Racial and Ethnic Differences in Experiences of Discrimination in Accessing Health Services Among Transgender People in the United States

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ABSTRACT. Transgender/gender-nonconforming (GNC) individuals experience discrimination at high rates, including 19% in one study who reported having been refused medical care based on their transgender/GNC identity. These individuals may also experience a lack of respect from medical personnel, a dearth of culturally competent knowledge and medical information around their medical needs, and concerns with safety when accessing medical care. Additionally, people of color experience higher levels of discrimination in health care than their White counterparts. This study examines the prevalence of discrimination faced by transgender/GNC people and compares by race/ethnicity those rates of discrimination when accessing medical services such as emergency rooms, doctors/hospitals, and ambulances/emergency medical technicians (EMTs). Data indicate that while a significant number of transgender/GNC individuals of all races/ethnicities experience discrimination based on transgender/GNC identity, when accessing medical services, transgender/GNC people of color experience higher levels of antitransgender discrimination, including in emergency rooms ($\chi^2[1, N = 6,454] = 31.018, p < .001$), with doctors/hospitals ($\chi^2[1, N = 6,454] = 32.831, p < .001$), and with ambulances/EMTs ($\chi^2[1, N = 6,454] = 40.523, p < .001$). Significant differences by region were found regarding discrimination when individuals attempted access to doctors/hospitals, ($\chi^2[1, n = 4,823] = 20.72, p < .001$). Implications of the findings and future research are suggested.

KEYWORDS. Discrimination, gender nonconforming, health services, medical services, racism, transgender issues

A major determinant of good health is having access to the health care system (Grant et al., 2011; Institute of Medicine, 2011), and the ability to have honest conversations with one’s providers about concerns, including one’s relationships, sexuality, and sexual behaviors (Hoffman, Freeman, & Swann, 2009; Stein & Bonuck, 2001). Additionally, disclosure of a lesbian, gay, bisexual, transgender, or queer (LGBTQ) identity is important, as members of the LGBTQ community face numerous health risks that their heterosexual counterparts do not (One Colorado Education Fund, 2011). In this article, we examine a few of the barriers to
health care access for LGBTQ persons as well as those specific to transgender/GNC individuals. While for some individuals, transgender identities may be very different from gender-nonconforming identities, the National LGBTQ Task Force (the Task Force) and the National Center for Transgender Equality (NCTE) have grouped them together for research and policy purposes, as both of these terms are used to describe those whose gender identity does not always align with the sex an individual was assigned at birth (Grant et al., 2011; National Transgender Discrimination Survey [NTDS], 2010). Within the context of this study, we will use these terms as used by these organizations.

**BARRIERS TO HEALTH CARE ACCESS**

LGBTQ persons experience multiple barriers to accessing health care, related, generally, to homophobia and transphobia and to anti-LGBTQ discrimination by medical providers (Institutes of Medicine [IOM], 2011; Lombardi & Van Servellen, 2000; Poteat, German, & Kerrigan, 2013; Stroumsa, 2014), including denial of treatment by health care providers because of the person’s sexual orientation or gender identity (Eliason & Schope, 2001; Harcourt, 2006). For example, in a report of LGBTQ Coloradans, 21.0% of participants reported being refused medical care because of their sexual orientation or gender identity (One Colorado Education Fund, 2011). Experiences of discrimination by LGBTQ individuals from medical providers may lead to members of the LGBTQ community concealing their sexual orientation or gender identity from their medical provider in order to avoid being discriminated against (IOM, 2011; Jillson, 2002). Additionally, because of stigma, LGBTQ individuals may delay seeking needed medical attention (Stein & Bonuck, 2001).

Discrimination against LGBTQ individuals not only affects individuals, but also their families. LGBTQ parents seeking health care for their children, for example, are less likely to disclose their sexual orientation or gender identity to medical providers than their heterosexual counterparts out of fear of substandard care for their family (Chapman et al., 2012; Perrin et al., 2004).

Access to medical care for transgender/GNC individuals is shaped by transphobic attitudes by medical professionals. In a study of transphobic attitudes by medical professionals, 65% of respondents stated that they had heard derogatory comments by medical staff, and 34% indicated that they had witnessed discriminatory care of transgender individuals (Eliason, Dibble, & Robertson, 2011). In studies of transgender individuals, between 20.0% and 23.0% of participants were denied access to health care due to transphobia (IOM, 2011; Kengay & Bostwick, 2005). As with LGB individuals, transgender individuals may also delay or forgo seeking medical attention because of concerns about discrimination. In a study of transgender Coloradans, researchers found that 61.0% of participants had delayed or avoided medical care at some point because of fears of reaction to their gender identity (One Colorado Education Fund, 2011). Lack of culturally competent practices is one of the main issues related to delayed medical care for transgender individuals. When engaging with medical providers, transgender patients frequently have to educate medical professionals about their health care needs and correct provider assumptions about them as individuals and patients (Keiswetter & Brotemarkle, 2010; IOM, 2011; One Colorado Education Fund, 2011; Poteat et al., 2013; Seelman et al., 2012; Xavier, Bobbin, Singer, & Budd, 2005).

Few studies have examined access to emergency care for the LGBTQ community, and what is known primarily comes from anecdotal evidence, typically experiential accounts of patients and providers (e.g., Gotbaum, 2008; Human Rights Campaign, 2014). One prominent example is that of Tyra Hunter, a 24-year-old transwoman who, following a 1995 hit-and-run accident, was denied treatment by emergency medical technicians (EMTs) when they determined she had male genitalia (Anonymous, 2007; Jillson, 2002). According to witnesses, the EMTs taunted Tyra with jokes and name-calling until a supervisor ordered them to resume care (Anonymous, 2007). Unfortunately, once at the emergency room, Tyra’s
injuries were improperly diagnosed and she died (Jillson, 2002). Nearly 2 decades later, qualitative data from Rounds, McGrath, and Walsh’s (2013) study of LGBTQ individuals’ perceptions of quality of care suggests that homophobia and transphobia still are common. In the words of one participant, “I went in for a broken hand and was grilled about my sexuality for ten minutes by the emergency room doctor” (Rounds, McGrath, & Walsh, 2013, p. 106).

In the first study of emergency department utilization among LGB persons (N = 360), 41.7% of participants reported at least one emergency department visit in the past year (Sánchez, Hailpern, Lowe, & Calderon, 2007). Scholars have suggested that LGBTQ individuals may rely more on emergency services for their health care needs due to perceived discrimination in primary care settings (e.g., Stotzer, Silverschanz, & Wilson, 2013), making discrimination in emergency rooms even more problematic.

In their study of various transgender health topics, Clements-Nolle, Marx, Guzman, and Katz (2001) found that one fifth of transgender participants had gone to an emergency department visit in the past 6 months. Researchers estimate that approximately 4.0% of transgender individuals rely primarily on the emergency room for health care needs (Clements-Nolle et al., 2001) as compared to having a primary care doctor or clinic use, with race being one correlate of increased emergency room use (Grant et al., 2011). In the NTDS, 17.0% of African American participants and 8.0% of Latino/a participants reported emergency room use (Grant et al., 2011), while a study of transgender people of color, based in Washington, DC, found that 30.0% of participants had ever visited an emergency room, while 27.0% had utilized DC Emergency Medical Services (ambulance) (Xavier et al., 2005).

As part of a needs assessment of transgender/GNC persons in Chicago (N = 111), Kenagy and Bostwick (2005) assessed health care access and barriers, finding that 14.0% of participants faced challenges in accessing emergency care because of their transgender identity. Results from the NTDS indicate similar findings with transgender/GNC persons reporting denial of equal treatment both at emergency rooms (13.0%) and by EMTs (5.0%) (Grant et al., 2011). In this study, Latino/a participants reported the highest rate of unequal treatment (19.0%) in emergency rooms (Grant et al., 2011), suggesting transgender/GNC persons of color may be at increased risk for discrimination when trying to access emergency services; the study, though, did not examine differential risks for discrimination based on race and ethnicity.

Discrimination extends to emergency care patients’ partners as well. As Jillson (2002) points out, when an individual arrives at an emergency room, staff must frequently make life-and-death care decisions; however, without durable Power of Attorney or designation as a Health Proxy, the patient’s partner if not biologically or legally defined as a family member may be excluded from the decision-making. Unfortunately, even if a partner has legal decision-making rights, it may be questioned in times of emergency care. In an anecdotal retelling, one man shared that, upon arriving at a Washington, DC, emergency room after his partner collapsed, a nurse told him she could only provide information to “immediate family members”; this was despite this man’s 6-year relationship with his live-in partner, with whom he was registered partners in California, shared an adopted son, and had Power of Attorney for such a situation (Human Rights Campaign, 2014). While the man went home to obtain the necessary Power of Attorney documents for the hospital, his partner died (Human Rights Campaign, 2014).

Similar to the experiences of LGBTQ individuals, racial and ethnic minorities often experience discrimination by the medical community based on their race or ethnicity (Benjamins & Whitman, 2014; Smedley, Stith, & Nelson, 2003). Racial discrimination in health care settings is associated with poor health outcomes including higher mortality (Kressin, Raymond, & Manze, 2008; Shavers et al., 2012). Studies suggest that racial minorities are less likely to receive adequate care or recommendations about treatments in trauma units and are 20% more likely than Whites to experience death after major surgery (Lucas, Stukel, Morris,
Siewers, & Birkmeyer, 2006). These inequalities are linked to racial and ethnic minority individuals’ delaying treatment out of fear of discrimination (Benjamins & Whitman, 2014; Inzlicht, McKay, & Aronson, 2006; Pascoe & Richman, 2009).

**POLICY**

Recently, lawmakers across the United States have been proposing legislation that would allow for discrimination against LGBTQ persons, including when trying to access health care, based on religious beliefs (e.g., Protecting Religious Freedom, 2014). For example, during the 2014 Session, Kansas House Bill 2453 (Protecting Religious Freedom, 2014) proposed allowing the denial of services “related to, or related to the celebration of, any marriage, domestic partnership, civil union, or similar arrangement.” The bill ultimately died in the senate (Hanna, 2014). If it had passed, it would have, in part, allowed state hospitals to deny treatment to gay couples (Stern, 2014). Moreover, as Stern (2014) points out, the “or similar arrangement” clause in Kansas H.B. 2453 provided obscurity that could have allowed providers to discriminate against gay individuals as well, not just couples. A similar bill was passed in Arizona in February 2014 (Exercise of Religion, 2014). However, in a letter addressed to the Arizona State Senate President, Arizona Governor Janice Brewer (2014) explained that she had vetoed the Bill in part because of its broad wording that could result in adverse consequences. The fact that policy in some areas is moving in the direction of legalizing discriminatory behavior against LGBTQ individuals is particularly concerning.

**REGIONAL DIFFERENCES**

In the United States, 21 states currently have nondiscrimination laws legally protecting individuals based on their sexual orientation; of these, 18 have additional nondiscrimination laws protecting individuals based on their gender identity (National LGBTQ Task Force, 2014). Most of the states offering these protections are in the western United States, in New England, or in the northern part of the Midwest, while the majority of states in the South, the mid-Atlantic, and most the Midwest do not offer any protections for transgender/GNC individuals (Tilcsik, 2011).

While there is no current research on differences specifically on transphobia and related biased behaviors by region, and very little in the literature on regional differences in homophobia and related behaviors, researchers have found that attitudes about LGBTQ individuals tend to vary by region; in general, the South has less tolerant attitudes toward LGBTQ individuals while attitudes in the West and Mountain regions are much more open to people who have these identities (Sullivan, 2003; Tilcsik, 2011). Young people in the West and Midwest are less likely to report having heard homophobic remarks than those living in the Northeast and youth in southern states are more likely to experience victimization based on sexual orientation, while those in the west were less likely to report having had those same experiences compared to those living in the Northeast. Additionally, young people from states in the South and Midwest were more likely to report victimization based on their gender expression.

**INTERSECTIONALITY**

In research that examines individual’s identities, intersectionality is an important lens through which to view lived experiences. Intersectional theory posits that every person has multiple identities, both to groups that hold social dominance and to groups that are socially marginalized (Warner & Shields, 2013). These intersections influence the experiences of these individuals, demonstrating the unique effects of power and privilege (or lack thereof) on how individuals navigate their social environment. This intersectional approach requires that researchers do an analysis of within-group differences to explore these intersections (Mahalingam, 2006). In this study, the intersection of gender identity and race will be examined to explore the impact it has on experiences of anti-transgender discrimination.
than those living in states in the Northeast (Kosciw, Greytak, & Diaz, 2009). Given the different legal protections for transgender/GNC individuals on a state-by-state basis and the need for more information about whether region impacts the experience of transphobia, this study will include an analysis of regional differences.

**RESEARCH QUESTION**

The current literature on access to health care and the impact of discrimination on transgender/GNC individuals is fairly limited, but what does exist paints a picture of a widespread lack of cultural competence and frequent concerns with discrimination. One remaining concern is whether there is a differential experience of discrimination within the transgender/GNC community based on race and ethnicity. This study aims to examine racial and ethnic differences in experiencing health care discrimination among transgender/GNC persons. Specifically, do transgender/GNC individuals of color experience differential levels of discrimination compared to White transgender/GNC counterparts when attempting to access various medical services? It extends the existing analysis of the NTDS data set and examines the patterns of discrimination by race across three different contexts—doctors and hospitals, emergency rooms, and ambulances/EMTs.

**METHODS**

Secondary data analysis of data from the 2010 NTDS (N = 6,456), which was collected by NCTE and the Task Force is used. In recruiting participants, this survey used the language, “You are invited to participate in a research project regarding transgender and gender nonconforming people in the United States” (NTDS, 2010, p. 1) and defined transgender and gender nonconforming as “people whose gender identity or expression is different, at least part of the time, than the sex assigned to them at birth” (NTDS, 2010, p. 3). The data from the NTDS were collected using online surveys, available in English and Spanish, advertised to potential participants via both NCTE and the Task Force’s email lists and partner organizations’ member lists, and via social media including blogs, Twitter, and Facebook. The sample includes residents of all 50 U.S. states, Washington, DC, Puerto Rico, and Guam who were age 18 and above and who self-identified as transgender and/or GNC. Among other survey items, participants were asked if they had ever experienced discrimination based on their gender identity/gender expression across a number of medical situations, including when trying to access services from doctors and hospitals, emergency rooms, and ambulances and EMTs. The university institutional review board approved the present secondary data analysis.

Before analysis began, all responses for variables of interest in this study were examined for missing data. For each health service area (doctors and hospitals, emergency rooms, and ambulances and EMT’s), the variables were recoded so that only respondents who tried to access that specific medical service were included in the analysis of whether or not they experienced discrimination when doing so. Individuals who had not used or attempted to use each of the health services were excluded from that specific analysis to avoid conflation of nonuse with lack of experience of discrimination. In examining differences in discrimination by region, the regional variable from the survey was used (New England, mid-Atlantic, South, Midwest, western United States including Alaska and Hawaii, and California). Given the large number of respondents from California, it was included as its own region rather than being included in the western United States group.

For the first analysis, race/ethnicity was recoded dichotomously (e.g., White or people of color) to determine the overall pattern. All individuals that responded that they were one or more non-White races or ethnicities were initially coded as people of color. All those who answered that they identified as White and indicated no other racial or ethnic identity were coded as White. Because of the small number
of Middle Eastern respondents \((n = 5)\), they were dropped from the analysis. Next, respondents’ race was then coded by individual races/ethnicities (Black, biracial/multiracial, Latino/a, Asian Pacific Islander, American Indian, White). Data analyses included descriptive statistics and chi-squared tests of independence to determine independence in prevalence and frequency of discrimination by race/ethnicity, first comparing people of color to Whites, then comparing each specific racial/ethnic group to Whites.

### RESULTS

#### Descriptive Statistics

After completing data cleaning, the sample size was 6,451. All identified as transgender and/or GNC, and among the respondents, 26.1\% \((n = 1,685)\) identified as male/man, 40.4\% \((n = 2,606)\) identified as female/woman, 19.7\% \((n = 1,274)\) identified as living part time in their authentic gender, and 13.4\% \((n = 864)\) identified with a term not listed and were given the opportunity to fill in their own preferred gender identity. The remaining 0.3\% \((n = 22)\) did not respond to this question. Racially, 75.6\% \((n = 4,879)\) identified as White, with 24.4\% \((n = 1,572)\) identifying as people of color. For both the specific racial and ethnic identities and the sexual orientations of the respondents, see Table 1. A wide range of ages was represented in the sample, with the smallest group being those aged 65 and older. The mean age was 36.7 years and the median age was 33 years. The range was 18 to 98 years \((n = 5,891)\). The age variable was normally distributed, and there were multiple participants with ages in the 80s and 90s. Regionally, the sample was diverse, with 8.7\% \((n = 540)\) living in New England, 21.7\% \((n = 1,314)\) living in the mid-Atlantic, 18.0\% \((n = 1,120)\) living in the South, 20.8\% \((n = 1,292)\) living in the Midwest, 16.7\% \((n = 1,035)\) living in the western United States (including Alaska and Hawaii), and 14.6\% \((n = 906)\) living in California.

**TABLE 1. Descriptive Statistics \((n = 6,456)\)**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>75.6</td>
<td>4,879</td>
</tr>
<tr>
<td>Black/African American</td>
<td>4.5</td>
<td>290</td>
</tr>
<tr>
<td>American Indian</td>
<td>1.2</td>
<td>39</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>4.7</td>
<td>204</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>2.1</td>
<td>137</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>0.1</td>
<td>5</td>
</tr>
<tr>
<td>Bi-/Multiracial</td>
<td>11.8</td>
<td>762</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay/Lesbian</td>
<td>20.5</td>
<td>1,326</td>
</tr>
<tr>
<td>Bisexual</td>
<td>22.8</td>
<td>1,473</td>
</tr>
<tr>
<td>Queer</td>
<td>19.7</td>
<td>1,270</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>20.8</td>
<td>1,341</td>
</tr>
<tr>
<td>Asexual</td>
<td>4.0</td>
<td>260</td>
</tr>
<tr>
<td>Other</td>
<td>10.8</td>
<td>698</td>
</tr>
</tbody>
</table>

#### Discrimination

A sizable portion of transgender/GNC individuals reported having experienced discrimination across all three types of medical service settings examined in the survey. Around one fifth (20.4\%) of all transgender/GNC individuals reported having experienced discrimination based on their gender identity/gender expression when attempting to access doctors/hospitals; 11.9\%, when attempting to access emergency room services; and 4.6\%, when attempting to access services of ambulances/EMTs. Turning now to examining differential rates of discrimination by race, as shown in Table 2, we first compared White transgender/GNC people with all transgender/GNC people of color, and then each racial/ethnic group of transgender/GNC individuals was compared to White transgender/GNC people.

**Doctors and Hospitals**

Transgender/GNC people of color (26.1\%) reported statistically significant higher rates of having experienced discrimination than their White counterparts (18.5\%) when accessing doctors and hospitals, \(\chi^2 (1, n = 4,986) = 32,831, p < .001\). Black/African American transgender/GNC individuals (11.7\%) reported statistically significant lower rates of discrimination based on their gender identity/expression than White transgender/GNC people, \(\chi^2\)
(1, n = 3,958) = 6.35, p < .01, while Latino transgender/GNC individuals (25.0%), \( \chi^2 (1, n = 3,900) = 4.13, p < .05 \), and biracial/multiracial individuals experienced higher rates than White individuals (32.8%), \( \chi^2 (1, n = 4,439) = 72.86, p < .001 \). Neither Asian/Pacific Islanders nor American Indians’ reports were significantly different from those of Whites.

**Emergency Rooms**

At emergency rooms, transgender/GNC people of color (16.8%) reported statistically significant higher rates of having experienced discrimination than their White counterparts (10.1%), \( \chi^2 (1, n = 3,655) = 31.018, p < .001 \). American Indian transgender/GNC individuals (18.46%) reported statistically significant higher rates of discrimination than White transgender/GNC people, \( \chi^2 (1, n = 2,723) = 4.89, p < .05 \), as did Latinos (16.6%), \( \chi^2 (1, n = 2,797) = 6.01, p < .05 \), and bi-/multiracial individuals (20.6%), \( \chi^2 (1, n = 3,191) = 47.82, p < .001 \). Asian/Pacific Islanders and Black/African Americans’ reports were not significantly different from those of Whites.

**Ambulances/EMTs**

When using ambulances and/or interacting with EMTs, transgender/GNC people of color (16.8%) reported statistically significant higher rates of discrimination than their White counterparts (10.1%), \( \chi^2 (1, n = 3,655) = 31.018, p < .001 \). American Indian transgender/GNC individuals (18.46%) reported statistically significant higher rates of discrimination than White transgender/GNC people, \( \chi^2 (1, n = 2,723) = 4.89, p < .05 \), as did Latinos (16.6%), \( \chi^2 (1, n = 2,797) = 6.01, p < .05 \), and bi-/multiracial individuals (20.6%), \( \chi^2 (1, n = 3,191) = 47.82, p < .001 \). Asian/Pacific Islanders and Black/African Americans’ reports were not significantly different from those of Whites.

**Regional Differences**

Given that this was a national sample, and there are no national laws in the United States protecting transgender/GNC individuals from discrimination, we examined the frequencies of discrimination based on regional location of the participants. The original survey recoded zip codes of participants into six regions: New England, mid-Atlantic, South, Midwest, western United States (including Alaska and Hawaii), and California. Table 3 details the lifetime experiences of discrimination reported by the participants by region. Chi-squared tests of independence were completed for each of the discrimination variables, significant differences by region were found regarding discrimination when attempting to access services of doctors/hospitals, emergency rooms, and ambulances/EMTs, with significantly higher rates of discrimination against those individuals who are also people of color. Across all three contexts examined, Latino/a and bi-/multiracial individuals reported

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**TABLE 2. Lifetime Experience of Discrimination by Race/Ethnicity for Participants Who Attempted to Access Health Services**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Health service</th>
<th>Doctors/Hospital</th>
<th>Emergency Room</th>
<th>Ambulances/EMTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (attempted to access services)</td>
<td>4,986</td>
<td>3,655</td>
<td>2,779</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>18.5%***</td>
<td>10.1%*</td>
<td>3.0%</td>
<td></td>
</tr>
<tr>
<td>People of color</td>
<td>26.1%***</td>
<td>16.8%**</td>
<td>8.6%***</td>
<td></td>
</tr>
<tr>
<td>Specific race/ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>11.7%**</td>
<td>10.4%</td>
<td>6.8%</td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>24.3%***</td>
<td>18.5%***</td>
<td>5.9%***</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>25.0%***</td>
<td>16.6%***</td>
<td>13.9%***</td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>13.6%</td>
<td>4.05%</td>
<td>4.8%***</td>
<td></td>
</tr>
<tr>
<td>Bi-/Multiracial</td>
<td>32.8%***</td>
<td>20.6%***</td>
<td>9.1%***</td>
<td></td>
</tr>
</tbody>
</table>

*Note. EMTs = emergency medicine technicians

*p < .05. **p < .01. ***p < .001.

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**DISCUSSION AND IMPLICATIONS**

The results of this study demonstrate high rates of discrimination against transgender/GNC individuals when they are trying to access doctors and hospitals, emergency rooms, and ambulances/EMTs, with significantly higher rates of discrimination experienced by those individuals who are also people of color. Across all three contexts examined, Latino/a and bi-/multiracial individuals reported
significantly higher rates of discrimination than did White individuals, while Asian/Pacific Islanders reported similar rates of discrimination to those reported by White individuals. African American respondents reported significantly different rates of discrimination than White respondents in two of the three contexts (lower in doctors/hospitals and higher in ambulances/EMTs), while American Indian respondents reported significantly higher rates of discrimination than White respondents in one of the three contexts (emergency rooms). Given these results, there is an indication of needed change in how health services professionals interact with patients who are transgender/GNC–identified in order to reduce levels of discrimination experienced by these individuals.

The results that American Indians and Black/African American transgender/GNC respondents experienced higher rates than their White counterparts in some contexts, but not others, suggests the need for further research considering potential qualitative differences between the contexts. Additionally, the fact that Black/African American transgender/GNC respondents actually experienced lower rates of antitransgender discrimination than White transgender/GNC respondents indicates not only the need for further research but the importance of using an intersectional lens. It is possible that the reason for this is because the discrimination they experienced may have been (all or in part) race related rather than related simply to gender identity and/or gender expression. While individuals who belong to multiple marginalized groups often experience increased levels of discrimination, they may also have trouble in nuancing which of their identities were on the receiving end of the discrimination. In this case, trying to distinguish racism from transphobia may have been difficult for the transgender/GNC people of color who responded. Intersectionality offers a lens through which to view this crossroads, and recognizes that an individual may experience discrimination based on multiple identities rather than just one.

The analyses run in this study did not find any statistically significant differences between transgender/GNC Asian/Pacific Islanders and their White transgender/GNC counterparts. It is possible that this finding may be due to Asian/Pacific Islanders being stereotyped as the “model minority” (Wang & Kleiner, 2001) by medical professionals, indicating that they may experience discrimination based on their race/ethnicity in a variety of different ways than individuals with other racial and/or ethnic identities, some of which may be more implicit, and less overt or obvious. As this study’s data does not have variables needed to delve deeper into the experiences of Asian/Pacific Islanders, further research is indicated to more deeply examine these findings.

<table>
<thead>
<tr>
<th>Region</th>
<th>Doctors/Hospital***</th>
<th>Emergency room</th>
<th>Ambulances/EMTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (attempted to access services)</td>
<td>4,823</td>
<td>3,530</td>
<td>2,683</td>
</tr>
<tr>
<td>New England</td>
<td>17.7%</td>
<td>12.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Mid-Atlantic</td>
<td>17.2%</td>
<td>10.5%</td>
<td>4.0%</td>
</tr>
<tr>
<td>South</td>
<td>21.4%</td>
<td>11.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Midwest</td>
<td>19.0%</td>
<td>12.3%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Western US/Alaska/Hawaii</td>
<td>24.3%</td>
<td>11.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>California</td>
<td>23.0%</td>
<td>14.3%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

***p < .001.
In examining potential regional differences in experiences of transphobic discrimination when accessing health services, there was a statistically significant different in experiencing discrimination when attempting to access doctors/hospitals with respondents in the South, in the western United States (including Alaska and Hawaii), and in California reporting higher rates of discrimination than those respondents living in New England, in the mid-Atlantic, and in the Midwest. There were no significant differences between experiences of discrimination based on region when examining access to emergency rooms or to ambulances/EMTs. While higher rates of transphobic discrimination in the South seems in line with the literature and attitudes, it was surprising to note that there were also higher rates of discrimination experiences when attempting to access doctors/hospitals in the western United States (including Alaska and Hawaii) and in California, two areas that tend to be viewed as more progressive and welcoming to alternative gender identities. Washington, Oregon, Hawaii, and California all offer legal nondiscrimination protections for transgender/GNC people (National LGBTQ Task Force, 2014). It is possible that people in these areas are more aware of implicit discrimination (as compared to more obvious or explicit) and may be reporting higher rates because there is more conversation around this topic or because they expect more transgender inclusive services given the legal protections and societal views of these areas. Further research is called for in order to better understand these nuances.

Additional research is needed in order to examine the lived experiences of people who have multiple identities, especially multiple marginalized identities. This includes looking at other identity variables such as sexual orientation, income level, and citizenship status. Doing so would allow for a more intersectional view of how people, particularly those who have multiple marginalized identities, experience discrimination. By looking at their experiences of discrimination, as well as the effects that this discrimination may have on physical health, mental health, and overall well-being, researchers can better inform policy decisions around these communities, ensuring that policies are put into place providing additional education for service providers and more inclusive access to these various services. Moreover, further research exploring those with intersectional identities within the transgender/GNC communities is needed, particularly with those who are immigrants to the United States, those for whom English is not the primary language, and those who have disabilities. Research on these marginalized identities may bring to light evidence supporting differential accrual of risk for those who embody these identities. Increased knowledge on these patterns can provide a foundation to help inform policy and may serve to challenge proposed policies such as the ones in Arizona and Kansas that were discussed in the review of the literature. Given that analyses of this national data set demonstrated high levels of discrimination experiences by transgender/GNC individuals when attempting to access health services, it is evident that change is needed not only at the government policy level but also at the organizational level and educational level regarding medical and health service professionals. Adding culturally responsive trainings regarding gender identity for medical students (including nurses and EMTs) and health service professionals could support a reduction in rates of antitransgender discrimination by health service workers.

LIMITATIONS

As with most secondary data analysis, some limitations exist which should be considered when interpreting the findings. These limitations include use of single measure items and measurement issues related to accurately capturing the nuances of a complex experience like discrimination. Another limitation concerns the exclusive use of the Internet for data collection, which may have excluded some members of the transgender/GNC community, including those with limited Internet access, such as older individuals, individuals who with a low income, chronically homeless individuals, and persons living in more rural areas. The
NTDS also used language that might be not accessible to certain individuals participating in the survey or may have multiple definitions that vary from person to person, such as the terms “transgender” as compared to “gender nonconforming” as two unique identities, or the option of being able to choose living “part-time” as one’s gender identity. Because of this, some participants may have opted to skip some questions that they did not understand or they may have understood the question differently than the survey administrators had intended. Additionally, while discrimination and gender are more nuanced than the constructs of doctors/hospitals, emergency rooms, and ambulances/EMTs, there could be some confusion around health services, including doctors being different from hospitals, how community medical clinics are categorized, and other like examples.

One last limitation is that there were few respondents who racially/ethnically identified as Middle Eastern (n = 5) or American Indian (n = 39). Given the extremely small size of the sample of Middle Eastern participants, we dropped these cases from the analyses but made the decision to keep American Indian respondents in the analysis as the sample was somewhat larger. It is possible that there are actual significant differences between American Indian transgender/GNC people and the rest of the sample with regard to accessing doctors/hospitals and ambulances/EMTs, but that the small sample size lead to type II error, indicating no significant differences where significant differences do exist in the general population.

**CONCLUSION**

The findings from this study draw much needed attention to the discrimination that exists toward transgender/GNC individuals accessing health services, including demonstrating the increased levels of discrimination experienced by those transgender/GNC people who hold multiple marginalized identities, including racial/ethnic identities. Given the general pattern that transgender/GNC people of color report experiencing significantly higher rates of discrimination from doctors and hospitals, emergency rooms, and ambulances/EMTs than their White counterparts, medical professionals need to increase their awareness of intersectional identities and to receive multicultural and culturally responsive education as part of their training before working in the health services field. By providing better training for medical and health service workers, society can provide more inclusive health services for transgender and gender-nonconforming persons, particularly people of color, allowing all individuals access to respectful and inclusive medical care.

**REFERENCES**


