared with others,” (Jaffey, 2016).

### *How Improper Pronoun Usage Reflects Lack of Cultural Competence*

Jesse explained, unfortunately, mis-gendering is very common occurrence, especially when visiting healthcare providers outside of the gender team, hugely because all medical identification forms are constructed using the binary code. Healthcare providers usually obtain gender identification information from health insurance forms and the gender marker listed on your health insurance forms are based on your legal gender. Even if someone were to try to change their gender identification on their medical forms, “as soon as it’s changed, it gets changed back after a month if it’s not a legal change.” They said, “You cannot autonomously change your registration. You can with health insurance, but it gets changed back automatically, because of a coupling of data. Your basic personal data profile is being exchanged with a couple of service providers; one of them the health insurance companies...but your gender marker is always a part of the limited set. We are in the process of getting that changed because we know there are levels of subscription. ” But Alex argued all progress away from the rigid binary approach is slow because the whole healthcare system is decorated in such a way to favor binary individuals.

To refresh, “Cultural competency refers to 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,

2015). And cultural competency with respect to the treatment of transgender health care users is an understanding of ,

“the complex array of identities and expressions that transgender and gender-nonconforming people represent. This includes people who identify as male or female as well as people who identify as something between or beyond male and female. It is also important to understand the various ways in which trans and gender-nonconforming people want to be addressed and to be equipped to successfully navigate appropriate name and pronoun use. Also key is the ability to respectfully obtain this information when it is unclear what is appropriate and to recover gracefully when a mistake is made,” (Wilkinson, 2014).

I would argue knowledge regarding the importance of proper pronoun usage especially for transgender folks is a component at the heart of trans-specific cultural competency. With regards to using proper pronouns, it would include an understanding of how painful it is to be mis-gendered and an idea of how often transgender individuals are likely mis-gendered due to a consciousness of the extent to which society is binarily constructed. Also, if a provider is forced to use documents and forms in their office, it would include a responsibility on the provider to personally ask the health care user for the the pronouns they prefer for identification.

### **C. Transgender Treated as a Pathology**

Another major obstacle that trans people face accessing the highest form of healthcare available in non-transitional related settings in the Netherlands, is the misunderstanding of transgender as a pathology. Poteat argues, “Understanding how stigma and discrimination manifest and function in health care encounters is critical to addressing health disparities for transgender people. In order for change to take place, this understanding must take into account both provider and patient perspectives on the health care encounter,”(Poteat, 2013). Due to the stigmatizing nature of pathologizing an aspect of your identity as central to your well being as gender, I found it important to investigate the reasons behind pathologizing.

### *How Pathologizing Transgender Reflects Lack of Cultural Competence*

One reason for this, is how being transgender is defined medically. With their organization and the help of other organizations, Jesse spent a portion of their earlier work in activism involved in the process of changing the international classification of disease to depathologize the definition of being transgender. Though “gender identity disorder” is now “gender dysphoria”, and the definition has been altered, in the context of healthcare, Jesse says providers are saying “‘We know you’re in the DSM so there is some mental health issue with you but not for being trans.’ And the DSM is not clear on this.” Comparing the two definitions they said, “to put it simple, the label on the mailbox has changed, but the mailbox is still the same mailbox. There are a couple of slight rephrasings but it’s very minor.” Because of this misinterpretation of gender dysphoria as a disease in itself, rather than a phenomenon experienced by the individual, mental health data is interpreted by medical professionals as reinforcing the pathological definition. For example Jesse says the, “lense is not wrong it’s just out of focus. It’s not untrue there are mental health issues, it’s not untrue that many transgender people have mental health issues like depression, anxiety, suicidality. That is true, but it serves no direct relation to being gender diverse.” These things like depression, “By default, 40% of cisgender youth is depressed and thirteen to thirty five, the population is depressed. We get our depression partly from different things...But, with those other people, 40% most of them are depressed because of expectations from outside society that you internalize. It’s minority stress, which is a specific form but, this is what is happening.”

Another reason has to do with the monopoly of transgender care by the VU. Jesse explained, “ Because the lense being, The Transgender Amsterdam Team lense, professionals

mostly look through that lense: through a pathologizing lense.... these non-transgender knowledgeable professionals because having this default gaze, using the VU lense, they treat people as being pathologized, as trans being a pathology in itself.”

Because cultural competency is absent in the medical approach to the care of transgender individuals, the perspective of the gender clinics, and medical school training in the Netherlands, the understanding of transgender as a disease therefore reflects this deficit in knowledge as well. As Alex pointed out, “doctors are just like people. Its often said, medicine or science of medicine is objective and I beg to differ. I think it’s very subjective. Science in general is made by humans and you do notice that too when it comes to doctors or healthcare providers. You know, they take their own positionality into their work.” To elaborate on this same idea, Jesse said, healthcare professionals are “just Dutch citizens. They see what’s on television. They see what appears in the newspaper and medical reviews don’t tell that much about it. So... they have the regular audience view on trans people.”

### *Discrimination Behind Pathologizing Transgender*

The findings of Poteat’s study pose maybe the most important rationale behind pathologizing, that “interpersonal stigma also functions to reinforce medical power and authority in the face of provider uncertainty.” They argue “Within functional theories of stigma, it is important to acknowledge the role of power and to understand how stigmatizing attitudes function to maintain systems of inequality that contribute to health disparities,”(Poteat, 2013). What is so inherently problematic about this relationship, the diagnosis process of gender dysphoria, and the treatment of transgender as a disease Alex pointed out, is, it forces

transgender individuals into a position of dependency on other people for your own wellbeing, confidence, and sense of self. Some people, they said,

“think this is the only possibility, so they kind of accept it and take it. But, it just puts you in such a dependent position and I think some people don’t even notice that, which in itself is really not okay. You’re basically waiting for the doctor, the hierarchical system to grant you permission and a lot of people really do see those doctors as their ‘saviors’ to say it in a dramatic way. And i really really think that’s the wrong way around.”

Whether pathologizing is due to a lack of cultural competency or is used manipulatively to establish the power, when pathologizing produces stigma it becomes a form of discrimination. And if treating the transgender identity as a disease is discriminating against transgender healthcare users like other forms of discrimination included in Jaffee’s findings, pathologizing, may also become an obstacle to the right to healthcare when it leads to delayed or avoided care.

#### **D. Due to the “Transgender Label, Physicians do not Carry Out Routine Treatments**

A third obstacle when seeking the right to healthcare is also due to uneducated healthcare providers. Both interviewees said it is not uncommon for the doctor’s individual agenda to become an obstacle to the general health care transgender people receive. My advisor did a presentation early in my semester studying with SIT on Trans Issues and Human Rights and they shared an experience in which they visited their healthcare provider, a general practitioner, for a broken finger, and the practitioner, upon learning my advisor was transgender, directed the focus of the appointment away from the treatment of the broken finger and referred them to the gender clinic. On the topic of how general practitioners treat transgender patients for non-trans related visits, both of the activists I interviewed spoke to similar stories of personal experience or fellow transgender people they knew. For example, Jesse said,

“These non transgender knowledgeable medical professionals, because having this default gaze, using the VU lense, they treat people, being pathologized, trans being a pathology in itself...Which means, say you go to your orthopedian, you come with a broken elbow and your hips are not aligned right. So you go to an orthopedian and they know you are a trans person because you look that way or you kind of identify differently from your papers, and they are not knowledgable and it has not been changed. Or for some other reason they think you are a trans person or they see you are a trans person and then, click, immediately the default gaze kicks in. Yes it still happens that such a doctor, such an orthopedian says, ‘Yes, I know you have issues with your hips and your elbow but you are a trans person and we have a team for that.... I cannot help you because *trans*.’”

In Alex’s case, they told me about a friend’s experience with this kind of pattern,

“He went into the doctor for, I think it was like, something completely unrelated to anything transgender, and the doctor kept asking him gender related questions. And he was like ‘I’m here for a,’ you know, whatever, ‘bladder infection,’ I don’t even know if that was it, ‘it has nothing to do with me taking hormones.’... But that happens a lot, that they also link everything to your medical transition”

#### *Discrimination Due to the Identity Label, “Transgender” and the Gap in Cultural Competency*

Whether the healthcare provider is turning the patient away, referring the patient to a specialist, or monopolizing the appointment with their curiosity with the patient’s identity, when a provider chooses not to provide routine treatment they provide to other health care users, the choice constitutes as unequal treatment. To reiterate the findings of Jaffee’s study, one way the transgender population in the U.S. is likely affected by discrimination in the healthcare field is through the denial of equal treatment in healthcare offices. As a result they are, “less likely to have a regular healthcare provider or to have had a health check up in the last 12 months compared to non-transgender survey participants,” (Jaffee, 2016). Once again, this kind of treatment can be linked to the gap in knowledge surrounding transgender issues. Within this theme, trans-specific cultural competency would entail an anatomical, medical understanding of the relationship or lack thereof between gender affiliation and various systems of the body.



For example, specific to Jesse and Alex's comments, the relationship between the healthcare user being transgender and how to treat a broken bone; Or the relationship between receiving trans-specific hormone therapy, and how to treat a urinary tract infection.

### *How Unequal Treatment leads to a Breach in Trust*

This kind of unequal treatment disrupts the health care user's trust in their physician. To reference Poteat, transgender health care users anticipate health care providers will be ill-prepared to respond to their needs when experiencing medical encounters in which health care providers are uncertain and ambivalent about how to care for the patient. They describe this precise form of discrimination experienced in health care then, directly influences transgender people's utilization and access to health care, (Poteat, 2013).

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### **E. Placement of Curiosity in the Wrong Place**

Along this same vein in which general practitioners lose sight of the intention of the visit in a non-trans related appointment, both interviewees explained, in some instances, the doctor's curiosity can stand in the way of accessing care. For example, Jesse explained,

“We know of med professionals in transition health care who want to know more about your the layout of how your sex is being constructed, the four categories of it: the chromosomes, your hormones, your gonads, and your genitals. That is only for endocrinology and for surgery bears any relevance. And then the relevance is chromosomes and hormones for your endocrinologist, and for the surgeons, only genitals and sometimes also gonads... and we know of too many healthcare providers being sort of curious. From complaints, we know of even at the gender team or at the gender team

hospital, some medical professional being too curious, and then touching the patient inappropriately...It happens everywhere and surely it happens when you are labeled or seen as a female. Below this transphobia lies misogyny. And also we still know there are armies of medical professionals who are treating women different than men. The you kind of are at an advantage when you ascend the social ladder as transmasculine as long as it has nothing to do with down there and you've had top surgery. But you are disadvantaged when you are a trans woman and you are transitioning from male to female. That is transmisogyny."

Alex said when physicians do this, "Sometimes it's curiosity. But then, it's not the place to do that with the quote-on-quote patient there. You're curious which is a good thing, you should seek courses or information elsewhere, and not with the patient."

Later when referring to personal experience with being treated as a spectacle in the train with a conductor they said, "there is a curiosity there, that is not in itself a bad thing, but it's just where they place it that is often very awkward and uncomfortable."

In a conversation I observed during my time in the Netherlands, a trans identifying person also told me they know friends who are afraid they may get "felt-up" by their physician during a doctor's visit.

### *Curiosity as Discrimination*

Of course as Jesse mentioned, in extreme cases in which patients are unnecessarily and inappropriately touched or examined by their providers, curiosity obviously becomes a form of discrimination via harassment or abuse and breaches the trust between provider and health care user.

But Alex also points out, in less extreme cases, curiosity does not have to be intentionally harmful, but, treating someone as a spectacle is hurtful and dehumanizing. Alex describes this kind of treatment by a provider in this way,

"If you do disclose that you're trans, it always makes you the other in a way so you are really also kind of treated as the other and that doesn't necessarily have to be malicious or anything but you do feel that because it's something that they don't really understand

from their personal experience of course, or from their medical training. So that kind of boundary you at least always feel.”

When referring to their personal experience with this kind of spectacle-ization, they compared curiosity in healthcare settings to outside the office, “Not even healthcare particularly practitioners. I had it in the train conductor asking me all these questions. There is a curiosity there, that is not in itself a bad thing, but it’s just where they place it that is often very awkward and uncomfortable”

. For transgender individuals, this uncomfortableness, discrimination via curiosity is universal to all settings. When it happens to them in spaces like the queer medical center they visit, they respond, “when I am the patient or the person who is seeking help, I am not there to answer questions.”

### *Curiosity as Lack of Cultural Competency*

In Willy Wilkinson’s definition of cultural competency as it relates to transgender individuals, cultural competency not only entails a rounded understanding of various aspects of gender, but an understanding of how transgender individuals face struggles in other aspects of society. An understanding of the painful repercussions of “othering” or treating a health care user as a spectacle would be an essential piece of this kind of competency.

For example, an observation of a conversation I shared with a young dutch cisgender woman while I was studying in Amsterdam displays this point well. To be clear, this was not a formal interview, but I was given verbal permission to use this conversation in this research paper. When I first spoke with this woman about transgender people, she told me she did not believe that transgender people exist in the Netherlands. She went on to tell me she did not

understand what transgender meant. I described to her, it was an umbrella term to describe any individual who experiences, identifies, or expresses their gender in a different way than the sex assigned at birth. She then proceeded to tell me eagerly about how she had seen “one of these people” at the store while shopping. She said she could tell they “looked like a girl” and they were wearing “beautiful makeup” but she could tell they “used to be a boy.” She wanted to ask them “what they were,” but her friend told her it was rude to ask questions like these. She said, in the future, she was excited to see one of “these people” again, just to see what they look like. The next day, during a separate conversation, she told me she still did not understand “what a transgender is.”

#### **F. Educating Your Physician on Your Own Care**

Bear and both of the activists emphasized a major gap in knowledge, when it comes to how informed general practitioners are on trans issues and trans care in the Netherlands. All three of them also have experience with educating their own physicians. Alex says “It is common that you as quote-on-quote patient are teaching your GP what trans issues are. That happens a lot.” On their own experience with this, said, “I made it my job, so in a sense that’s my own choice, however indeed when I am the patient or the person that’s seeking help I am not there to answer questions. It even happens at the VU medical center. Where they asked me for advice or an explanation or whatever. So I do have that experience.” They went on to explain, one of the biggest issues at the VU when it comes to education of care providers, is the inconsistency of education from provider to provider,

“The situation is as follows there, you get appointed a therapist, you don’t have a choice in that yourself. Basically what happens then is either you are lucky because some do have you know the accurate knowledge and are up to speed and understand non-binary you know, have a sociological approach so for some people it’s a really pleasant

experience too. You know they feel seen and heard. And if you're not lucky, then you either have someone who is still learning and is trying to take you on that journey or you have somebody who is just very binary and will not change their perspective. That's the tricky thing there is that it's very individual, basically you are lucky or you're not. And that of course is not okay."

This inconsistency is not unique to trans-specific care alone. On the topic of the knowledge basis of trans issues and care among general practitioners, Alex says, because there are so few general education courses offered in the Dutch context to health care providers on the topic, "there is very little knowledge. It really depends on that individual GP to do his or her own research and some really do. Some people really take their first trans patient as a moment of realization, 'I do not know anything, I really need to educate myself.' ...Others are kind of oblivious, others are very stuck in their binary system. It's very individual."

Based on an observation during a meeting with my advisor, I was told doctors have to educate themselves if they want to know about transitional care or trans topics. They described they have presented their doctor with a stack of literature and articles and their doctor refused to read it. But mentioned they have to want to do the learning themselves if they want to know. Alex confirmed medical schools in the Netherlands are especially doing a poor job of addressing transgender topics. "It's very disappointing," they said. A priority of Alex's organization is to develop education modules on trans care for physicians. Jesse says the discrimination stems from, "Prejudice. it's all lack of knowledge, lack of cultural competence which is not taught... And actually transgender diversity cultural competence is hardly taught about in the Netherlands."

Jesse explained the coverage of transgender topics in medical schools in the Netherlands as such,

"There are some workshops for sexologists sometimes for medical students, some people do that... It's sometimes through elective modules it is addressed because one or two trans doctors are then helping them out. But then against that's a very recent development and thought they do know what they're talking about I'm not sure it falls on .. ground

because you need to have cultural competence and interracial cultural competence is not taught that well, let alone gender diversity. We have quite a lot of issues with that, and then of course, that translates to the theme we are talking about non-transgender related health care. Because the lens being the transgender amsterdam team lens is professionals mostly look through that lens through a pathologizing lens.”

Jesse says due to the this failure, trans patients have to educate and inform their practitioners all the time.

“Some trans people can some trans people can’t. A couple of us know our way or have enough context so we can find the right articles from medical journals like *The Journal of Endocrinology* or something, or from transgender related healthcare review so we can come up with two important articles. This is state of the art. You are the professionals so you can check it out. Use your knowledge and see this is state of the art, or gloss it over and see that this is irregular, get educated read it again more thoroughly, more closely, and then decide to help us. But that doesn’t happen too often because on the one hand the gender team in amsterdam say ‘No refer your patient to us.’ On the other hand, just lack of knowledge because it’s not part of your regular medical education.”

#### *When Educating Your Provider Becomes a Barrier to Healthcare*

The findings of *Discrimination and Delayed Health Care Among Transgender Women and Men* suggest the possibility that these kinds of encounters might function as barriers to healthcare for trans individuals in the Netherlands in the same way they do in the United States. To refresh, the study found of the 30.8% transgender participants who delayed or did not seek needed health care at all due to discrimination in healthcare settings, “respondents who had to teach health care providers about transgender people were 4 times more likely to delay needed health care due to discrimination”( Jaffee, 2016).

#### **G. When in Doubt, General Practitioners Contact the VU**

Technically, when it comes to the prescription of hormones, though it falls within a general practitioner’s scope of practice in the Netherlands, Jesse says, “your GP usually is not knowledgeable about all the details that hormone therapy can give.” Jesse explained the

monopoly the KcGZ holds on trans-specific care bleeds into the general care of trans folks as well, as the KcGZ is considered the only trans-care resource providers have access to in the Netherlands. Jesse said “There’s roughly one lense available because the gender team has been appointed by the ministry of public health to be the expert and healthcare center for trans health....And because there is only one knowledge center, everybody, when in doubt has a question, goes there.” On a side note, though I did not investigate further, it may be important to mention, despite this status, according to research done by a colleague of Jesse, the KcGZ technically does not even exist as an official legal entity. A second dimension to the monopoly the KcGZ has on information regarding gender dysphoria, is typically when a physician calls the gender team for advice or a specialist referral, the gender team will insist the doctor transfer the care of the patient to the gender team. Jesse describes, such an encounter usually plays out like this, “If a general practitioner calls and they’re like, ‘Hey we got a trans healthcare user in our office and we’ve done some blood checks, we just want to know, just want to verify one or two details with you, can I speak to one of your endocrinologists?’” The gender team will respond, “No you must stop treating this person and refer them to us’ ....They tell them to ‘refer your patient to us’, they literally say that.” Jesse added, “ They even sometimes send letters to the GP saying, ‘If you continue treating this patient we stop treating them,’ because of no double treatment.”

As mentioned in the literature review, and throughout my interviews with both activists the perspective and the aim of the gender clinics in the Netherlands are extremely problematic, so when GPs begin to use them as a source of information, or hand them over altogether, rather than prescribing or monitoring hormones themselves, due to a lack of cultural competency and



proper medical training to feel the confidence to do so, the problematic protocol of the gender clinics bleeds into non-trans specific care.

## **Concluding Thoughts and Recommendations for the Future**

To reiterate what was stated earlier, due to the fact only two interviews were obtained in conducting this research, it would be inappropriate to draw generalizing conclusions in regards to answering the research question I investigated. While this is largely the case regarding each interviewee's personal experience with healthcare providers in the Netherlands as healthcare users, I believe due to the nature of both interviewee's experience with activism and education, in the sense that they have interacted with large numbers of transgender individuals, the information they provided should not be completely discounted or treated as case study information.

### **A. Future Research**

My findings would be best served in providing insight for future research to improve education on the care of transgender health care users, especially trans-related cultural competency in medical schools and health related career training. Also, due to the major gap in research on the topic of obstacles faced by transgender individuals in non-trans specific health care settings, I think this research also provides a strong argument for further research investigating this specific topic. To further specify, this would involve qualitative research with a diverse sample of transgender health care users, healthcare providers, those in charge of education on transgender topics or cultural competency, and possibly public health policy makers. I would argue the most necessary research needed would be qualitative research similar

to the two studies discussed in the literature review from Poteat and Jaffee, but focused in the Dutch context with the Dutch healthcare system.

## **B. Final Recommendations from Interviewees**

Though this problem cannot be solved overnight, in the meantime, to leave health care providers with some final recommendations, one of the research participants concluded, “A good health care provider looks at the person in front of them. They see their healthcare user as more than a collection of diagnosis or a living bag of illness. They see a, *person*, with a couple of issues. They listen to the person in front of them.”

And for transgender folks currently struggling with the current system in the Netherlands, the second participant advised to look into transitional care options outside of the gender clinics. They said, most people do not know these kinds of options exists. After having a challenging, negative experience with the gender clinic at the VU themselves, beginning with diagnosis, seeking hormone therapy and chest surgery, they decided to reach out to a physician practicing independently from the VU. They experienced drastically shorter waiting times and care from understanding and knowledgeable care providers.

## **Limitations**

### **A. Interviews**

The limitation most restricting to this research was the recruitment of interviewees.

Interviewees were initially recruited through networking within the transgender community with the help of my advisor, Bear and SIT staff member and assistant to director, Sabine. I wrote the following interviewee announcement which I and Sabine posted to a list of transgender related group pages on Facebook:

“Shout out to all trans folks in the Netherlands!

Hey there, my name is Nicole Sharpe. I am a student from the University of Colorado, Boulder studying international perspectives on gender and sexuality in the Netherlands with S.I.T. (School for International Training). I am conducting a research project on obstacles transgender individuals face when seeking general health care through the healthcare system in the Netherlands. More specifically, I am looking at non-transition specific care. The goal of this research project is to improve the healthcare system in the Netherlands as well as healthcare systems across the globe in hopes of making the right to the highest form of healthcare available to all transgender people. I would love to interview you about your experiences! If you are interested in getting involved, please email me at [nicole.sharpe@colorado.edu](mailto:nicole.sharpe@colorado.edu).”

Interviewees were also recruited with help from Bear at the Vrankrijk, an event venue that aims to create a safe queer space every Wednesday night through performances that celebrate visible queer cultural diversity. Upon introduction to each potential participant, I explained my research, the purpose, and ensured interviews could be done with complete anonymity.

In the end, after exhausting all resources available through SIT yielding no responses, the only participants I had the opportunity to interview were two educator/activists who have worked with SIT in the past.

When recruiting transgender interviewees, my advisor, Bear, and I both observed similar patterns in responses from potential participants. The first trans person I connected with at the Vrankrijk, was young, and reluctant to participate, stating, they only go to a doctor if they are “dying.” The second person I approached identified as trans and is also a student in medical school in the Netherlands. They told me they did not feel they had any relevant experience with my research topic, most specifically in their education. And two other people I spoke with told me they did not have any experience with this topic personally. My advisor shared with me, that in recruiting individuals, they also experienced this response, that people did not feel they had experienced obstacles when seeking healthcare for non-trans related problems.

I thought it important to note these themes as both Bear, a transgender activist and trans identifying man; and one of the activists I interviewed, believed these limitations to be of significance possibly for further research. I wanted to use this space to present possible explanations. Also to clarify, these are not explanations I received from potential interviewees themselves, they are simply hypotheses.

### *Research is not Advantageous to the Transgender Population*

One explanation, is transgender individuals in the Netherlands are skeptical about participating in research because as one of the activists I interviewed informed me, research involving transgender individuals usually does not work to benefit them, so there is no incentive to participate. So, they may be using the explanation that they have no experience with this topic

because they are not interested in getting involved in research at all. Along these same lines, from what I understand from American transgender healthcare users, negative experiences when seeking healthcare can be very sensitive and traumatic to discuss openly.

*They are Young and Healthy Enough They don't need to see a doctor*

Another explanation, is some of the people I asked at the Vrankrijk and many people involved in social media are very young, 18 to 20 year olds, and it is possible they do not have much experience with unequal treatment in their healthcare provider's office because they are healthy and rarely seek care. Or, when ill or injured, they can use an over-the-counter remedy. My advisor mentioned some people in the Netherlands prefer to see homeopathic specialists outside of the formal medical system.

*They don't realize what constitutes unequal treatment*

It is possible, the healthcare user sees a healthcare provider who is culturally competent, well informed on transgender issues, or treats them fairly, everytime they need medical assistance. But, it is also possible, if in the case the healthcare user is receiving unequal treatment, they are unaware of it or they do not feel empowered enough to do anything about it.

*Obstacles do not exist in the Netherlands for Transgender Individuals in Non-Trans Related Settings*

Of course, I do not want to discount the possibility that I investigated a phenomenon that does not exist. Thought, from speaking with my advisor and the two activists extensively on

these topics combined with the flaws in transition specific healthcare, I would argue, this explanation would prove false.

### *Medical School*

In the one instance when approaching the medical student, because they felt they did not have any experience with my research topic or transgender individuals, I believe this validates my earlier research on the curriculum of medical schools in the Netherlands. This response suggests, as a student, they have not been exposed to a discussion surrounding treating transgender healthcare users or topics related to trans-specific cultural competency.

### *My Positionality and Recruitment Method*

It is also possible, my positionality being an outsider to Dutch culture, American, and most importantly obviously cis-gender, participants may have felt skeptical about sharing personal, possibly traumatic experiences with me for fear of my intentions. I did not receive a single Facebook response which suggests the recruitment advertisement may have been too public or impersonal, or it possibly placed too much responsibility on the potential interviewee to participate.

## **B. Time**

Finally, it is important to mention, though I began recruiting interviewees online about two months prior to the formal ISP period, the ISP period was only four weeks. This places a lot of pressure to respond in a timely manner, especially through online recruitment methods including Facebook and emailing. And I felt, due to the sensitivity of the issue, when recruiting

interviewees in person, establishing a basis of trust, ethically, to be extremely important before inviting someone to participate.

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