

# NARRATIVE MATTERS



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## ‘Go Back To California’: When Providers Fail Transgender Patients

*A transgender doctor is mistreated by a health care provider—and wants to make the system better for patients like her.*

BY LAURA ARROWSMITH

**G**o back to California, the physician at a minor emergency center in a suburb of Tulsa, Oklahoma, told me. The words were flung—practically vomited—at me. I had gone to the center, a relatively new building that was beautifully decorated, on a Sunday morning in 2010 in terrible pain due to complications from a previous surgery. The receptionist was pleasant, and the physician had entered the exam room smiling. He was about fifty

years old and seemed friendly. But when I explained why I was there, the friendly smile quickly disappeared, and his face contorted into an expression of disgust and revulsion.

Two days earlier I had returned to Tulsa from a week-long stay in California, where I had undergone a secondary labiaplasty—a procedure that refines the shape of the inner labia of the vagina. For this procedure, I had returned to the surgeon who performed my original genital reassignment surgery in 2005,

confident that she could make some minor improvements. She was one of the leading specialists in the world, a gynecologist who herself had traveled the same medical journey as me, from male sex assigned at birth to female. After returning home from this second surgery, I had developed a minor abscess around one suture. It was extremely painful and terribly frightening. I lived more than a thousand miles from where the surgeon practiced, and my family practice physician was not available on the weekend. Hence, the demoralizing and disastrous weekend visit to the minor emergency center.

The doctor’s words reverberated in my head: “Go back to California.” He fled the exam room soon after he’d uttered them, without examining me or obtaining any further history.

I was devastated, angry, scared, embarrassed...and ashamed. It wasn’t the first time a physician had made me—also a physician—feel this way. And it’s a problem in health care that simply must change.

### Living ‘Like A Girl’

I am a transgender woman, meaning that I was identified at birth as male, but I have known since my earliest memories that I am a woman. When I was growing up in small-town Kansas during the 1950s and 1960s, there was no Internet, and there were no books, television shows, or other media that could have affirmed for me that I was not the only person who felt this way.

For many Americans, life was easier, simpler, and less cluttered during the decades of my childhood. For me, that was not the case. My only sibling, a younger sister, was my main playmate before my school years began. We played with dolls—dress-up and paper—during the day when my father wasn’t around. I learned quickly that in the evenings when he was home, it had to be trucks and toy guns, cowboys and Indians. He was the gender police for me.

“You walk like a girl,” he would tell me. Or you throw a ball like a girl. You

stand like a girl. You get dressed like a girl. You blow your nose like a girl (yes, he even said that). These were behaviors that were to be eliminated. I quickly learned to be ashamed of the woman inside me and became fearful of showing any suggestion of femininity lest I be punished. At night, I would pray for God to let me wake up as a girl, but I intuitively knew that I could share my true feelings with no one else. My father was never physically abusive, but he was an intimidating presence not to be crossed or disappointed.

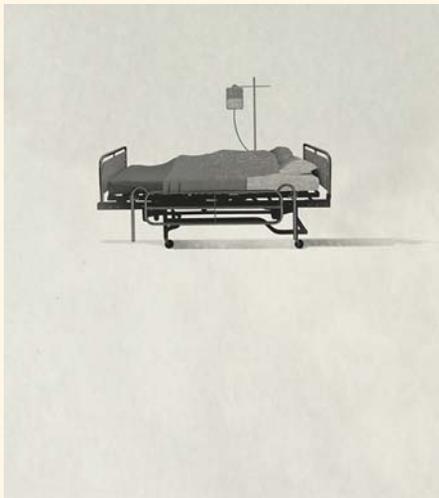
Suppression and denial became my daily ritual. I spent decades living as society expected me to do, and hid “her” (my true self) behind a veneer of masculinity. I went to college and medical school to become an osteopathic physician. I got married and helped raise four children.

Yet in moments when I found myself alone, I would put on women’s clothing. It just felt so right. I would look at myself in a mirror and be so disappointed in the reflection. Sometimes I “borrowed” a few items of my wife’s clothing. When I could, I purchased my own feminine clothes, carefully hidden to put on in private moments. Eventually, I would promise myself I would never dress up that way again. I would discard my treasured clothing in some place where it would never be discovered. This cycle repeated itself endlessly.

This emotional turmoil is common and is known as “gender dysphoria.” In some transpeople, the disorder may be accompanied by substance abuse, self-harm, or eating disorders as a means of coping with the tremendous pain that is experienced. Forty percent will attempt suicide.

By the time I was in my fifties, my gender dysphoria—which previously would strike me for a period of unbearable hours, days, or even weeks but then would pass—had become constant. The condition was there when I awoke and lasted until I fell asleep. It was like a car alarm I was powerless to silence.

One afternoon I parked my truck in a parking lot next to a busy four-lane street. I got out of the truck and watched as a large red semi headed my way. I walked in front of it, hoping my death might be viewed as an accident. The driver managed to swerve away from me,



somehow, and I was unharmed. The next thing I remember, I was walking back to my truck. I sat inside and cried and cried. It was then I knew that I had to find help. Soon.

By then, with the advent of the Internet, I was able to learn more about what I was feeling. In time, I found websites with credible information. One of the first things I learned was that there was a word for people like me: transgender. Soon I found other websites that provided information that likely saved my life—lists of mental health therapists who provided therapeutic support for transgender people, and information about successful hormonal and surgical treatments that could enable me to become my true self. Finally, I had hope. I found an online support group of transgender women at various stages in their journeys: They were happy, beautiful, and alive. Over the next few months I was able to connect with some of them by telephone and in person. Finally I knew that there was a path to becoming who I felt myself to be. I ran down that path and never looked back.

### Gender Identity Is Hardwired

Gender identity—that internal sense of knowing oneself to be a man, woman, or other—is understood to typically be fully developed by around the age of four years, sometimes even earlier. Gender identity is unchanging and unchangeable, hardwired into our brains. All of us inherently know our gender identity: It is not a conscious decision, but rather one aspect of everything that makes each of us an individual. Transgender

people are simply born with a gender identity that does not match their body.

Research has shown that being transgender is most likely due to a hormonal imbalance in utero that happens during the period of a pregnancy when the fetal brain is differentiating into a male or female brain. Autopsy studies, functional MRI scans, and SPECT (single-photon emission computed tomography) scans suggest that some people are born with a male brain and a female body, or vice versa. (Male and female brains have been shown to be slightly different in structure.) These studies suggest that transgender people have the brains that match their gender identity even before taking any cross-sex hormones.

It should be noted that not all of the people who identify as transgender feel themselves to be of the opposite sex. The 2015 US Transgender Discrimination Survey of approximately 28,000 transpeople showed that many respondents identified themselves variously as gender nonbinary, androgynous, gender nonconforming, gender queer, gender fluid, or agender. Younger generations are moving beyond the idea that one must live in the world with a strictly binary (male or female) gender identity.

A lot has changed. During my childhood, teen, and even adult years, transgender people were viewed as defective. Attempts to cure what was viewed as deviant behavior or mental illness included electroshock therapy, massive hormone doses, intense psychotherapy, and psychiatric hospitalization. Aversion therapy, which attempted to replace “maladaptive” with “normal” behavior through a system of negative stimuli and rewards, was advocated. None of these treatments were effective in treating transgender children, teens, and adults. Research and clinical experience gradually demonstrated that it is not efficacious to attempt to “fix” the brain; rather, it is effective to provide medical and surgical treatment (if desired) to change the body to conform with and affirm a person’s gender identity.

When I began my journey to become my authentic self, my family practice physician of many years refused to see me. She said that I had lied to her about who I was. This was a shock—but then, I guess I had lied to myself for decades,

## Policy Checklist

**The issue:** Too often, health care professionals are not trained to provide sensitive and appropriate medical care to the transgender community, and they may even refuse to treat transgender patients. Medical education must prepare medical students and residents to care for this population, so that no patient meeting a new physician need fear denial of care or incorrect treatment.

### Resources:

The Endocrine Society, <https://www.endocrine.org/>

The National Center for Transgender Equality, <http://www.transequality.org/>

The World Professional Association for Transgender Health, <http://www.wpath.org/>

### Related reading:

Haas AP, Rodgers PL, Herman JL. Suicide attempts among transgender and gender non-conforming adults: findings of the National Transgender Discrimination Survey [Internet]. New York (NY): American Foundation for Suicide Prevention; 2014 Jan [cited 2017 Aug 2]. Available from: <https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf>

Hyderi A, Angel J, Madison M, Perry LA, Hagshenas L. Transgender patients: providing sensitive care. *J Fam Pract.* 2016;65(7):450–61.

James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The report of the 2015 U.S. transgender survey [Internet]. Washington (DC): National Center for Transgender Equality; 2016 [cited 2017 Aug 2]. Available from: <http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf>

World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people, 7th version [Internet]. Elgin (IL): WPATH; [cited 2017 Aug 2]. Available from: [https://s3.amazonaws.com/amo\\_hub\\_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf)

body or masculinize the female one. Various sophisticated surgeries can be performed to do the same thing. Numerous professional organizations, including the American Medical Association, have issued policy statements to the effect that gender affirmation surgery is medically necessary for the treatment of gender dysphoria.

It should be noted, however, that most transgender people do not choose gender-affirming surgeries. One common reason is a lack of insurance coverage. Many patients have no financial ability to pay for any medical care. Such treatment also may be contraindicated because of a co-occurring medical issue. Still others choose not to transition out of fear of loss of employment, family, extended family, or friends.

Unfortunately, information about the appropriate treatment for transgender patients has not been taught in medical schools or postgraduate programs until recently, and even now it is only infrequently included in the basic few hours of LGBT education that the schools and programs provide. Most physicians currently in practice have no training in how to care for transgender people.

In fact, several studies, including those by Lambda Legal and the National Center for Transgender Equality, have consistently shown that there is extensive discrimination in health care directed toward transgender patients, including the refusal of medical care, the provision of incorrect care, and verbal or physical abuse by physicians.

There is a critical need for state and federal transgender antidiscrimination legislation, insuring not only employment rights—the focus of most current efforts—but also the right to competent medical care, housing, and education.

## Not Uncommon

After being refused medical care for my acute abscess at the minor emergency center, I was able to tolerate the pain until my family practice physician could drain the abscess and provide antibiotics. I healed physically without further difficulty, but the emotional scars from this event and countless others remain. When I meet a new physician for the first time, I automatically anticipate rejection or discrimination—or at the very

too. On numerous other occasions I have been refused care by physicians, sometimes due to discrimination and bigotry, but at other times due to an expressed concern that “we have no idea how to care for a transgender patient.”

A 2010 Lambda Legal study showed that 50 percent of transgender patients who were fortunate enough to find a physician who would care for them had to teach the physician what to do. Providing sensitive medical care to transgender patients should be relatively straightforward. Multiple organizations such as the Endocrine Society and the World Professional Association for Transgender Health (WPATH) provide online protocols for this type of medical care. The July 2016 issue of the *Journal of Family Practice* also published a fairly comprehensive article outlining ways to provide sensitive care to transgender patients.

But because so few physicians will treat this population, many transgender

people have given up trying to find medical care or are afraid to seek routine and emergency care. A January 2014 Williams Institute study on transgender suicidality showed that 60 percent of transgender patients who, because of anti-transgender bias, are unable to find physicians who will provide medical care for them have attempted suicide.

Fortunately, after several years I finally found a family practice physician who is accepting and open-minded. I was the first transgender patient she had treated, so I have had to educate her about our treatment, follow-up care, and culture. She has proved to be a wonderful learner.

Appropriate treatment for transgender patients, as outlined by the WPATH standards of care, includes supportive mental health counseling to deal with the emotional turmoil created by years of dealing with the body-soul-brain mismatch. Medical treatment includes hormonal therapy to feminize the male

least, the need to educate the physician about the transgender population, the proper terminology to use, and what constitutes appropriate care.

During medical school, my peers and I were taught about obscure medical diseases, conditions that I never saw during my thirty-plus years of medical practice. Many of these were covered multiple times, in different classes. Transgender

patients, in contrast, are not uncommon. Every practicing physician will encounter transgender patients in his or her practice. Yet medical education in the United States is failing to teach medical students and residents how to care for this population. This has to change. No patient meeting a physician for the first time should fear being denied care or given incorrect treatment. The ex-

pression on a caring professional's face should be one of concern and interest, not a snarl of angry disgust. ■

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