Social Science & Medicine 110 (2014) 65–73

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

# Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination

Taylor M. Cruz

*Department of Social and Behavioral Sciences, University of California, San Francisco, 3333 California St, Suite #455, San Francisco, CA 94118, United States*

ARTICLE INFO

*Article history:*
Received 28 September 2013
Received in revised form
26 March 2014
Accepted 28 March 2014
Available online 29 March 2014

*Keywords:*
United States
Access to care
Transgender
Gender nonconforming
Stigma

ABSTRACT

Transgender and gender nonconforming people face stigma and discrimination from a wide variety of sources and through numerous social realms. Stigma and discrimination originating from biomedicine and health care provision may impact this group's access to primary care. Such stigma and discrimination may originate not only from direct events and past negative experiences, but also through medicine's role in providing treatments of transitioning, the development of formal diagnoses to provide access to such treatments, and the medical language used to describe this diverse group. This paper examines the postponement of primary curative care among this marginalized group of people by drawing from the National Transgender Discrimination Survey, one of the largest available datasets for this underserved group. This paper also proposes an innovate categorization system to account for differences in self-conceptualization and identity, which has been of considerable concern for transgender and gender nonconforming communities but remains underexplored in social and health research. Results suggest that experience, identity, state of transition, and disclosure of transgender or gender nonconforming status are associated with postponement due to discrimination. Other findings suggest that postponement associated with primary place of seeking care and health insurance has ties to both discrimination and affordability. These findings highlight the importance of combating stigma and discrimination generated from within or experienced at sites of biomedicine or health care provision in improving access to care for this group of people. Improving access to care for all gender variant people requires a critical evaluation of existing research practices and health care provision to ensure that care is tailored as needed to each person's perspective in relation to larger social processes.

## 1. Introduction

This paper seeks to explore access to care among transgender and gender nonconforming (trans and GNC) people through a quantitative analysis of primary care postponement. Trans and GNC people face stigma and discrimination across numerous areas of life, which shapes their social experiences and realities (Bradford et al., 2013; Bauer et al., 2009). Real or perceived stigma and discrimination originating from within biomedicine and health care provision may impact this marginalized group of people's access to care (Bockting et al., 2004; Cobos and Jones, 2009). Additionally, stigma and discrimination may be experienced differently among this diverse group of people along the lines of identity, experience, and social positioning (Lombardi, 2009; Lombardi et al., 2002). Given trans and GNC people's historically uneasy relationship with biomedicine due to social stigma originating from formal diagnoses and the barriers encountered in receiving hormones, surgeries, and other treatments of transition (Drescher et al., 2012), this group of people faces unique considerations in addressing access to primary care issues. However, newer forms of identification and organization among this group of people potentially pose new and different social relations toward health care providers and treatments of transitioning than those often described in existing medical discourse and research. The purpose of this study is two-fold: first, to define and incorporate what diversity means in this population in an adequate and comprehensive manner by introducing a new categorization scheme of difference, and second, to determine how such diversity impacts the postponement of care.

I begin by reviewing the literature on stigma, discrimination, and access to care for this group of people, and follow by describing differences among trans and GNC people along the lines of identity and experience. I then conduct regression analyses using data from the National Transgender Discrimination Survey to explore associations between these and other points of difference and

---

*E-mail address:* Taylor.Cruz@ucsf.edu.

http://dx.doi.org/10.1016/j.socscimed.2014.03.032
0277-9536/© 2014 Elsevier Ltd. All rights reserved.

postponement of primary curative care, including the reason provided for such postponement. Finally, I discuss implications of these findings for access to care among trans and GNC people and for health research with this group more broadly.

## 2. Definitions

Defining transgender has been fraught with difficulties for both trans and GNC communities and researchers alike. While early definitions usually required a gender identification "opposite" of that assigned at birth in line with transsexual conceptualizations, recent efforts also include people who simply identify as anything other than what they were assigned at birth (WPATH, 2011; Center of Excellence, 2011). As part of the study design for the data analyzed in this paper, the National Gay and Lesbian Task Force and the National Center for Transgender Equality use the terms transgender and gender nonconforming to refer to people whose gender identity or expression is different than that typically associated with their assigned sex at birth (Grant et al., 2011). This is the working definition that will be used throughout this paper. I also use the term gender variant interchangeably with trans and GNC: this includes both people who identify or live within existing sex/gender categories (i.e., as male or female) and those who identify outside of them.

Stigma has also been defined differently among researchers, with some emphasizing deviation from the norm more so than the discrimination that results from such stigma (Link and Phelan, 2001). In Link and Phelan's (2006) work on stigma and public health interventions, they propose that stigma contains several key components, including the process of labeling others via points of difference, stereotyping others through such point of difference, discriminating against and devaluing others through these stereotypes, and exercising power such that these actions and beliefs maintain substantial cultural and political hold on the lives of others. In this paper, I use stigma and discrimination together to emphasize that stigma may manifest through discrimination.

## 3. Stigma, discrimination, and access to care

Trans and GNC people face stigma and discrimination across numerous social realms (Bradford et al., 2013; Bauer et al., 2009). Gender variant people often experience barriers in securing stable employment, housing, education, and legal protection (Nemoto et al., 2005; Xavier et al., 2007; Monro, 2005; Kenagy, 2005). Additionally, trans and GNC people face challenges in public spaces and in accessing social services (Nemoto et al., 2005; Bauer et al., 2009). These barriers and challenges stem from the stigma and discrimination directed toward trans and GNC people from society, in which these people are socially punished for transgressing normative gender expectations based on assigned sex.

Goffman's (1963) influential work on stigma posited that stigmatization is inherently a social process in which people experience marginalization due to a perceptible point of difference that is placed onto them. Link and Phelan (2001, 2006) expand upon Goffman by bringing stigma in conversation with public health. These authors contend most research on stigma has focused on micro level interactions, such as the process of stereotyping, rather than at the macro structural level, where processes of grouping and labeling originate. Link and Phelan (2006) argue that stigma and discrimination may be experienced through three distinct forms: direct discrimination, such as the outward rejection of a group of people; structural discrimination, such as the preference for certain groups due to social organization and networks; and internal discrimination, such as the feelings and beliefs stigmatized individuals may hold toward themselves or that they recognize others place onto them that shape their behaviors and interactions. Thus, stigma and discrimination targeted toward trans and GNC people may operate at different levels; the severity of this issue is magnified considering all of the social realms through which this may occur.

Few studies have sought to assess differences among trans and GNC people in experiencing discrimination. Lombardi (2009) found that those who transitioned under the age of 30 were more likely to experience discrimination than those who transitioned after 30. Transition was defined as the point in which the participant began presenting as male for those designated female at birth or female for those designated male. Other factors, including lower income and level of being out, were positively associated with recent experience of discrimination. In a previous study, Lombardi and co-authors (2002) found that being non-heterosexual, low income, and identifying as transsexual was associated with higher odds of experiencing economic discrimination. Furthermore, being younger, identifying as transsexual, and experiencing economic discrimination all served as predictors of experiencing violence, a form of direct discrimination. This research suggests that there may be important differences among trans and GNC people to consider in assessing discrimination.

Prior to discussing stigma and discrimination's connection to access to care, access must first be conceptualized. Levesque and co-authors' (2013) systematic review of access to care identifies five different aspects of accessibility: approachability, acceptability, availability, affordability, and appropriateness. For each case seeking care, for example, the individual must know that the service exists, must engage in social and cultural factors that shape the service and its structure (such as beliefs associated with a practice or practitioners providing the care), must be able to reach the service physically in a timely manner, must be able to afford the service, and must believe that the service fits the need. Furthermore, characteristics of the health care delivery system, characteristics of the population at hand, current health policy, type and quality of care of interest, and patient perceptions also influence issues of access (Aday and Andersen, 1974).

Existing research on access to care issues among the general population suggests that the postponement of care is associated with perceptions of limited access to care. Cunningham and Felland (2008) report that approximately 20% of the United States population did not receive or delayed seeking needed medical care in 2007, with this figure having steadily increased since 2003. The CDC estimated that 9% of the United States population delayed seeking needed medical care in the year 2008 due to cost alone (Adams et al., 2009). Those with the worst health conditions were more likely to delay seeking care than those with the best health conditions, further exacerbating health disparities (Adams et al., 2009; Diamant et al., 2004). Additionally, perceptions of poor access to medical care are correlated with higher rates of hospitalizations, and difficulties in receiving care have been suggested to contribute to deterioration in health (Bindman et al., 1995). Other research suggests that patient trust that a physician will act in the patient's best interest and patient delay in seeking needed care are inversely related (Mollborn et al., 2005).

These issues are of considerable importance for trans and GNC people and their experiences. Difficulties in accessing treatments of transitioning (i.e., hormones or surgery) have created the perception of providers as gate-keepers among trans and GNC people (Bockting et al., 2004; Cobos and Jones, 2009). The process through which people must engage with medical systems in order to modify their bodies has been critiqued as undermining trans and GNC people's own autonomy, and more recent efforts have sought to set forth newer models of accessing this form of care (WPATH, 2011; ICATH, n.d.). However, others have argued that formal diagnoses inherently pathologize trans and GNC experiences, despite playing a crucial role in the provision of care (Drescher, 2010; Drescher et al., 2012). These issues undoubtedly shape trans and GNC people's concern with the role that medicine plays in determining their lives beyond patient-provider interactions through the above concepts of acceptability and appropriateness.

Bauer and co-authors (2009) highlight challenges that transgender patients face within the context of a health care setting. Encounters with health care providers, provider knowledge regarding trans and GNC issues, and institutional erasure all contribute to patients' perceptions of medicine and shape barriers to the provision of care. Providers themselves were found to be not well-equipped to provide competent care for trans and GNC patients (Snelgrove et al., 2012; Poteat et al., 2013). Physicians were not knowledgeable about transgender health, did not know where to turn to for needed knowledge, and had difficulty making referrals to other competent providers. Transgender health issues are rarely incorporated into medical school curricula, thus further rendering physicians poorly equipped to provide care to trans and GNC people (Sequeira et al., 2012; Stoddard et al., 2011). These findings suggest that stigma and discrimination manifest within the realm of health care provision for trans and GNC people across multiple levels, shaping their access to care.

## 4. Transgender activism and diversity

The birth of transgender activism in the late 1990s served to counter the stigma and discrimination faced by trans and GNC people, whether in relation to medicine or beyond (Stryker, 2008). Organizing among this diverse group of people proved itself to reveal important differences among trans and GNC people in their own self-conceptualizations. Davidson's (2007) extensive qualitative work on transgender activism identified two groups of people. The first group, described as transsexual separatists, primarily sees itself as a collection of transgender men and women, and is portrayed as primarily concerned with seeking treatments of transitioning and recognition as men and women. The second group, described as genderqueer, is more interested in transcending the sex/gender binary of male versus female. This may include using and preferring non-traditional pronouns (i.e., singular they, ze/hir), alternating and combining gender presentations on a regular basis, and embracing an “other” category of gender rather than switching over to male or female. Other work also noted these differences (Roen, 2002; Monro, 2005).

This question of identification has been a central concern for trans and GNC people. Popular accounts of trans and GNC experience reflect both of these conceptualizations (Bornstein and Bear Bergman, 2010; Nestle et al., 2002; Serano, 2007). Some have sought to bridge these tensions to move beyond a binary distinction of transsexual versus queer approaches (Hines, 2006). Namaste (2005), on the other hand, argues that a broad definition of transgender serves to erase the experience of transsexuals, who often seek to medically transition from one gender to the other and have unique needs. At the same time, some of Davidson's (2007) gender variant participants reported being excluded from transgender spaces and organizing for “not being trans enough,” such as not fitting the stricter criteria that others set forth as a requisite for belonging. These tensions may have considerable implications in studying trans and GNC people. Different groups of people may have different social networks, different language, different goals, as well as different relationships to biomedicine and health care, especially in relation to transitioning.

These differences, however, are rarely given adequate attention within medical and health services research. Trans and GNC people are often only divided along the lines of sex designated at birth, such that this group is divided into “MTF” (male-to-female, trans women) and “FTM” (female-to-male, trans men) people. A review of research on transgender health and HIV conducted by Melendez and co-authors (2006), for example, categorizes other research as focused on either MTFs or FTMs. A meta-analysis assessing HIV prevalence among transgender people similarly divides trans and GNC people this way (Herbst et al., 2008). These reviews also highlight that the majority of research has focused on those designated male at birth (Melendez et al., 2006; Herbst et al., 2008; Rachlin et al., 2008). This approach fails to adequately consider differences in defining transgender among researchers (Davidson, 2007). When used without explanation, MTF may refer strictly to transsexual women concerned with accessing medical treatment and living as women. It may also refer to any trans and GNC people designated male at birth, including other gender variant people. Potential differences are obscured in only considering sex designated at birth as a salient point of difference among trans and GNC people.

One study, however, did choose to incorporate these considerations throughout the research process. In their analysis of the health needs of transgender and gender nonconforming people, Irwin and co-authors (2012) categorize participants as trans women, trans men, or genderqueer/gender nonconforming, finding that a greater proportion of trans men reported binge drinking than trans women or genderqueer people. However, the categorization scheme used in this research combined genderqueer people designated male at birth with those designated female, most likely due to small sample sizes (Irwin et al., 2012). This may gloss over differences within this group that may be tied to experience in transcending gender from a particular body type. There may indeed be similarities between transsexual and genderqueer people designated male at birth, for example, especially if they are subjected to similar experiences. Separating out differences between self-conceptualization and sex designated at birth allows for research to explore differences and similarities between groups. Without this consideration, differences among trans and GNC people remain obscured within social and health research.

Little to no research has quantitatively assessed access to primary care among this marginalized population. Furthermore, no quantitative research has adequately explored the importance of both identity and sex designated at birth. This paper then contributes to the literature on access to care for transgender and gender nonconforming people by exploring how diversity, stigma, and discrimination may inform the postponement of primary curative care.

## 5. Methods

The current study draws upon the National Transgender Discrimination Survey (NTDS), which was a joint collaboration between the National Center for Transgender Equality and the National Gay and Lesbian Task Force. Data were collected between September 2008 and March 2009. The NTDS dataset represents one of the largest datasets on trans and GNC people, collecting over 6,000 valid responses and thus providing greater statistical power for analysis than other sources. One of the main barriers in researching trans and GNC health issues is the availability of data due to the hard-to-reach nature of this population and limited funding (Melendez et al., 2006). Although convenience sampling was used, researchers have noted the difficulties in employing other sampling methods with this marginalized group of people (Melendez et al., 2006; Baral et al., 2013). In a meta-analysis on HIV prevalence among transgender people in the United States, nearly all of the studies used for analysis employed convenience sampling (Herbst et al., 2008). Other sampling methods are costly, difficult to execute, and may result in smaller sample sizes. Given the lack of funding and attention given to trans and GNC health issues, convenience sampling is often the only feasible approach for data collection.

There are no reliable population estimates of the size or characteristics of this group of people. Mayer and co-authors (2008) report the geographic distribution of same-sex households across the United States using census data; no such distribution can be provided for trans and GNC people, as the census does not collect information pertaining to trans and GNC status (Baral et al., 2013). However, data collected for the NTDS had a geographically similar distribution to that of the general population (Grant et al., 2011). Despite its limitations, convenience sampling provides the strengths of larger sample sizes and greater participant outreach, both of which are issues of concern is assessing diversity among trans and GNC people. The NTDS dataset thus provides the opportunity to examine research questions that have not been analyzed before.

The survey was made available to a network of over 800 transgender-led or transgender-serving community based groups, and announced through 150 online community listservs. Paper surveys were given to organizations that serve low-income, homeless, and rural trans and GNC people; all other surveys were completed online. In collecting data, the goal was to reach as many different types of trans and GNC participants as possible. As such, the distribution through the Internet provided the opportunity to collect responses from participants who may not associate themselves with trans and GNC-specific organizations (Melendez et al., 2006). Online samples may also provide greater access to genderqueer people (Kuper et al., 2012).

A total of 6,456 valid responses were collected. A more detailed explanation of the data collection process and the geographic distribution is explained elsewhere (Grant et al., 2011). A total of 4,049 observations were used in the final analysis due to missing data and question applicability. Most of the excluded respondents were excluded due to dependent variable response. When asked regarding postponement of care due to discrimination or affordability, 82.5% ($n = 1{,}985$) of the excluded respondents selected “not applicable” to one or both questions. These responses were excluded from the analysis because of the ambiguity in interpreting such responses. Participants could have selected “not applicable” because they have not postponed seeking care, or because they have postponed for reasons other than affordability or discrimination. The other excluded respondents had missing data for the independent variables used in the analysis.

### 5.1. Dependent variables

The dependent variables of interest sought to measure postponement of curative care by capturing different reasons for postponing care. Different reasons for postponing included discrimination and affordability. Participants were asked to check yes, no, or not applicable for the following two statements: “I have postponed or not tried to get needed medical care when I was sick or injured” (1) “because I could not afford it”, and (2) “because of disrespect or discrimination from doctors or other healthcare providers.”

For the first dependent variable, respondents were collapsed into the binary variable of having postponed seeking care for any reason compared to not having postponed. The second dependent variable was created through the organizing of respondents into three categories: not having postponed for either reason, having postponed solely due to discrimination or due to both discrimination and affordability, and having postponed solely due to affordability. The collapsing of postponement solely due to discrimination with postponement due to discrimination and affordability sought to tailor the variable to the research question’s emphasis on stigma and discrimination.

### 5.2. Independent variables

Participants were categorized into one of four categories based on the participant’s reported designated sex at birth (male or female) and primary gender identity (male, female, part-time, or other). These include: male-to- female (MTF), male-to-other (MTX), female-to-male (FTM), and female-to-other (FTX). The categories of MTX and FTX were created by collapsing respondents with primary identities of part-time, other, or the same primary gender identity as the designated sex assigned at birth. While these “other” categories may have considerable heterogeneity and may represent unique concerns, forming this categorization scheme helps designate a difference from those who identify as men (FTM) or women (MTF). MTF is used as the reference category as it is the largest segment of the sample, and most research done on transgender individuals has focused on the MTF experience (Melendez et al., 2006; Herbst et al., 2008). Personal identity was also included for the identities of transsexual and genderqueer. Participants responded not identifying with each term, somewhat identifying with it, or strongly identifying with it. Entering these identity terms helps to further explore differences in self-conceptualization among the four categories by examining the connection between these two measures. These measures also allow for respondents to report identity with both terms and to specify the degree of such identity. Engagement with transitioning treatment was also included. Participants reported not wanting treatment, wanting treatment, or having had treatment for the following services: hormone therapy, top/chest/breast surgery, or bottom/genital surgery. Desiring treatments were coded separately than not having accessed the treatment (“not wanting”) given the importance that transitioning may have for identity, category, and relation to biomedicine (Kuper et al., 2012).

Variables pertinent to the medical care experience were also included. Participants were asked where they visit most often when sick or when needing health advice, including a doctor’s office, the emergency room, a clinic, or not using a regular provider. Participants also provided their level of being out when seeking care, selecting none, a few, some, most, or all people. Type of health insurance was collapsed into the categories of having private, public, or no insurance.

Background variables as controls were also used. Demographic data were collected on race/ethnicity, age, and income. Respondents selected relationship status as being single, partnered, married, in a civil union, separated, divorced, or widowed. Being married and in a civil union were collapsed as being legally partnered, and being separated, divorced, and widowed were collapsed as being separated. There are similarities between marriages and civil unions due to legal recognition, and there is a common experience in being separated, divorced, or widowed, which all imply the end of a serious relationship. Including these variables into the models seeks to ensure that these factors are also considered in the analysis.

### 5.3. Analysis

Two logistic regression models were used in the data analysis. In the first model, a binary logistic regression model sought to predict any postponement of care. A stepwise model was used to consider the effects of each group of variables on the other variables in the model. Because one of the goals of this paper is to propose a new categorization scheme for research with trans and GNC people, the category variables were entered in first, followed by the identity terms. Because of the possibility of connections between treatments of transitioning and identity or self-conceptualization (Kuper et al., 2012; Davidson, 2007; Namaste, 2005), variables representing treatments of transitioning were then added to consider their effects on any relationship between category or identity and postponement of care. Medical encounter variables were then entered into the model, followed by background variables, in order to consider some of the contextual differences respondents have in experience beyond trans and GNC category, identity, and treatment of transitioning. In the second model, a multinomial logistic regression model sought to predict reason behind postponement of care. This model reveals associations between independent variables and the reason behind postponement while still considering all other independent variables from the first model.

## 6. Results

The majority of respondents identified themselves as MTF (39.7%), followed by FTM (28.4%). The two other categories also comprised substantial segments of the sample (MTX, 20.3%; FTX, 17.7%). The high number of respondents who do not identify strictly as male or female introduces an innovative aspect of identity that has not traditionally been explored. The substantial segments of MTX and FTX in this sample suggest that these differences in identity warrant their own consideration.

Of the 4,049 observations used in the analysis, 79.2% were identified as white (Table 1). A small percentage of racial/ethnic minorities were within each group (black, 3.1%, Native American, 1.0%; Latino/a, 2.6%; Asian 2.1%) compared to their white counterparts. 12.1% of the respondents identified themselves as multiracial or as belonging to more than one of the aforementioned categories. A quarter of the respondents reported receiving a gross annual household income of less than $20,000. An additional 23.7% reported receiving between $20,000–40,000, 16.6% reported receiving between $40,000–60,000, 20.7% reported receiving $60,000–100,000, and 13.5% reported receiving over $100,000. Half of the sample reported receiving an annual household income of less than $40,000. Respondents had a mean age of 36.5 years of age.

Half of the participants reported having postponed seeking curative care when sick due to either discrimination or affordability (Table 2). This figure is much higher than national average estimates at 20% (Cunningham and Felland, 2008). Reasons for postponement each accounted for half of the postponement, such that half of the respondents did not postpone seeking care, a quarter postponed due to discrimination, and another quarter postponed due to affordability.

**Table 1**
Demographics ($n$ = 4049).

| | $n$ | % |
|---|---|---|
| Race/ethnicity | | |
| White | 3205 | 79.2 |
| Black | 124 | 3.1 |
| Native American | 41 | 1 |
| Latino/a | 105 | 2.6 |
| Asian | 86 | 2.1 |
| Multiracial | 488 | 12.1 |
| Income | | |
| <$20,000 | 1048 | 25.9 |
| $20-40,000 | 943 | 23.3 |
| $40–60,000 | 672 | 16.6 |
| $60–100,000 | 838 | 20.7 |
| >$100,000 | 548 | 13.5 |
| Category | | |
| MTF | 1606 | 39.7 |
| MTX | 821 | 20.3 |
| FTM | 1151 | 28.4 |
| FTX | 716 | 17.7 |
| Age (mean) | 36.5 | |

**Table 2**
Dependent variables ($n$ = 4049).

| | $n$ | % |
|---|---|---|
| Postponement of curative care | | |
| Yes | 2042 | 50.4 |
| No | 2007 | 49.6 |
| Reason for postponement | | |
| Did not postpone | 2007 | 49.6 |
| Discrimination or both | 1029 | 25.4 |
| Affordability only | 1013 | 25 |

### 6.1. *Postponement of curative care*

In the first model (Table 3), MTX respondents were significantly less likely to postpone than MTF respondents (OR = 0.484, $p \leq .001$); on the other hand, FTM respondents were more likely to postpone than MTF respondents (OR = 1.406, $p \leq .001$). FTX respondents were not found to be more or less likely to postpone seeking care than MTF respondents. This first step suggests that there may be substantial differences in access to care among trans and GNC people by both sex designated at birth and gender category.

Adding in the identity terms of transsexual and genderqueer did not substantially change the relationship between the category variables and care postponement in terms of effect size or significance. Interestingly, identifying as either transsexual (somewhat, OR = 1.454, $p \leq .001$; strongly, OR = 1.388, $p \leq .001$) or genderqueer (somewhat, OR = 1.299, $p \leq .001$; strongly, OR = 1.536, $p \leq .001$) of any magnitude was significant compared to not identifying as of those terms in terms of predicting care postponement. Upon adding the variables measuring treatment of transitioning, however, identifying as transsexual is no longer significant and decreases in effect size for postponement of care compared to not identifying with the term at all (somewhat, OR = 1.187, $p > .05$; strongly, OR = 1.064, $p > .05$). Instead, having been on hormones, desiring top surgery, having had top surgery, and desiring bottom surgery compared to not having nor desiring each respective treatment all served as better predictors of postponement. Variables representing treatments of transition had little effect on the relationship between identifying as genderqueer and postponing care. This suggests that at least part of the postponement observed by identifying as transsexual can be explained in relation to hormones and/or surgery. However, there remains additional variation to explain in identifying as genderqueer at any level in relation to postponement of care.

After adding in variables corresponding to medical encounters, all of the relationships between the variables previously entered into the model and the dependent variable remain significant. One notable exception is the relationship of the category of FTX and postponement, which is now significant and has shifted in effect size (OR = 1.534, $p \leq .01$) to suggest greater postponement of care than the category of MTF. The relationships of the rest of the previous variables remain similar in effect size. Not surprisingly, respondents who primarily use the emergency room as their main place of seeking care are over three times more likely to postpone than those who access care primarily at a doctor's office (OR = 3.429, $p \leq .001$); those who primarily use a clinic or do not have a primary place of seeking care are also more likely to

**Table 3**
Predictors of postponement of care.

| | Step 1 | Step 2 | Step 3 | Step 4 | Step 5 |
|---|---|---|---|---|---|
| Category | | | | | |
| MTF (ref) | | | | | |
| MTX | 0.484*** | 0.485*** | 0.551*** | 0.667*** | 0.743* |
| FTM | 1.406*** | 1.396*** | 1.335*** | 1.488*** | 1.287* |
| FTX | 1.082 | 1.012 | 1.264 | 1.534** | 1.327 |
| Transsexual identity | | | | | |
| Not at all (ref) | | | | | |
| Somewhat | | 1.454*** | 1.187 | 1.181 | 1.212 |
| Strongly | | 1.388*** | 1.064 | 1.079 | 1.111 |
| Genderqueer identity | | | | | |
| Not at all (ref) | | | | | |
| Somewhat | | 1.299*** | 1.35*** | 1.395*** | 1.314** |
| Strongly | | 1.536*** | 1.632*** | 1.628*** | 1.472*** |
| Hormones | | | | | |
| Do not want (ref) | | | | | |
| Want it someday | | | 1.138 | 1.092 | 0.999 |
| Have had it | | | 1.528** | 1.548** | 1.474* |
| Top surgery | | | | | |
| Do not want (ref) | | | | | |
| Want it someday | | | 1.384*** | 1.28** | 1.276* |
| Have had it | | | 1.308* | 1.326* | 1.407** |
| Bottom surgery | | | | | |
| Do not want (ref) | | | | | |
| Want it someday | | | 1.267** | 1.223* | 1.239* |
| Have had it | | | 0.941 | 1.012 | 1.195 |
| Main place seeking care | | | | | |
| Doctor's office (ref) | | | | | |
| Emergency room | | | | 3.429*** | 2.951*** |
| Clinic | | | | 1.534*** | 1.337*** |
| Do not use | | | | 1.73** | 1.465* |
| Out when seeking care | | | | | |
| None (ref) | | | | | |
| Few | | | | 1.457** | 1.481** |
| Some | | | | 1.542*** | 1.571*** |
| Most | | | | 1.328* | 1.348* |
| All | | | | 1.308* | 1.317* |
| Health insurance | | | | | |
| Private (ref) | | | | | |
| Public | | | | 1.396*** | 1.14 |
| None | | | | 4.449*** | 3.704*** |
| Race/ethnicity | | | | | |
| White (ref) | | | | | |
| Black | | | | | 0.864 |
| Native American | | | | | 1.679 |
| Latino/a | | | | | 0.761 |
| Asian | | | | | 0.512** |
| Multiracial | | | | | 1.41** |
| Age | | | | | 0.987*** |
| Relationship status | | | | | |
| Single (ref) | | | | | |
| Partnered | | | | | 1.61*** |
| Married/civil union | | | | | 1.497*** |
| Separated, divorced, or widowed | | | | | 1.294* |
| Income | | | | | |
| <$20,000 (ref) | | | | | |
| $20–40,000 | | | | | 1.056 |
| $40–60,000 | | | | | 0.653*** |
| $60–100,000 | | | | | 0.454*** |
| >$100,000 | | | | | 0.378*** |
| Constant | 1.051 | 0.697*** | 0.410*** | 0.177*** | 0.359*** |
| Log likelihood | 5476.081 | 5437.004 | 5382.723 | 4968.71 | 4799.84 |

$p \leq .001$***, $p \leq .01$**, $p \leq .05$*.

postpone than those primarily seeking care at a physician's office. Being out as trans and/or GNC while seeking care also had a significant effect on postponement when sick compared to not being out. Respondents were only out to few (OR = 1.457, $p \leq .01$) or some health care providers (OR = 1.542, $p \leq .001$) had larger effect sizes than those who were out to most (OR = 1.328, $p \leq .05$) or all (OR = 1.308, $p \leq .05$). Not having health insurance was strongly associated with high rates of care postponement, as these respondents were over four times as likely to postpone than those with private health insurance.

The last and final step included background variables. Relationship status and income were found to be associated with access to care, with all relationship statuses other than single more likely to postpone, and higher income levels strongly associated with decreased likelihood of care postponement. This step slightly decreased the effect size of not having health insurance, and explained some of the variation previously attributed to having public insurance.

### 6.2. *Reason for postponement of curative care*

A multinomial logistic regression model (Table 4) was developed to explore the reasons associated with the independent variables used in the previous logistic regression model. Patterns emerged between groups of independent variables and postponement due to discrimination or affordability. For example, variation in postponement attributed to trans and GNC categories was associated with discrimination and not affordability. Treatments of transition were similarly associated with discrimination and not affordability, with respondents having been on hormones and having had top surgery nearly twice as likely to postpone due to discrimination when sick or injured compared to not postponing. Similarly, being out when seeking care was associated with postponement due to discrimination rather than affordability; those out to few or some health care providers were nearly twice as likely to postpone due to discrimination than to not postpone compared to respondents not out when seeking care. Alternatively, relationship status and its relation to care postponement can be mostly explained through affordability, with being partnered, married or in a civil union, or separated, divorced, or widowed more likely to postpone due to affordability than to not postpone compared to single respondents.

**Table 4**
Predictors of reason for postponement.

| | Did not postpone (ref) | Affordability | Discrimination |
|---|---|---|---|
| Category | | | |
| MTF (ref) | | | |
| MTX | | 0.8 | 0.648$^{**}$ |
| FTM | | 1.116 | 1.414$^{**}$ |
| FTX | | 1.133 | 1.564$^{**}$ |
| Transsexual identity | | | |
| Not at all (ref) | | | |
| Somewhat | | 1.266 | 1.14 |
| Strongly | | 1.188 | 1.033 |
| Genderqueer identity | | | |
| Not at all (ref) | | | |
| Somewhat | | 1.286$^{*}$ | 1.358$^{**}$ |
| Strongly | | 1.401$^{**}$ | 1.542$^{***}$ |
| Hormones | | | |
| Do not want (ref) | | | |
| Want it someday | | 1.077 | 0.889 |
| Have had it | | 1.212 | 1.775$^{**}$ |
| Top surgery | | | |
| Do not want (ref) | | | |
| Want it someday | | 1.058 | 1.624$^{***}$ |
| Have had it | | 0.989 | 1.936$^{***}$ |
| Bottom surgery | | | |
| Do not want (ref) | | | |
| Want it someday | | 1.178 | 1.308$^{*}$ |
| Have had it | | 1.226 | 1.219 |
| Main place seeking care | | | |
| Doctor's office (ref) | | | |
| Emergency room | | 3.028$^{***}$ | 2.906$^{***}$ |
| Clinic | | 1.309$^{**}$ | 1.37$^{***}$ |
| Do not use | | 1.254 | 1.715$^{**}$ |
| Out when seeking care | | | |
| None (ref) | | | |
| Few | | 1.279 | 1.766$^{***}$ |
| Some | | 1.224 | 1.992$^{***}$ |
| Most | | 1.242 | 1.515$^{*}$ |
| All | | 1.263 | 1.413$^{*}$ |
| Health insurance | | | |
| Private (ref) | | | |
| Public | | 1.048 | 1.225 |
| None | | 4.931$^{***}$ | 2.534$^{***}$ |
| Race/ethnicity | | | |
| White (ref) | | | |
| Black | | 0.645 | 1.099 |
| Native American | | 1.438 | 1.961 |
| Latino/a | | 0.519$^{*}$ | 0.988 |
| Asian | | 0.453$^{*}$ | 0.57 |
| Multiracial | | 1.155 | 1.663 |
| Age | | 0.997 | 0.977 |
| Relationship status | | | |
| Single (ref) | | | |
| Partnered | | 1.728$^{***}$ | 1.512 |
| Married/civil union | | 1.631$^{***}$ | 1.401$^{**}$ |
| Separated, divorced, or widowed | | 1.539$^{**}$ | 1.019 |
| Income | | | |
| <$20,000 (ref) | | | |
| $20–40,000 | | 1.213 | 0.884 |
| $40–60,000 | | 0.631$^{***}$ | 0.664$^{**}$ |
| $60–100,000 | | 0.437$^{***}$ | 0.467$^{***}$ |
| >$100,000 | | 0.251$^{***}$ | 0.512$^{***}$ |
| Log likelihood | 7369.131 | | |

$p \le .001^{***}$, $p \le .01^{**}$, $p \le .05^{*}$.

Some variables revealed similarities in postponing due to discrimination or affordability compared to not postponing. Health insurance and income, for example, both served as significant predictors for postponement of care due to discrimination or affordability in relation to their respective categories of comparison. Respondents without health insurance are nearly five times more likely to postpone due to affordability compared respondents with private health insurance. While this direction might be expected, the magnitude of this effect size signifies extreme disparity. Interestingly, place of seeking care and degree of genderqueer identity were both associated with not seeking care when sick or injured due to both discrimination or affordability compared to not postponing. Respondents primarily seeking care at the emergency room compared to a private doctor's office, for example, were three times more likely to postpone due to affordability ($OR = 3.028$, $p \le .001$) or discrimination ($OR = 2.906$, $p \le .01$). Discrimination and affordability were found to both play considerable roles in explaining issues of access to care for these groups of respondents.

## 7. Discussion

Trans and GNC people face rampant stigma and discrimination, including from biomedicine and health care provision (Drescher, 2010; Poteat et al., 2013; Bauer et al., 2009). Not surprisingly, this marginalized group of people's access to care is particularly limited compared to the rest of the United States population, with over 50% delaying seeking needed care compared to the 20% noted by Cunningham and Felland (2008). This alarmingly high rate provides empirical evidence to affirm the needed enhancement and development of trans and GNC health within wider medical contexts and health provision. It is quite clear that the needs of this group of people need further attention from researchers and health care providers alike.

In considering access to care, Link and Phelan's (2001) reminder that stigma and discrimination may manifest at distinct levels provides a starting place in interpreting the results toward a call for action. For example, direct discrimination may constitute refusing to serve trans and GNC patients or making such patients uncomfortable when seeking care. An important factor in addressing direct discrimination brings in the issue of visibility. Dozier's (2005) research suggests that (in)visibility regarding trans status, traditionally referred to as "passing," may be connected to the use of hormones. Changes in visibility and perception may change social expectations and behaviors. The findings from this study suggest that being on hormones is associated with a greater likelihood of postponing care, likely because of changes in perception and being read as trans and/or GNC.

Visibility provides the link beyond Goffman's original distinction between discredited and discreditable stigma. Not being seen as trans or GNC may prevent outward experiences of discrimination. At the same time, disclosure plays a role that counteracts and complicates visibility. Being out when seeking care is crucial for the provision of certain forms of care. While those who were not out postponed the least, those who were out to few or some postponed more than those who were out to most or all. Being out to select providers likely brings on additional challenges in managing the selective process of disclosure. Disclosure, operating in conjunction with changes in visibility and perception that may be brought on by hormonal therapy, marks the point at which participants become discreditable or discredited, exposing them to direct stigma. Status as a gender or sexual minority needs to be contextualized with a wide variety of factors that influence different experiences of stigma and discrimination. These findings mark unique considerations for sexual and gender minorities that potentially have wider applications in our understanding of stigma.

An example of structural discrimination would be the lack of providers equipped to serve trans and GNC patients. Snelgrove and co-authors (2012) found that providers are often unsure of how to provide optimal care for trans and GNC patients. This is a direct result of the lack of an incorporation of transgender health into medical school curricula (Sequeira et al., 2012; Stoddard et al., 2011). These realities have severe consequences for trans and GNC people. In terms of accessibility, trans and GNC people may have to travel great distances in order to access sensitive care, or they may have to access care in a clinic setting rather than through a personal physician. Even worse, it may force participants to delay care until they are required to resort to the emergency room: results suggest that those who primarily use the emergency room as a site care tend to have the highest rates of postponement. Furthermore, location of primary site of accessing care was associated with both discrimination and affordability in explaining postponement. While cost may indeed be an issue for some trans and GNC people, such as those lacking health insurance, those who are under- or unemployed, or those in committed relationships with limited household income, the importance of discrimination cannot be refuted. Structural decisions within medicine, such as the content and breadth of medical training, location of sites of care, and funding and policies that constrain research and knowledge production regarding trans and GNC health all contribute to the stigma and discrimination experienced by trans and GNC people.

Internal stigma and discrimination is more difficult to identify and remedy. This form may manifest such that trans and GNC perceive poor access to care and thus choose not to seek out care. This may help explain higher rates of postponement among those designated female at birth (FTM and FTX) than MTF individuals. Given that most of the research and knowledge on trans and GNC health issues have focused on the MTF experience (Melendez et al., 2006), these other groups of people may choose to not seek out care because of researchers and health care providers' lack of focus on them. This is further supported in identifying the reason behind postponement, as the category measures were all associated with discrimination rather than affordability. Additionally, communities and groups of people that conceptualize themselves in new ways that differ from the traditional MTF/FTM or transsexual experience may similarly question how they fit into the current state of trans and GNC health care provision. If both research and health care protocols prioritize the importance of sex designated at birth in differentiating among groups of people, such a strategy may gloss over considerations that are crucial in understanding identity and self-conceptualization. As others have documented, this newer line of thinking poses considerable challenges to conventional ways of understanding "transgender", and part of this challenge may also include different relations to health care provision and treatments of transition (Kuper et al., 2012). The use of broad binary categories based on sex designated at birth may conceal differences within groups, as the results indicated that MTX respondents were less likely to postpone than MTF respondents. Building off of Lombardi's (2009) findings, postponement associated with transsexual identity can be partly explained through desire for and engagement with hormones and/or surgery. This finding also confirms other understandings of transsexuals that emphasize transitioning treatment (Namaste, 2005; WPATH, 2011). However, additional research is needed to examine how other self-conceptualizations challenge traditional patient-provider relations, the role of transitioning on experience, and access to care concerns.

A major limitation of this research is the measurement of primary curative care. Respondents could have postponed due to a wide range of major or minor illnesses due to the item's broad framing. Similarly, the reasons captured behind postponement as either discrimination or affordability left out possibilities to properly assess exactly how issues of cost and stigma and discrimination impact access to care. There are also concerns regarding sampling of trans and GNC people of color. However, the dataset utilized for the analyses presents the unique opportunity to assess access to care issues among a large, diverse group of trans and GNC people sampled across the United States. Findings from this study may inform future research by suggesting general direction and conceptual frameworks; future research should also address some of the limitations presented here.

As a final note, this paper puts forth a new categorization scheme to consider points of difference among trans and GNC people. While this categorization scheme may be adapted in future research, it also serves as a reminder that research is a social process. The categories we use in biomedicine health research are social categories, and need to be carefully considered in any work, especially with this marginalized group of people (Wright and Treacher, 1982; Lorber, 1993; Melendez et al., 2006). Valentine (2007) argues that social science researchers often produce their own objects of investigation, such that research plays a role in constructing the phenomenon it seeks to study. Lorber (1993) makes a similar argument about data analysis and the presumption of difference such that researchers see in the data what they believe to be there. While there have been tensions among trans and GNC people in relating their self-conceptualizations, similarities, and differences, research and care provision have rarely considered these concerns in understanding and reaching out to this group. A careful evaluation of how these processes can shape research findings and protocol guidelines will potentially improve gender variant health for all trans and GNC people. Increasing access to care will require understanding the diversity among trans and GNC people in order to provide optimal care for each person that aligns with personal goals, views, and expectations in engaging with health care provision.

## References

Adams, P.F., Heyman, K.M., Vickerie, J.L., 2009. Summary health statistics for the U.S. population: National Health Interview Survey, 2008. Vital and Health Statisitics 10 (243).

Aday, L.A., Andersen, R., 1974. A framework for the study of access to medical care. Health Services Research 9 (3), 208–220.

Baral, S.D., Poteat, T., Guadamuz, T.E., Beyrer, C., 2013. Authors' reply. Lancet 13, 832–833.

Bauer, G.R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K.M., Boyce, M., 2009. I don't think this is theoretical'; this is our lives: How erasure impacts health care for transgender people. Journal of the Association of Nurses in AIDS Care 20 (5), 348–361.

Bindman, A.B., Grumbach, K., Osmond, D., Komaromy, M., Vranizan, K., Lurie, N., Billings, J., Stewart, A., 1995. Preventable hospitalizations and access to health care. Journal of the American Medical Association 274 (4), 305–311.

Bockting, W., Robinson, B., Benner, A., Scheltema, K., 2004. Patient satisfaction with transgender health services. Journal of Sex & Marital Therapy 30 (4), 277–294.

Bornstein, K., Bear Bergman, S., 2010. Gender Outlaws: the Next Generation. Seal Press, Berkeley, CA.

Bradford, J., Reisner, S.L., Honnold, J.A., Xavier, J., 2013. Experiences of transgender-related discrimination and implications for health: Results from the Virgina transgender health initiative study. American Journal of Public Health 103 (10), 1820–1829.

Center of Excellence for Transgender Health, University of California, San Francisco, Department of Family and Community Medicine, 2011. Primary Care Protocol for Transgender Patient Care. http://transhealth.ucsf.edu/trans?page=protocol-terminologyth (accessed 01.01.14.).

Cobos, D.G., Jones, J., 2009. Moving forward: Transgender persons as change agents in health care access and human rights. Journal of the Association of Nurses in AIDS Care 20 (5), 341–347.

Cunningham, P.J., Felland, L.E., 2008. Falling behind: Americans' Access to Medical Care Deteriorates, 2003–2007. http://www.hschange.com/CONTENT/993/993.pdf (accessed 18.03.13.).

Davidson, M., 2007. Seeking refuge under the umbrella: Inclusion, exclusion, and organizing within the category transgender. Sexuality Research & Social Policy 4 (4), 60–80.

Diamant, A.L., Hays, R.D., Morales, L.S., Ford, W., Calmes, D., Asch, S., Duan, N., Fielder, E., Kim, S., Fielding, J., Sumner, G., Shapiro, M.F., Hayes-Bautista, D., Gelberg, L., 2004. Delays and unmet needs for health care among adult primary care patients in a restructured urban public health system. American Journal of Public Health 94 (5), 783–789.

Dozier, R., 2005. Breasts, beards, and bodies: Doing sex in a gendered world. Gender & Society 19 (3), 297–316.

Drescher, J., 2010. Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the diagnositc and statistical manual. Archives of Sexual Behavior 39, 427–460.

Drescher, J., Cohen-Kettenis, P., Winter, S., 2012. Minding the body: Situating gender identity diagnoses in the ICD-11. International Review of Psychiatry 24 (6), 568–577.

Goffman, E., 1963. Stigma: Notes on the Management of Spoiled Identity. Prentice Hall, Upper Saddle River, NJ.

Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M., 2011. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf (accessed 18.03.13.).

Herbst, J.H., Jacobs, E.D., Finlayson, T.J., McKleroy, V.S., Neumann, M.S., Crepaz, N., HIV/AIDS Prevention Research Synthesis Team, 2008. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. AIDS and Behavior 12 (1), 1–17.

Hines, S., 2006. What's the difference? Bringing particularlity to queer studies of transgender. Journal of Gender Studies 15 (1), 49–66.

Informed Consent for Access to Trans Health. n.d. Informed Consent for Access to Trans Health http://www.icath.org/default.html (accessed 01.01.14.).

Irwin, J.A., Fisher, C.M., Coleman, J.D., 2012. Trans* in Nebraska: Descriptive results from the Midlands LGBT Needs Assessment. Paper presented at the meeting of the American Public Health Association, San Francisco, CA. https://apha.confex.com/apha/140am/webprogram/Paper265178.html (accessed 01.01.14.).

Kenagy, G.P., 2005. Transgender health: Findings from two needs assessment studies in Philadelphia. Health & Social Work 30 (1), 19–26.

Kuper, L.E., Nussbaum, R., Mustanski, B., 2012. Exploring the diversity of gender and sexual orientation identities in an online sample of trangender individuals. Journal of Sex Research 49 (2–3), 244–254.

Levesque, J., Harris, M., Russell, G., 2013. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health 12 (18).

Link, B.G., Phelan, J.C., 2001. Conceptualizating stigma. Annual Review of Sociology 27, 363–385.

Link, B.G., Phelan, J.C., 2006. Stigma and its public health implications. Lancet 367, 528–529.

Lombardi, E., 2009. Varieties of transgender/transsexual lives and their relationship with transphobia. Journal of Homosexuality 56 (8), 977–992.

Lombardi, E.L., Wilchins, R.A., Priesing, D., Malouf, D., 2002. Gender violence. Journal of Homosexuality 42 (1), 89–101.

Lorber, J., 1993. Believing is seeing: Biology as ideology. Gender & Society 7 (4), 568–581.

Mayer, K.H., Bradford, J.B., Makadon, H.J., Stall, R., Goldhammer, H., Landers, S., 2008. Sexual and gender minority health: What we know and what needs to be done. American Journal of Public Health 98 (6), 989–995.

Melendez, R.M., Bonem, L.A., Sember, R., 2006. On bodies and research: Transgender issues in health and HIV research articles. Sexuality Research & Social Policy 3 (4), 21–38.

Mollborn, S., Stepanikova, I., Cook, K.S., 2005. Delayed care and unmet needs among health care system users: When does fiduciary trust in a physician matter? Health Services Research 40 (6), 1898–1917.

Monro, S., 2005. Gender Politics: Citizenship, Activism and Sexual Diversity. Pluto Press, Ann Arbor, MI.

Namaste, V., 2005. Sex Change, Social Change: Reflections on Identity, Institutions, and Imperialism. Women's Press, Toronto, Ontario.

Nemoto, T., Operario, D., Keatley, J., Nguyen, H., Sugano, E., 2005. Promoting health for transgender women: Transgender Resources and Neighborhood Space (TRANS) program in San Francisco. American Journal of Public Health 95 (3), 382–384.

Nestle, J., Howell, C., Wilchins, R. (Eds.), 2002. Genderqueer: Voices from Beyond the Sexual Binary. Alyson Books, Los Angeles.

Poteat, T., German, D., Kerrigan, D., 2013. Managing uncertainty: a grounded theory of stigma in transgender health care encounters. Social Science & Medicine 84, 22–29.

Rachlin, K., Green, J., Lombardi, E., 2008. Utilization of health care among female-to-male transgender individuals in the United States. Journal of Homosexuality 54 (3), 243–258.

Roen, K., 2002. "Either/or" and "both/neither": Discursive tensions in transgender politics. Signs 27 (2), 501–522.

Serano, J., 2007. Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity. Seal Press, Berkeley, CA.

Sequeira, G.M., Chakraborti, C., Panunti, B.A., 2012. Integrating lesbian, gay, bisexual, and transgender (LGBT) content into undergraduate medical school curricula: A qualitative study. The Ochsner Journal 12 (4), 279–382.

Snelgrove, J.W., Jasudavisius, A.M., Rowe, B.W., Head, E.M., Bauer, G.R., 2012. "Completely out-at-sea" with "two-gender medicine": A qualitative analysis of physician-side barriers to providing healthcare for transgender patients. BMC Health Services Research 12 (110), 1–13.

Stoddard, J., Leibowitz, S.F., Ton, H., Snowdon, S., 2011. Improving medical education about gender-variant youth and transgender adolescents. Child & Adolescent Psychiatric Clinics of North America 20 (4), 779–791.

Stryker, S., 2008. Transgender History. Seal Press, Berkeley, CA.

Valentine, D., 2007. Imagining Transgender: an Ethnography of a Category. Duke University Press, Durham, NC.

World Professional Association for Transgender Health, 2011. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People: 7th Version. http://www.avitale.com/SOCv7.pdf (accessed 01.01.14.).

Wright, P., Treacher, A., 1982. The Problem of Medical Knowledge: Examining the Social Construction of Medicine. Edinburgh University Press, Edinburgh.

Xavier, J., Honnold, J.A., Bradford, J., 2007. The Health, Health-related needs, and Lifecourse Experiences of Transgender Virginians. http://www.vdh.virginia.gov/epidemiology/diseaseprevention/documents/pdf/THISFINALREPORTVol1.pdf (accessed 01.01.14.).