
Barriers to Healthcare and Disclosure of LGBTQIA + Identity for Transgender Males in Obstetrics and Gynaecology

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Abstract: Changes in culture and legislation have brought inclusivity and cultural competence to the forefront of medicine. Clinicians must be competent at delivering care for minority-status individuals, such as those who identify as transgender. The purpose of this study is to review the literature regarding the transgender patient group's experience of healthcare, and to propose suggestions for outcome improvement in transgender medicine. English-language articles published after 2010 were searched for under the headings 'transgender Gynaecology' on PubMed and 'female-to-male transgender disclosure Gynaecology' on Ovid. Journal articles on disclosure of female-to-male transgender status in Obstetrics and Gynaecology were selected for analysis. Qualitative themes were identified and categorised under four main headings: barriers to access; forms of disclosure; clinician facilitation; implications for Obstetrics and Gynaecology. Twenty-five journal articles were included. Systemic stigma was a considerable force in determining whether patients felt properly managed within their healthcare system. Structural changes such as renaming 'Women's Health Services' to 'Reproductive Health Services' and embedding transgender medicine into healthcare curricula could improve the experiences of transgender men in Obstetrics and Gynaecology.

Keywords: Obstetrics and Gynaecology, Transgender Males, Disclosure, Stigma, Feminist Medicine, LGBTQIA+ Medicine

1. Introduction

The Equality Act 2010 [1] established a holistic UK policy regarding discrimination. Characteristics such as gender and sexuality are now better protected by law. The legal integration of LGBTQIA+ individuals into society has prompted leaders of public infrastructure to assess their services for inclusivity and promote better access for the vulnerable [2]. Theoretically, this should lead to unprejudiced access and experiences for protected-characteristic individuals, but such legislative changes can be challenging to implement [3]. In the United States, the Healthy People 2020 objectives aim to reduce delays in access to healthcare by minority subgroups in order to improve patient outcomes [4]. The Healthy Outcomes legislation highlights how individuals on the fringes of mainstream culture, such as the transgender community, are still subjected to stigma in healthcare [3].

Whilst 'transgender' is included in the categorisation of LGBTQIA+ individuals, gender identity and sexual orientation are distinct constructs that in many cases do not overlap [5]. That is to say that a transgender man who is emotionally or sexually attracted to cisgender women is part of a gender minority, but their heterosexuality is culturally 'normative'. This fundamental distinction is often lost in clinical research: the use of transgender as an "umbrella term" [6] for gender-nonconforming individuals overlooks the diverse biology of this patient group.

A transgender individual is one whose "[gender identity is incongruent with their natal sex]" [2]: by definition, transgenderism rejects a binary system of gender. As a result, barriers to basic services originally constructed around binary gender roles (such as education, healthcare and housing) are still highly prevalent in this patient group [7]. Cadaveric studies have implicated the pattern of the bed-nucleus development in

the stria terminalis as an aetiological theory of the determination of sex behaviours [7] but specific biology of transgenderism, if such aetiology is present, is yet to be identified. The breadth of transition procedures for transgender men results in significant heterogeneity in secondary sexual characteristics between patients. Thus, transition is a spectrum, with the degree of “feminising” procedures dependent on individual conception of gender and self [5].

For transgender men that have not undergone reassignment surgery (such as phalloplasty and ‘top surgery’), the innate medical complications associated with having a uterus, ovaries and breast tissue are equally as relevant as for cisgender women [8]. A problematic situation arises here, whereby patients must access specialty services for organ systems that do not represent their gender identity and may cause dysphoria. Subsequent misgendering by the provider or non-disclosure of transgender status by the patient become significant barriers to appropriate care. One study conducted in the San Francisco Bay Area found that hormonal or surgical treatments sometimes act as the primary decider as to whether a patient’s transgender status is routinely accepted by healthcare staff [9], as opposed to self-identification. This can perpetuate structural mis-labelling of patients as one binary gender or another. The 1:3 ratio of transgender men to transgender-women in Europe highlights the complexity of assuming opposite gender roles in society. This ratio suggests that for female-to-male transgender people to adopt a masculine role without medical or surgical reassignment is significantly easier than for the male-to-female converse [7].

The nuances of gender roles create a complex web of identities that, when superimposed onto healthcare services that traditionally serve a binary system, become increasingly challenging to navigate. The dichotomy of “natal sex” and current gender, along with the opposing societal pressures these represent, are challenging obstacles that transgender men face in their pursuit of good gynaecologic and obstetric care [6]. To facilitate this experience, healthcare professionals must understand the factors that lead to disclosure and its implications on wellbeing, as well as how to medically manage transgender patients. This paper aims to provide a synopsis of the current literature regarding disclosure of transgender status in obstetric and gynaecologic settings, and to offer constructive suggestions on how to improve the experiences of these patients within our healthcare systems.

2. Materials and Methods

This review considers English-language articles published after 2010 sourced from Ovid and PubMed. The search criteria for Ovid was ‘female-to-male transgender disclosure Gynaecology’, with each search term expanded using the ‘map for subheading’ tool (for example: transgender OR transgendered persons OR transgendered person OR transgenders OR transsexual OR transsexual OR transsexuals). PubMed returned fewer results and thus the search terms were reduced to ‘transgender Gynaecology’. All journal article forms were accepted in order to attain a range

of qualitative and quantitative studies, literature reviews and RCTs. Papers on transition surgery formed one exclusion criterion as the focus of the review was to look at patients whose genitalia are incongruent with their gender identity. Studies situated in nonmedical contexts, and those in medical contexts other than Obstetrics or Gynaecology (such as HIV or mental health services) were not used. Other exclusion criteria included: discussion of gender dysphoria about breasts; lesbian or gay service access; transgender healthcare workers or students and discussion of male-to-female transgender patients. The two searches generated 552 studies which were title-screened based on the exclusion criteria. This left 80 articles for abstract screening, after which the total was reduced to 60. The final screening process was to assess the full texts under inclusion criteria. Journal articles with explicit discussion of disclosure of transgender status were selected, which narrowed the search to 25 for data extraction. Selection process summarised in figure 1.

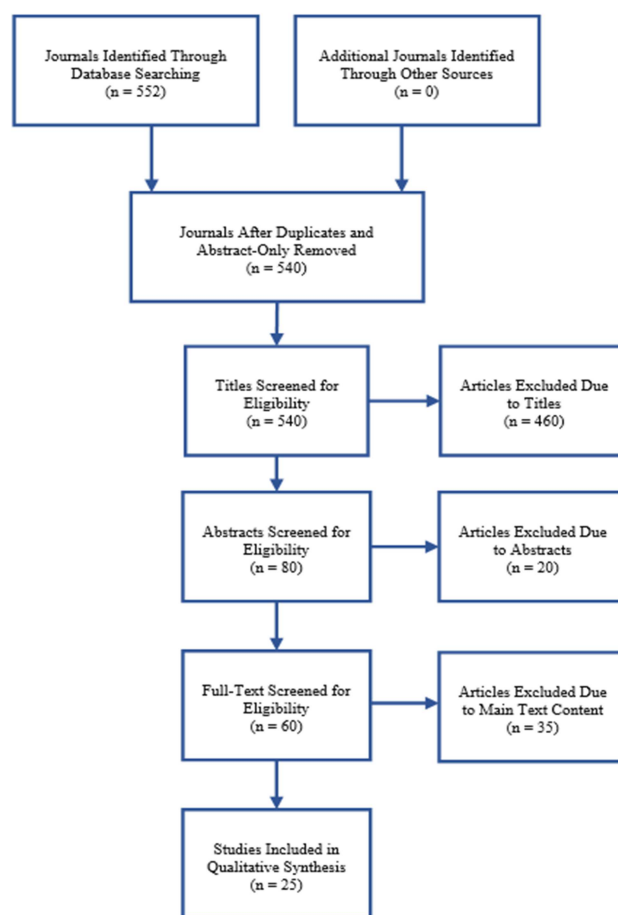


Figure 1. Modified PRISMA Strategy [10].

3. Results

The 25 remaining studies included both quantitative and qualitative data. Data was extracted and grouped thematically under the headings of barriers to care; instances of disclosure and implications for Obstetrics and Gynaecology. As this paper aims to evaluate the experience of patients in the field,

most of the data obtained was qualitative. Some demographic statistics derived from the included journal articles were used.

4. Discussion

The predominant finding from synthesising the literature was that whilst interpersonal factors certainly contribute to the process and implications of disclosure, the prevailing heteronormativity of infrastructure had the most influence on transgender men accessing care. Whilst the passing of legislation like the Equality Act and the Healthy People 2020 objectives has better legitimised the nature of transgenderism as a protected characteristic, widescale reformation to make services more mindful of this patient group has not followed. Access to healthcare is a fundamental issue in the transgender community, delays in which can be attributed to both proximal and distal stressors: proximal stressors deriving from within the patient and distal stressors deriving externally [10]. Societal attitudes are shifting towards inclusivity, yet many services have been founded on outdated gender identities and thus structurally lag behind. Individual clinicians play an important role in promoting the integration of marginalised patient groups into healthcare, celebrating diversity without sensationalising it. Cultural competence in clinical encounters is paramount in forming a strong therapeutic alliance with marginalised minority subgroups, particularly when the architecture of the system is inherently alienating.

4.1. Barriers to Access

4.1.1. Personal Barriers

The theory of “identity concealment” [11] is an important factor for minority-characteristic patients, as presenting to healthcare services often necessitates some degree of ‘outing’. Transgender men who have not undergone transition procedures carry a “concealable stigma” [11] and must choose at which point, if ever, to disclose their minority gender status. Deducing which service-providers will be supportive and non-discriminatory can lead to “hypervigilance about avoiding victimisation” [11]. Fear of discrimination subsequently contributes to delay between desire to seek treatment and presenting at services. Intersectionality theory (the concept that health inequities are confounded in those with multiple minority identities [4]) is a significant contributor to the postponement of care by transgender men. The cultural norm that cisgender-men are likely to delay visiting their doctor [12] combined with the structural disparities faced by cisgender-women are combined and confounded, leading to transgender men being the most likely group to delay access to healthcare [4].

Patient perception of health and healthcare play a significant role in determining when (and whether) medical care is sought. If a patient’s past experiences in the healthcare system have been discriminatory, their willingness to return may be diminished [12]. Furthermore, if the patient attributes little significance to a service, then the potential negatives of disclosing transgender status may be felt as

reason enough to forgo treatment. Negative expectations about a care service may be reinforced by the fact that transgender people are repeatedly found to have decreased access to general (and therefore health) education. For example, a transgender man whose genitalia is biologically female may place little value to routine Pap screening as their cervix is not anatomically congruent with their gender identity. The benefits of screening are outweighed by the potential psychological impact of accessing a typically female health service, putting this patient at greater risk of cervical disease.

4.1.2. Provider Barriers

Distal stressors are those which originate from external forces such as the healthcare provider. The primary reason for provider bias in the literature was uncertainty, stemming from a lack of education and training in transgender medicine [5]. Uncertainty can lead to an “atmosphere of disapproval” [4] that further marginalises the patient and contributes to doubt in provider’s competence [9]. Whilst transgender identity is no longer classified as a psychopathology, many providers seem not to have adjusted their care delivery accordingly [13]. This becomes increasingly problematic in services constructed upon outdated binary systems of sex and gender.

Alienation often arises for transgender men in Gynaecology services: providers appeared to value childbearing expectations over sexual health [14]. This attitude wrongly assimilates sexuality with gender identity, and implies female genitalia are synonymous with maternity. Providers exhibit internal bias through the “sensationalisation” [2] of transgender patients, characterised by asking questions that are not medically necessary, but rather as an inquisition of transgenderism in general. Whilst this may be with the intent of education, it leads to patients’ intimate medical problems or personal experiences becoming a spectacle, and compromises patient autonomy and dignity.

4.1.3. Structural Barriers

Structural barriers are a distal stressor centred around the organisation of healthcare infrastructure. In cases where a service is designed under cisgender binaries, transgender patients must confront an environment specifically tailored to the gender identity they reject. In the context of Obstetrics, pregnant transgender men are faced with an entire system designed for women: once again leading to the structural isolation of those who deviate from the norm [14]. This isolation can perpetuate the “stigma-sickness slope” [15] wherein the systemic alienation of patients based on minority status leads to their rejection of the healthcare system, manifesting in delays presenting to services, risky health behaviours and in extreme cases serious illness.

Information systems such as intake forms derived from a gender binary lead to the institutional erasure of transgender patients [9]. On an individual level this can be distressing for the patient as they are systematically rejected from the normal standards of caregiving. Standardised forms, such as those used for patient registration at a service, hinder patients’

ability to give a relevant history. The wider implications of these forms include patients not being allowed, as standard, to seek care for their natal sex despite being equally at risk of ill-health as their cisgender counterparts [7]. This is particularly poignant in healthcare systems that rely on medical insurance.

4.2. Forms of Disclosure

Whilst verbal communication is the most obvious method of transgender status disclosure, non-verbal strategies were also found to contribute; physical appearance and gender history are both important components in establishing identity [11]. These methods clinicians an insight into facilitating gender affirmation. For example, a transgender man presenting to a Gynaecology clinic may feel that their outward male identity is significant disclosure of their transgender status, without the need to verbally confirm so. The relay of this information is far more nuanced than ticking a box for 'male, female or other' on an intake form. For patients with a 'concealable stigma' such as gender history, there is no uniform level of 'outing'. Disclosure depends upon what is asked and what the patient feels is appropriate.

This conflict was explored in a study of how transgender men chose to present themselves during pregnancy [16]. The first approach ("acting so as to incline others to think one is a cisgender woman") affirmed pregnancy but renounced male identity to the wider public. The second ("acting so as to incline others to think one is a cisgender male") worked conversely, promoting public acknowledgement of their gender identity but outwardly questioning their pregnancy. The final strategy ("acting so as to incline others to see one as transgender") was seen to be the most certifying for patients in terms of their pregnancy and gender identity but increased the likelihood of encountering anti-trans discrimination.

One American study found that participants living 'out' as men were likely adopt a cisgender-female role when accessing services such as sperm banks and sexual health clinics to maximise the likelihood of good care [16]. Another paper from the United States expressed that patients were hesitant to allow medical documentation of their gender identity in case employers, for example, required access to these records and thus were able to use the information negatively [17]. In these instances, it was the potential wider ramifications that led to patients' non-disclosure. This was further supported in studies that suggested patients would not prefer transgender-only clinics for fear that this would lead to their 'social outing' [18]. The respondents' disinterest in transgender-only clinics confirms how disclosure is an amorphic process, adapted by patients to fit the circumstances. Disclosure may be achieved through direct dialogue but is equally as valid for some when expressed through other non-verbal means such as clothing and speech.

4.3. Clinician Facilitation

The data showed that Gynaecology was a common

specialty in which patients first disclosed their transgender status, highlighting the necessity of cultural competence amongst clinicians in the field. The experience of disclosure is cited as a predictor of patient satisfaction with services: if the clinician is inclusive, understanding and gender-affirming it lays the foundation for a healthy therapeutic alliance between the patient, the provider and the system [2].

One study found that 12% of participants believed gender identity should "rarely" or "never" be discussed, stressing how clinicians must validate their history taking with health-centric rationale [19]. Clear explanation of the use of information demonstrates to patients that disclosure of gender status is medically relevant and not merely driven by curiosity or even transgender-phobia. Gender and sexual history are clinically significant for transgender-male patients as they encounter specific health risks: side effects from transition procedures, mental health problems related to transgender-phobic experiences and higher risk of HIV infection are all prevalent among transgender men [20]. As well as creating a positive open dialogue with patients, encouraging disclosure of personal information in clinical settings can create opportunities for targeted health promotion, such as HIV prevention. Disclosure is most productive when supported by sensitive, neutral questioning from health care providers. This grants patients agency over what information is shared whilst allowing clinicians to ensure appropriate care is administered.

Positive instances of disclosure were found to be "gender affirming experiences" [11], which can contribute to a healthy rapport between patients and providers. On the converse, feelings of shame regarding gender identity led to difficulty in forming authentic mutual connections between patients and staff. If a patient is made to feel 'othered' because of their minority status this can result in physical manifestations such as raised cortisol levels associated with stress [10]. Assumption of heterosexuality and cisgender status by clinicians is one of the most astute barriers to disclosure, as it led to patients feeling it was their duty to reframe the consultation and educate the provider about their identity in the process.

4.4. Implications for Obstetrics and Gynaecology

4.4.1. Targets for Improvement

It was repeatedly noted that although clinicians have the physical skills to provide care such as pap smears and breast examinations, up to 71% of staff do not feel competent performing these procedures on transgender-male patients [21]. The very name 'women's health' under which any of these procedures are performed poses mental discordance in healthcare workers and existing patients when someone outwardly male presents in clinic. Such services are often designed to fit a stereotyped view of womanhood in their language and aesthetic. Sitting in waiting rooms designed for, and full of, cisgender-women was a significant stressor for patients in Obstetrics and Gynaecology clinics [22], as it contributed to the systemic sense of othering. Reframing the field to focus on one's reproductive organs as opposed to

their normative natal gender could begin to systemically address this problem. This is an issue that spans beyond the scope of healthcare: a societal approach is indefinitely required to fully integrate transgender men into other aspects of mainstream culture.

Many transgender patients seek primary care through Gynaecology specialists [7], so establishing an inclusive and competent sexual health service is paramount for facilitating patient trust and ease within the healthcare system. Gynaecologic examinations can understandably be physically and emotionally distressing for patients who experience dysphoria around the 'female' components of their anatomy [23]: one study found up to 54% of participants subsequently avoided appointments where these procedures may happen [24]. From a public health perspective, these delays are hugely important as transgender men are reported to have high rates of Gynaecology-specific health risks and behaviours such as unprotected sex [6] and endometrial carcinoma secondary to testosterone treatment [7].

4.4.2. Future Recommendations

Moving towards more gender-neutral terminology and conscious use of pronouns was found to be key in accommodating gender-queer patients in the system. For example, referring to a patient's genitalia as their 'pelvic organs' as opposed to typically feminine terms (e.g. 'vagina' or 'uterus'), and using 'partner' instead of gendered terms such as 'girlfriend' or 'husband' [7]. An effective method of tackling language barriers in one study was simply to adopt the terminology used by patients [25]. Suggested changes to the clinical environment included renaming services from 'women's health' to 'reproductive health', ensuring intake forms have scope for the expression of minority identities and advertising clinical spaces as gender neutral environments that are confidential and safe. These adjustments all challenge the systemic heteronormativity that patients battle, ensuring reproductive health services are addressed to the diverse spectrum of patients they support.

Finally, specific education in transgender medicine and cultural competence is a key intervention to guarantee providers' best practice [4]. Identifying and addressing internal bias through open dialogue in medical schools and beyond would allow clinicians to understand the detrimental effects of transphobia on their patients [26]. These specific communication skills coupled with proper education on the health risks of transgender-male patients [13] would equip the healthcare system with the tools not only to offer evidence-based, considerate care but also to champion inclusivity and contribute to social change. Clinicians working as active allies of the transgender community have the potential to instill acceptance and approval in a much wider audience.

5. Limitations

Whilst this review aims to take a global perspective, it is

difficult to form targeted interventions when healthcare systems are organised so differently across countries. Many of the studies used were conducted in the United States where they have an insurance-based system, so administrative denial of care based on natal sex is potentially more of a barrier than in universal healthcare systems such as the National Health Service of the United Kingdom. This has meant that whilst the proposed changes have been informed by global perspectives, implementation would need to be tailored to each system. Secondly, conducting a study as a sole researcher makes it far more difficult to eliminate bias, both in the search and in drawing conclusions. Given that the purpose of this review was to better understand the patient experience and provide suggestions on how best to go forward, having multiple researchers would have afforded a more balanced perspective. Finally, as there was no primary qualitative data collected in the research, it is difficult to discern whether the proposed suggestions would be found to be beneficial for the patient group they are targeting. Integrating interviews with real patients and clinicians into the work would have supplemented the research and allowed suggestions to be authentic and grounded in novel experiences.

6. Conclusions

Transgender medicine is significantly understudied, and thus more data is required for the medical field to best understand the experiences and outcomes of this group as they access and engage in healthcare. Overall, this study achieved the aims of synthesising the current research on the barriers to and impact of disclosure upon clinical encounters for transgender men in Obstetrics and Gynaecology. Disclosure was found to be a fluid, repeated process, shaped by a variety of systemic and interpersonal factors. As expected, in many instances transgender men come up against barriers to good care, often stemming from the heteronormative origins of our healthcare systems. Fields such as Obstetrics and Gynaecology that specifically address sex and gender roles have unique grounding to make changes for the benefit of this patient group. Better integrating transgender medicine into healthcare curricula and evolving services from their cisgender-centric origins to use inclusive nomenclature and administrative formats could be key to achieving a patient centred approach.

Whilst these conclusions might have been drawn from the context of sexual health, there is no reason to suggest these changes could not improve transgender health outcomes on a wider scale. Further research into the financial viability of these proposals as well as their acceptance by the transgender-male community would be needed to validate the findings of this research, in order for them to be implicated in the future. Medical professionals must act as champions for equality in healthcare and replicate social shifts towards tolerance and diversity.

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