Trans individuals' experiences in primary care

Justin Bell MD CCFP Eva Purkey MD MPH CCFP FCFP

Abstract

Objective To explore past experiences and describe the expectations of members of the trans community regarding the delivery of primary care by their family physicians.

Design Qualitative phenomenologic approach.

Setting Kingston, Ont, which has a population of approximately 123 000.

Participants A convenience sample of 11 individuals older than 18 years of age who self-identified as trans was recruited through community agencies and family medicine clinics.

Methods Semistructured interviews were recorded and transcribed verbatim, and thematic analysis of transcripts was carried out by 2 independent researchers using NVivo.

Main findings Eleven interviews took place between September and November 2016; 4 individuals identified as trans men, 6 as trans women, and 1 as gender nonconforming. Themes identified included perceived physician knowledge of trans identities, patient self-advocacy, discrimination, positive spaces, and expectations of ideal care. The expected role of the family physician for trans patients includes hormone assessment and prescription and referrals for gender-affirming surgeries.

Conclusion The trans community has several physical and mental health needs that are not being met by the current health care system. Family physicians need to be empowered to provide services such as hormone initiation and gender-affirming surgery referrals. Although other specialists might have a role for some patients, most trans people expect care to be delivered by family physicians whenever possible.

Editor's key points

- The provision of health care for trans individuals has been historically relegated to non–family physician specialist clinics in tertiary care centres. Recent provincial health policy changes have shifted considerable responsibility for care of these patients to family physicians. This population has well-documented mental and physical health disparities when compared with cisgender Canadians, and family physicians need to be prepared to provide for their specific health needs.
- Despite their negative experiences, this study suggests that the trans community has achievable expectations of family physicians. Owing to family physicians' accessibility and capacity to provide all-inclusive care, participants reported a preference for having their family physicians provide hormone replacement therapy and surgical referrals instead of other specialists. Providing safe spaces for trans patients can increase the likelihood that individuals will access care appropriately.
- All family physicians must be involved in providing these services so that trans care can be accessible to everyone across the country. In regions where trans care is still delivered largely through other specialists, increasing the role of family physicians will improve access. Participants waited years in some cases to see other specialists, and suicide attempts are highest when care has been sought but transition has not yet started.

Points de repère du rédacteur

- Traditionnellement, ce ne sont pas des médecins de famille qui dispensent des soins de santé aux personnes trans, mais plutôt des spécialistes œuvrant dans les cliniques spécialisées de centres de santé tertiaires. Des changements récents dans les politiques provinciales ont remis une partie considérable de cette responsabilité entre les mains du médecin de famille. Il est bien établi qu'en comparaison des Canadiens cis genre, ces patients ont des problèmes de santé mentale et physique différents, si bien que le médecin de famille doit être habilité à répondre à leurs problèmes particuliers.
- Même si les contacts des patients trans avec les médecins de famille étaient plutôt rares, les résultats de cette étude laissent entendre que ces patients prévoient être en mesure de bien s'entendre avec eux. Comme les médecins de famille sont plus accessibles et qu'ils peuvent leur offrir des soins complets, les participants mentionnaient préférer que ce soit leur médecin de famille plutôt que d'autres spécialistes qui leur procurent leurs traitements hormonaux de substitution ainsi que les références en chirurgie. De plus, en fournissant des lieux sécuritaires aux patients trans, on améliorerait probablement leur accès à des soins adéquats.
- Les médecins de famille devraient tous s'engager à offrir de tels soins de façon à les rendre accessibles à tous les Canadiens. Dans les régions où les trans sont encore traités en grande partie par d'autres spécialistes, une augmentation du rôle du médecin de famille améliorera l'accès aux soins. Certains participants avaient dû attendre des années avant de rencontrer un spécialiste et on sait que le nombre de tentatives de suicide augmente lorsqu'un traitement a été demandé, mais que la transformation n'a pas encore débuté.

Ce que les patients trans ont comme expérience des soins primaires

Justin Bell MD CCFP Eva Purkey MD MPH CCFP FCFP

Résumé

Objectif Déterminer ce que des membres de la communauté trans ont déjà eu comme expérience des soins primaires reçus de leurs médecins de famille.

Type d'étude Une méthode phénoménologique qualitative.

Contexte Kingston, en Ontario, dont la population est d'environ 123 000 personnes.

Participants Un échantillon arbitraire de 11 personnes de plus de 18 ans qui se disaient trans a été recruté via des agences communautaires et des cliniques de médecine familiale.

Méthodes Des entrevues semi-structurées ont été enregistrées et transcrites mot à mot; deux chercheurs indépendants ont ensuite effectué une analyse thématique des transcrits à l'aide du progiciel NVivo.

Principales observations Onze entrevues ont été effectuées entre septembre et novembre 2016 avec 4 sujets se disant trans mâles, 6 se disant trans femelles et 1 d'un sexe non conformiste. Parmi les thèmes identifiés, mentionnons leur opinion de ce que les médecins connaissent des différents types d'identité trans, la façon dont le patient s'en tire, la discrimination, des endroits sécuritaires et l'espoir de recevoir les meilleurs soins possibles. Les participants s'attendaient à ce que le rôle du médecin de famille inclue l'évaluation et la prescription hormonales ainsi que la référence en chirurgie devant confirmer le sexe choisi.

Conclusion Les membres de la communauté trans ont plusieurs problèmes de santé physique et mentale auxquels ne répond pas le système de santé actuel. Les médecins de famille devraient être habilités à dispenser des services comme l'initiation d'un traitement hormonal et la référence en chirurgie pour confirmer le sexe choisi. Même si des spécialistes peuvent intervenir chez certains patients, la plupart des sujets trans souhaitent être traités par un médecin de famille le plus souvent possible.

Trans people in Canada are a diverse group, with specific social, medical, and psychological needs. While recent evidence suggests that trans people represent 0.5% of Canada's total population,[1] this number is expected to grow as trans people feel more comfortable expressing their gender identity. Recent political actions, including the passing of Bill C-16—a federal act enshrining protection against discrimination of trans people[2]—have brought trans issues to public attention. Considerable work is required to change the culture of exclusion and intolerance surrounding this population, as trans people continue to be marginalized.

Trans individuals constitute a historically underserved population at high risk of poor mental and physical health outcomes. Lifetime prevalence of suicide attempts among trans people is as high as 46% compared with 3.8% of cisgender people.[3,4] The reasons for this are complex, including the internal discordance between felt gender and the appearance of one's physical body. Although not all trans people pursue hormone or surgical transition, among those who do seek help but have yet to start transitioning, up to 27% might attempt suicide.[5] This figure drops to 18% after beginning transition, and might be as low as 1% once transition is completed.[5] Access to appropriate transition care is difficult for many trans individuals, and delays in treatment might contribute to these high suicide rates.[5]

While treatment for trans people was previously relegated to specialized clinics in large cities, there has been a shift in the duty of responsibility toward community physicians. Using educational tools produced by organizations like Rainbow Health Ontario,[6] family physicians have access to the resources required to initiate hormone replacement therapy (HRT) and refer patients for surgery. Despite this, in Ontario, 43.9% of trans individuals identified unmet health care needs compared with 10.7% of age-adjusted cisgender controls.[7]

Recently published data from the TransPulse study—an Ontario-wide survey of trans individuals—identified a 47.7% to 54.5% rate of discomfort among trans individuals when accessing care through their family physicians.[8] Factors included perceived lack of physician knowledge about trans health needs and previous negative interactions.[8] Qualitative data are required to further examine the reasons for this discomfort and suggest pathways for improvement. Existing qualitative studies largely examine health care providers' perspectives on barriers to care experienced by trans patients,[9] with limited information gathered from the trans community itself.

Methods

Objective

This study seeks to fill this knowledge gap through interviews with trans-identifying patients about their primary care experiences. Investigators sought to use a transformative lens, which holds that research can and should engage with an agenda of political change to confront social oppression,[10] to identify strengths and weaknesses in the existing systems, and to explore enhancers of or barriers to care, all from the point of view of trans persons accessing primary care. **Box 1** provides definitions of terms relevant to providing primary care to transgender individuals.

Design

This was a qualitative study inspired by a phenomenologic approach[11] seeking to explore the common experiences of trans people when accessing health care. While both investigators have either personal or clinical experience with trans people, neither had explored in any detail the lived experience of trans people when accessing health care. Investigators used a transformative worldview[10] in giving voice to a traditionally marginalized group with the objective of identifying opportunities to improve existing health disparities.

Approval for this study was obtained from the Health Sciences and Affiliated Hospitals Research Ethics Board at Queen's University in Kingston, Ont.

Participants

Inclusion criteria were age older than 18 years and self-identification as trans. Despite the incidence of trans identities being estimated at 1 in 200, suggesting a population of 615 trans people in Kingston, local advocacy groups estimate there to be only 50 to 100 openly trans people in the community. Participants were recruited through convenience sampling. Recruitment posters were posted in family medicine clinics, community health centres, and community agencies serving trans people. Local physicians were asked to invite their trans-identifying patients to participate. Posters and invitations included e-mail and telephone number contact information. The principal investigator (J.B.) spoke with each potential participant who contacted the

Box 1. Definitions

The following are definitions of terms relevant to providing primary care to trans individuals:

- **Cisgender:** Applies to individuals whose gender identity is congruent with their sex assigned at birth
- **Transgender:** Applies to individuals whose gender identity is different than their sex assigned at birth
- **Trans:** An umbrella term used to describe an individual who does not identify as cisgender. This includes not only those who identify as transgender but also those with identities that fit outside of the male-female binary. These identities include but are not limited to *trans man, trans woman, gender nonconforming, agender, nongendered, genderqueer, nonbinary, 2-spirit,* and *third gender*

team and reviewed inclusion criteria and confidentiality before arranging in-person interviews. All individuals who contacted the study team were offered interviews.

Setting

All participants were recruited in Kingston (population of approximately 123 000), a medium-sized urban centre in southeastern Ontario.

Data collection and analysis

Semistructured interviews were conducted by the principal investigator (J.B.) using a standardized script developed with the input of trans community leaders. Questions were organized into 6 categories: use of primary care services, trans-specific health needs, relationship with family physician, experience with learners, clinic environment, and ways to improve. A demographic characteristic questionnaire was filled out by all participants. Interviews lasted approximately 1 hour and were recorded and transcribed verbatim. Transcripts were read in their entirety by both researchers independently. Important phrases were identified and meanings were formulated and clustered into recurring themes that highlighted common experiences of participants. Phrases that were important but that did not seem to represent common experiences were discarded. Where there was disagreement about a particular experience among participants, both sides were retained and included in the analysis. Validity of the themes was achieved through building consensus between investigators based on the meanings and themes identified. NVivo software was used for data manipulation.

Participants were compensated for their involvement with $20 gift cards.

Findings

Fifteen volunteers contacted the research team. Four were unable to participate owing to scheduling or transportation limitations. The remaining 11 participants met inclusion criteria, completing the questionnaire and interview between September and November 2016. Demographic characteristics are reported in **Table 1**.

Emerging themes

Eleven complete transcripts were reviewed and coded by the researchers. Five main themes emerged: perceived physician knowledge of trans identities, patient self-advocacy, positive spaces, discrimination, and expectations of ideal care.

Perceived physician knowledge of trans identities. Overall, participants reported that physician knowledge of trans identities and health care needs was lacking. Issues around providing safe trans care were common; physicians had limited understanding of appropriate interactions with trans patients, including correct use of gender pronouns. It was important to participants that their physicians understood how meaningful their trans identity was to their well-being and how far they would go to live their felt gender.

> When [we] get on that [operating room] table—we don't care at that point if we live or die. Because we're at the point now where if we die on that table, we're going to die as a woman and we're fine with that. Because we'd rather die on that table as a woman than live as a guy. That's how important this is to us .... Doctors have to understand ... this is our survival, our well-being, our everything. Without it we're just shadows. (Participant 6)

Participants perceived that few family physicians had a baseline understanding of the initiation, dosing, and monitoring protocols for HRT (**Table 2**, quotations 1 and 2). This led to other specialist referrals, delaying access to

Table 1. Demographic characteristics: *N = 11. Mean age (range) was 46.5 (24-64) years and mean (range) no. of years living in felt gender was 6.5 (2-11) years.*

CHARACTERISTIC	N
Sex assigned at birth	
• Male	6
• Female	5
• Intersex	0
Gender identity	
• Transfeminine	6
-Female	5
-Trans woman	1
• Transmasculine	4
-Male	2
-Trans man	2
• Nonbinary	1
Level of education	
• Did not finish high school	1
• High school graduate	2
• Some college or trade school	1
• College or trade school graduate	1
• Some university	1
• Completed bachelor's degree	3
• Completed graduate or professional degree	2
Hormones	
• Taking hormones	10
• Not taking hormones	1
Surgery	
• Completed surgery	6
• Awaiting surgery	4
• Not seeking surgery	1

Table 2. Interview quotations

THEME	QUOTATION NO.	QUOTATION
Physician knowledge of trans Identities	1	"I'm always educating. So it's, like, I get that you didn't freak out—I love that, because 10 years ago that would have been different, but the questions … it's like, read a textbook, right? I'm always very polite and I answer the questions because they're curious and at least they're curious—they aren't hateful. It's just exhausting emotionally to, like, constantly always be teaching. Like, I've taught so many nurses and doctors so many things" (P3)
	2	Interviewer: "Do you think your current family physician would have been able to support you on your journey?" Participant: "Not at all … I don't think. No, she knows nothing" (P3)
	3	Interviewer: "And so how did you feel about that? That your doctor … wasn't particularly knowledgeable but was willing to learn?" P7: "I said that 'If you are willing to learn, I will be willing to teach you'"
Patient self-advocacy	4	"I'm just exhausted with having to navigate these things and be so proactive. It's not a bad thing. I think it's awesome for patients to be proactive … but there's a line where I think the physician should take up the slack" (P3)
	5	"It was, like, really frustrating to be a 20-year-old kid teaching your doctor how to do something" (P11)
	6	"We literally had a support group in [city]. And, like, one of the main focuses was, like 'Here's the script you go to your doctor with.' And, like, [they] would run you through interviews. Like, fake interviews so you knew exactly what to say to get [hormones]" (P11)
	7	Interviewer: "Have you ever had to educate your family doctor or nurse practitioner about your gender identity and-or trans health–specific needs?" P10: "I believe I, like, tried to do that with my doctor in [town] a little bit. Like, I did try to have these conversations with him but 'in one ear, out the other'" [laughs]
Positive spaces	8	"If they had something, like, queer positive … you know, one of those positive-space stickers, that would be amazing! But they don't. And that's just life … even a small tiny sticker means the world to me … and it doesn't necessarily mean everyone in that clinic is positive, but it means that … somebody's thinking about this and they care enough to put that there and they care enough to at least create a space that's a little bit safer. To let everybody, clients, everybody know that this is what is expected here. You're going to treat everybody well. We don't accept homophobia or anything like that" (P3)
	9	"It would be nice if they had some kind of posters or something in the waiting room to help educate the cis people about trans people and gay people in general about the LGBT community" (P6)
	10	"The receptionist is great—she is a big-time ally. She is a doll …. She refers to me by my name and she was, like, 'OK, what do you need?'" (P7)
Discrimination	11	"I changed my name 3 years ago. I changed my ID, etc, for the right gender marker, etc. Up until 6 months ago his secretary was still calling me by my old name. Still calling me 'him' … and I go to correct her and she's 'I'll try to remember eventually,' which, every other place I deal with they get it right, so …." (P1)
	12	"[The psychiatrist] was supposed to be, like, counseling me for my gender issues. And he knew that I identified as male and I used male pronouns but he never used them" (P4)
	13	"Lack of education, lack of interest in learning more about it. Which considering … he's getting more and more patients that are coming out as trans" (P1)
	14	"But, like, I—most trans people are really uncomfortable going in the emergency [department] because that's when you're—if you're going to get clocked by the medical profession—that's the place it's going to happen. That's where they're going to do you in, right there. And there are horror stories that are just awful. So you know … you don't ever want to go into emergency if you can avoid it" (P6)
	15	"So we all have kind of these issues of, like, running into doctors discriminating against us, especially for mental illness. And I feel like that's where a lot of doctors put transgender in. And, I mean, I guess that kind of makes sense because transgender was seen for a long time [as] a mental illness" (P10)
	16	"[I] feel very, like, trapped by my doctor into presenting a certain way and if I even deviate from that a little bit then I won't have my options. And I've heard that over and over from nonbinary people, binary people …. Like, if I don't do this the right way my doctor's going to take away what I need, which is not a very nice way to have to interact with your doctor" (P10)
	17	"I said 'I'm a female-to-male transsexual and … I do have an appointment here' and she … like, everything in her just went silent. And she said 'Just wait over there,' there's a clock and she said 'Go wait over there,' and so I stood under the clock. Literally she just had to sit there for like 2 whole minutes. I think it was 1 to 2 minutes and she was just collecting herself. It was even kind of funny back then. But these things kind of add up and they're a bit humiliating" (P3)

Table 2 *continued on page e152*

Table 2 *continued from page e151*

THEME	QUOTATION NO.	QUOTATION
Expectations of ideal care	18	"I would love it if everyone would have the expertise to deal with it. I would love it. The realist in me says 'Let's start small.' Starting with just the desire and the understanding to want to learn and to know where to go to get the answers. And be willing to take that journey. That would be the willingness. Let's start with the willingness to not be afraid of taking a new patient when they say 'Oh, by the way, I'm transgendered.' You don't want to hear *click, zzzzzz*. It's not a big deal—say 'Yeah, oh, sure'—whatever. Right. That's—we need health care. We need basic-human-right health care. That's all we're asking. That's it" (P9)
	19	"In an ideal world it would be really nice if your family doctor could do it directly because you know, like, it's really hard getting [hormones]. So it's nice to have it with somebody you have an actual relationship with all the time" (P10)
	20	"Well, I'd want [residents] to, like, talk to an actual trans woman and actual trans man who are going through hormonal transition ... and kind of hear their take on it. And hear their experiences with it" (P10)
	21	"I think like the *ABC*s of trans ... like, you show those few definitions. I think if people had the slightest ... just knowing the definitions and the different possibilities and knowing what FTM is or MTF. Just that sort of basic knowledge so that when they meet a trans person—like, I know it's not a usual occurrence and there might be a little bit of a, like, a human hiccup, 'Oh, interesting,' right? But just the basic knowledge so that they are not starting from absolutely nothing" (P3)
	22	"I'd like them to have at least a basic knowledge and have some reading and kind of be able to troubleshoot some things" (P10)

FTM—female to male; ID—identification; LGBT—lesbian, gay, bisexual, or transgender; MTF—male to female; P—participant.

HRT and incurring substantial transportation costs, as providers often had to be found in different communities. Some participants reported that family physicians approached about providing trans care were both willing to learn about the protocols (quotation 3) and were perceived by participants to then provide appropriate care after a brief educational intervention. The overall preference of participants was to have a family physician who was willing to learn about trans HRT manage their care through prescriptions and surgical referrals.

Patient self-advocacy. Owing to limited physician expertise about trans health needs and the many systemic barriers faced by trans individuals, a common experience for study participants was the need for substantial self-advocacy beyond what would normally be expected in the patient-physician encounter. Participants commonly reported educating their family physicians about trans health needs (**Table 2**, quotations 4 and 5). Many participants brought in copies of trans hormone guidelines to their physicians, or referred them to local education events. Physicians who were eager to provide care still required support from participants to manage the bureaucracy associated with transitioning. Participants sought advice from trans community members about how to speak to physicians to access the health interventions they required (quotation 6).

Participants reported that some physicians were unwilling to provide health care services despite being given education materials (quotation 7). This led participants to spend considerable effort seeking trans-positive physicians, sometimes in other cities. These experiences led to a lack of faith in family physicians and the health care system in general, leaving some participants to limit their interactions with physicians, with little attention paid to preventive care.

Positive spaces. In general, participants felt that their primary care clinic environment was acceptable. Although few individuals spontaneously expressed specific needs, when prompted there was widespread interest in the introduction of positive-space posters and representation of the lesbian, gay, bisexual, transgender, 2-spirit, and queer (LGBT2SQ) community in office spaces (**Table 2**, quotations 8 and 9). Washrooms were generally not problematic, as most clinics had single-person bathrooms that were not gendered.

Front-end staff were identified as playing a critical role in ensuring a positive space, and were often quick to catch on to pronoun and name changes. Several positive health care experiences began with supportive interactions from receptionists (quotation 10). To ensure appropriate interactions with trans individuals there was an expectation that all staff members receive cultural safety training for LGBT2SQ patients.

Discrimination. All participants reported discriminatory experiences while seeking health care. For some this was a rare occurrence, while others reported multiple episodes including with their family physicians. Overt discrimination was most commonly experienced through misgendering and having a physician refuse to provide care. Most episodes of misgendering were accidental missteps that were quickly remedied. Some participants, however, reported frequent misgendering that was felt to be malicious (**Table 2**, quotations 11 and 12).

Refusal to provide care to participants was uncommon and typically rationalized by a lack of expertise in trans health, although it was often felt to be owing to underlying transphobia (quotation 13).

Overall, participants were tolerant of mild forms of discrimination, but stressed that even seemingly minor offenses like accidental misgendering can cause great distress for some people.

Both within family medicine and in other settings, participants reported avoiding care owing to their fear of discrimination. Participants had multiple reports of discriminatory behaviour in the emergency department and in non–family physician specialist offices, with some completely refusing to present to these settings, even when indicated (quotation 14). A common request of participants was to ensure that referrals to non–family physician specialists or counselors were done only after ensuring they were supportive of trans identities.

Expectations of ideal care. Participants had relatively modest expectations for their family doctors. They expect a supportive physician who provides a positive space for those with trans identities, and who is willing to learn. Participants did not expect their family physicians to have a deep understanding of trans health needs, but did hope for some basic knowledge around hormone initiation and where to access further resources (**Table 2**, quotation 18).

While participants recognized the occasional role of non–family physician specialists in delivering care, the overall desire was to have their health care centralized in their family physicians' offices (quotation 19). Participants thought that their family physicians knew more about their medical, psychological, and social needs and thus could provide more holistic care. Several participants who were referred to non–family physician specialists for HRT experienced long wait times and incurred substantial travel costs. Participants thought that family medicine residents should graduate with a basic understanding of trans HRT and surgical referrals (quotations 20, 21, and 22). It was also suggested that they be exposed to trans individuals during training to heighten their empathy and eventual willingness to provide culturally safe care.

Discussion

Family physicians function as the gateway to the health care system, managing most patients' needs and arranging for other specialist help when required. Historically, family physicians have had a limited role in the care of trans patients, but in some regions the bulk of clinical responsibilities is shifting to primary care providers. This study explored the trans community's experience of accessing care through family physicians, illustrating a range of positive and negative experiences, providing insight into existing strengths, and exploring how the delivery of health care to trans individuals can be improved.

Previous studies have demonstrated that discrimination against trans people within health care is common[12,13] and leads to health care avoidance.[8,14] This study confirms that finding. Although many physicians were supportive of trans patients, they generally had very little knowledge of trans-specific care needs, and several participants reported negative experiences that left them reluctant to access care. Participants who had unsupportive or uneducated physicians put in considerable effort to secure health care resources they required. For many trans patients their physicians were a barrier, and patients might expend unreasonable effort to convince their physicians to provide appropriate care.

Despite their negative experiences, this study suggests that the trans community has achievable expectations of family physicians. Owing to family physicians' accessibility and capacity to provide comprehensive care, participants reported a preference for having their family physicians provide HRT and surgical referrals instead of other specialists. Providing safe spaces for trans patients can increase the likelihood that individuals will access care appropriately. Cultural safety training about LGBT2SQ populations for clinic staff should be a universal standard of care.

All family physicians must be involved in providing these services so that trans care can be accessible to everyone across the country. In regions where trans care is still delivered largely through other specialists, increasing the role of family physicians will improve access. Participants waited years in some cases to see other specialists, and suicide attempts are highest when care has been sought but transition has not yet started. If trans health care can be provided by family physicians, some of the negative mental health outcomes might be mitigated. Organizations like Rainbow Health Ontario have reduced barriers to education by creating accessible online guides for family physicians on how to provide trans health care. Work needs to be done with both residents and practising family physicians to encourage more family doctors to start caring for trans patients.

Limitations

This study is limited in its generalizability owing to the small sample size and limited geographic setting. Kingston, as a medium-sized urban centre, has fewer resources than larger centres but has more resources than rural or remote areas across Canada. Despite accessing approximately 10% to 20% of openly trans community members in Kingston, this study had a small number of participants, and given the diversity of experiences of these individuals saturation was not believed to have been reached.

Conclusion

This study provides a rare opportunity for the trans community's voice to be heard about their experience

of health care, and is uniquely positioned to provide feedback directly to family physicians about patients' expectations of care. The findings of these interviews demonstrate 2 key points for Canadian family physicians. First, that appropriate trans care can be delivered by family physicians and, in many cases, that would be preferred by patients. The ability to provide holistic care for a trans person's medical and psychological needs is seen as an asset, and brief educational interventions can provide family physicians with the basic knowledge needed to initiate and monitor HRT. Second, appropriate care for trans people is inconsistently delivered owing to lack of education and physician discomfort. Trans patients have the expectation and the right to culturally safe care from family physicians who are willing to learn about trans health needs. Work needs to be done to educate and empower family physicians about providing trans primary care. Trans health curricular objectives are being implemented in several Canadian medical schools and residency programs, but to reach currently practising physicians community-based educational events need to be as accessible as possible and delivered in a variety of formats. Additional networking opportunities such as the development of e-consultations in some regions can serve to support physicians who are learning and are not yet comfortable with the spectrum of trans care.

As trans health care evolves toward a primary care–focused discipline, research looking into the experiences of trans patients needs to continue. The systemic oppression of trans people has led to an intersectionality with poverty, mental illness, and substance abuse.[13] This has left trans Canadians facing a unique set of historical, societal, and medical barriers to living a healthy life, and their voices should be central in determining how their care is organized. All family physicians need to be involved in providing trans primary care to limit the negative social, psychological, and medical outcomes experienced by this population.

Dr Bell is Assistant Professor in the Clinical Sciences Division of the Northern Ontario School of Medicine. **Dr Purkey** is Assistant Professor and Director of Global Health in the Department of Family Medicine at Queen's University in Kingston, Ont.

Contributors
All authors contributed to the concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

Competing interests
None declared

Correspondence
Dr Justin Bell; e-mail **justin.bell@nosm.ca**

References

1. Conron KJ, Scott G, Stowell GS, Landers SJ. Transgender health in Massachusetts: results from a household probability sample of adults. *Am J Public Health* 2012;102(1):118–22. Epub 2011 Nov 28.
2. *Bill C-16. An Act to amend the Canadian Human Rights Act and the Criminal Code.* Ottawa, ON: House of Commons; 2016. Available from: **www.parl.ca/DocumentViewer/en/42-1/bill/C-16/third-reading**. Accessed 2017 May 31.
3. Weissman MM, Bland RC, Canino GJ, Greenwald S, Hwu HG, Joyce PR, et al. Prevalence of suicide ideation and suicide attempts in nine countries. *Psychol Med* 1999;29(1):9-17.
4. Bauer GR, Pyne J, Francino MC, Hammond R. Suicidality among trans people in Ontario: implications for social work and social justice. *Serv Soc Que* 2013;59(1):35-62.
5. Bauer GR, Scheim AI; for the TransPulse Project Team. *Transgender people in Ontario, Canada: statistics to inform human rights policy.* London, ON: TransPulse; 2015.
6. Speck K. *Rainbow Health Ontario Trans Primary Care.* Toronto, ON: Institute of Medical Science, Faculty of Medicine, University of Toronto; 2016. Available from: **http://rainbowhealth.wpengine.com/TransHealthGuide/index.html**. Accessed 2017 May 31.
7. Giblon R, Bauer GR. Health care availability, quality, and unmet need: a comparison of transgender and cisgender residents of Ontario, Canada. *BMC Health Serv Res* 2017;17(1):283.
8. Bauer GR, Zong X, Scheim AI, Hammond R, Thind A. Factors impacting transgender patients' discomfort with their family physicians: a respondent-driven sampling survey. *PLoS One* 2015;10(12):e0145046.
9. Snelgrove JW, Jasudavisius AM, Rowe BW, Head EM, Bauer GR. "Completely out-at-sea" with "two-gender medicine": a qualitative analysis of physician-side barriers to providing healthcare for transgender patients. *BMC Health Serv Res* 2012;12:110.
10. Creswell JW, Poth CN. *Qualitative inquiry and research design. Choosing among five approaches.* 4th ed. Thousand Oaks, CA: Sage Publications; 2018.
11. Creswell JW. *Research design. Qualitative, quantitative, and mixed methods approaches.* 4th ed. Thousand Oaks, CA: Sage Publications; 2014.
12. Bauer GR, Hammond R, Travers R, Kaay M, Hohenadel KM, Boyce M. "I don't think this is theoretical; this is our lives": how erasure impacts health care for transgender people. *J Assoc Nurses AIDS Care* 2009;20(5):348-61.
13. Poteat T, German D, Kerrigan D. Managing uncertainty: a grounded theory of stigma in transgender health care encounters. *Soc Sci Med* 2013;84:22-9. Epub 2013 Feb 19.
14. Bauer GR, Scheim AI, Deutsch MB, Massarella C. Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: results from a respondent-driven sampling survey. *Ann Emerg Med* 2014;63(6):713-20.e1. Epub 2013 Nov 1.

This article has been peer reviewed.
Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2019;65:e147-54