CADTH

CADTH RAPID RESPONSE REPORT:
SUMMARY WITH CRITICAL APPRAISAL

Gender Affirming Therapy for Gender Dysphoria: A Rapid Qualitative Review

Service Line:	Rapid Response Service
Version:	1.0
Publication Date:	June 08, 2020
Report Length:	33 Pages

Authors: Ann-Sylvia Brooker, Hannah Loshak

Cite As: Gender affirming therapy for gender dysphoria. Ottawa: CADTH; 2020 Jun. (CADTH rapid response report: summary with critical appraisal).

ISSN: 1922-8147 (online)

Disclaimer: The information in this document is intended to help Canadian health care decision-makers, health care professionals, health systems leaders, and policy-makers make well-informed decisions and thereby improve the quality of health care services. While patients and others may access this document, the document is made available for informational purposes only and no representations or warranties are made with respect to its fitness for any particular purpose. The information in this document should not be used as a substitute for professional medical advice or as a substitute for the application of clinical judgment in respect of the care of a particular patient or other professional judgment in any decision-making process. The Canadian Agency for Drugs and Technologies in Health (CADTH) does not endorse any information, drugs, therapies, treatments, products, processes, or services.

While care has been taken to ensure that the information prepared by CADTH in this document is accurate, complete, and up-to-date as at the applicable date the material was first published by CADTH, CADTH does not make any guarantees to that effect. CADTH does not guarantee and is not responsible for the quality, currency, propriety, accuracy, or reasonableness of any statements, information, or conclusions contained in any third-party materials used in preparing this document. The views and opinions of third parties published in this document do not necessarily state or reflect those of CADTH.

CADTH is not responsible for any errors, omissions, injury, loss, or damage arising from or relating to the use (or misuse) of any information, statements, or conclusions contained in or implied by the contents of this document or any of the source materials.

This document may contain links to third-party websites. CADTH does not have control over the content of such sites. Use of third-party sites is governed by the third-party website owners' own terms and conditions set out for such sites. CADTH does not make any guarantee with respect to any information contained on such third-party sites and CADTH is not responsible for any injury, loss, or damage suffered as a result of using such third-party sites. CADTH has no responsibility for the collection, use, and disclosure of personal information by third-party sites.

Subject to the aforementioned limitations, the views expressed herein do not necessarily reflect the views of Health Canada, Canada's provincial or territorial governments, other CADTH funders, or any third-party supplier of information.

This document is prepared and intended for use in the context of the Canadian health care system. The use of this document outside of Canada is done so at the user's own risk.

This disclaimer and any questions or matters of any nature arising from or relating to the content or use (or misuse) of this document will be governed by and interpreted in accordance with the laws of the Province of Ontario and the laws of Canada applicable therein, and all proceedings shall be subject to the exclusive jurisdiction of the courts of the Province of Ontario, Canada.

The copyright and other intellectual property rights in this document are owned by CADTH and its licensors. These rights are protected by the Canadian *Copyright Act* and other national and international laws and agreements. Users are permitted to make copies of this document for non-commercial purposes only, provided it is not modified when reproduced and appropriate credit is given to CADTH and its licensors.

About CADTH: CADTH is an independent, not-for-profit organization responsible for providing Canada's health care decision-makers with objective evidence to help make informed decisions about the optimal use of drugs, medical devices, diagnostics, and procedures in our health care system.

Funding: CADTH receives funding from Canada's federal, provincial, and territorial governments, with the exception of Quebec.

Questions or requests for information about this report can be directed to **requests@cadth.ca**

Abbreviations

GAT	gender affirming therapy
GCS	gender confirmation surgery
GM	gender minority
HRT	hormone replacement therapy
LGBTQ	lesbian, gay, bisexual, transgender and queer
NP	nurse practitioner
TGN	transgender and gender non-conforming
TGNC	transgender and gender non-conforming
WPATH-SOC	World Professional Association for Transgender Health Standards of Care

Context and Policy Issues

Transgender, non-binary, and genderqueer people face high levels of discrimination, stigma and violence.[1] Recent surveys indicate that transgender people represent approximately 0.5% of the population,[2] and this number is expected to grow as people feel more comfortable expressing their gender identity. In the political sphere, recent federal legislation has granted protection against the discrimination of transgender people in Canada.[3]

Transgender individuals comprise a diverse group with specific and varied social, medical and psychological needs. Transgender people can experience high rates of distress and suicidality.[1,4] Almost half (43%) of transgender people have a history of attempting suicide.[1] Suicide risk is highest when experiencing transphobia and when waiting to transition.[1,4] Rates of suicidality can drop markedly once transition has been completed.[1] Some transgender individuals choose hormone therapy or gender reassignment surgery. Currently, candidates for hormone therapy must demonstrate a consistent and persistent gender-variant identity that meets criteria for gender dysphoria as categorized by the DSM-5.[5]

Within the health care setting, transgender people have been underserved and often experience discrimination.[1] This is may be due to the absence of training about transgender health in health professional education. Historically, transgender people's needs for hormone therapy were served exclusively by endocrinologists. More recently there has been a shift in the duty of responsibility toward community physicians.[6]

Given the historical context of marginalization of this community, their diverse health needs, and the shift of medical care from specialists to primary care physicians, it is important to examine the experiences of transgender individuals within the current Canadian context and to explore the experiences of the health care providers who treat them.

Research Questions

- How do people living with gender dysphoria experience the initiation of gender affirming therapy and what are their expectations of this process?
- Given that the initiation of gender affirming therapy has traditionally been within the domain of specialist practitioners, how do primary care providers caring for people living with gender dysphoria understand their role in, and comfort level with, initiating this process?

- How are primary care providers involved in decision-making regarding gender affirming therapy? How is this experienced by patients? By primary care providers?

Key Findings

Transgender youth and adults faced numerous obstacles when seeking gender affirming care. Their journey required self-advocacy, and they often encountered stigma and discrimination. There was no evidence that the decision to undergo hormone replacement therapy was a shared decision between patients and providers. Transgender youth developed an understanding of the transgender experience through their own research, primarily independently and frequently online. The challenging process of navigating the health care system to find a clinician who was knowledgeable and willing to provide gender saffirming care began. Primary care physicians often lacked knowledge about hormone replacement therapy. Sometimes, primary care physicians would refer the individual elsewhere. This could lead to treatment delay and could result in increased levels of anxiety and suicidality. Participants described educating their primary care physicians by providing them with resources or information about continuing education.

Participants noted that it can be difficult to access gender affirming care because the assessment criteria for gender dysphoria are highly subjective. Some individuals described efforts to "present" in a way that is consistent with the assessment criteria. Individuals with complex mental health problems, or those with financial insecurity, faced particular barriers to care, as clinicians could make the decision that they were not ready to transition. Non-binary individuals also face unique challenges because their needs regarding hormone therapy and surgeries are not consistent with a binary narrative. Some of them described difficulties in obtaining the care that they needed even at clinics oriented toward transgender individuals.

In general, participants expressed a preference for having primary care physicians rather than specialists provide hormone replacement therapy and surgery referrals. Primary care physicians were viewed as preferable because of their greater accessibility and because they were viewed as more able to provide holistic care that included medical, psychological and social needs.

Social and environmental factors are also relevant. Participants sought supportive primary care physicians who could provide positive spaces. However, participants frequently reported experiencing discriminatory encounters in the health care setting. Discriminatory practices such as misgendering, deadnaming or being outed in the health care space often led to the avoidance or delay of health care, including for gender affirming care. By contrast, participants noted that positive interaction and symbols and information that indicated acceptance of transgender identities would lead to increased use of health care.

Clinicians reported that they had received virtually no formal education regarding transgender health. They learned on the job through courses, through resources and through their patients. Clinicians emphasized the importance of fostering a positive patient-provider relationship built on trust. Some clinicians recognized that using the patient's preferred name and pronoun is an important aspect of building a respectful relationship with their patients. However, some clinicians noted that the intake forms for new patients present only binary options (male or female), and thus impeded their ability to use the correct pronouns for their patients. Furthermore, some clinicians stated that they refused to use the patient's preferred name and pronoun and instead opted to use the patient's birth name and sex at birth. Some clinicians noted that the hormone assessment readiness tool is highly subjective.

Both clinicians and transgender patients thought that primary care physicians lack foundational knowledge regarding transgender health needs. Many clinicians were aware of the discrimination and stigma faced by their transgender patients. However, clinicians did not seem aware of other aspects of the health care environment that are important to transgender individuals, such as the need for privacy and sensitivities regarding the physical exam.

Methods

Literature Search Methods

A limited literature search was conducted by an information specialist on key resources including Medline and PsycINFO via OVID the Cochrane Library, the University of York Centre for Reviews and Dissemination (CRD) databases, the websites of Canadian and major international health technology agencies, as well as a focused internet search. The search strategy was comprised of both controlled vocabulary, such as the National Library of Medicine's MeSH (Medical Subject Headings), and keywords. The main search concepts were gender affirming therapy and primary care. Search filters were applied to limit retrieval to qualitative studies or studies relevant to the perspectives and experiences of patients and their caregivers. Where possible, retrieval was limited to the human population. The search was also limited to English language documents published between January 1, 2010 and April 17, 2020.

Selection Criteria and Methods

One reviewer screened citations and selected studies. In the first level of screening, titles and abstracts were reviewed and potentially relevant articles were retrieved and assessed for inclusion. The final selection of full-text articles was based on the inclusion criteria presented in Table 1.

Table 1: Inclusion Criteria

Sample	Adults and youth living with (or who are being treated for) gender dysphoria
Phenomenon of Interest	Q1,2: Experiences and expectations of people living with (or who are being treated for) gender dysphoria , their primary care providers and their families regarding gender affirming therapy (e.g., hormone replacement therapy) when initiated by a primary care practitioner (e.g., physician, nurse practitioner); Q3: Experiences of decision making regarding the initiation of gender affirming therapy
Design	Qualitative studies of any qualitative design (e.g., phenomenology, grounded theory, qualitative description)
Evaluation	Q1: From a person living with (or who has experienced) gender dysphoria, issues emerging from the literature that relate to the research questions, including but not limited to perspectives on, expectations of, and experiences with gender affirming therapy initiated by a primary care practitioner. As appropriate, differences will be explored by personal characteristics including, for example: • age, • different geographies (i.e., urban, rural, remote),

	• situatedness within typically marginalized or vulnerable populations (e.g., immigrants/refugees; Indigenous Peoples). Q2: From a health care provider’s perspective, issues emerging from the literature that relate to the research questions, including but not limited to perspectives on, expectations of, and experiences with gender affirming therapy initiated in primary care. As appropriate, differences will be explored by provider’s characteristics, including for example: • level of proficiency, • different geographies (i.e., urban, rural, remote), • practice setting. Q3: From a person living with (or who are being treated for) gender dysphoria’s, their family, and their health care provider’s perspective, issues emerging from the literature that relate to the research questions, including but not limited to their engagement around decision making regarding gender affirming therapy when initiated by a primary care provider.
Research Type	Primary qualitative studies using qualitative methods for both data collection (e.g., interviews, focus groups) and analysis (e.g., constant comparative method, content analysis)

Exclusion Criteria

Articles were excluded if they did not meet the inclusion criteria outlined in Table 1, they were duplicate publications, or were published prior to 2010.

Critical Appraisal of Individual Studies

The included studies were critically appraised by one reviewer using CASP.[7] Summary scores were not calculated to report the quality of included studies; rather, the strengths and limitations of each included study were described narratively. Results of the critical appraisal were not used to exclude studies from this review.

Data Analysis

One reviewer conducted the analysis. The coding process and analysis were iterative. First, all articles were read to get a sense of major themes. Then, each article was coded using line by line coding. Initial codes were based on the themes and concepts derived by the authors of the included studies; however, codes and themes were changed, revised and reconceptualized throughout the coding and writing process as the analysis progressed and to meet the objectives of this review.

A process of constant comparative methods drawn from grounded theory methods was used to help analyze and interpret the results.[8] There was a difference between the experience of transgender patients and the clinicians who treat them. However, there were also some differences between the type of clinician. In addition, differences in experiences were revealed between the experiences of transgender youth and transgender adults; between transgender people who present as binary, and non-binary transgender individuals; between those who have transformed bodies and those whose bodies are untransformed. Therefore, these distinctions were carefully elucidated in the analysis and used to help interpret the results.

Another difference relates to social context. Some of the studies were conducted in Canada and many of the studies were conducted in the United States. The policy, legal and economic context concerning the treatment of gender dysphoria differs between these two countries. As a result, the report generally states where the study was conducted to help with the interpretation of findings. As this report is geared towards a Canadian audience, there was a slight emphasis on reporting the results from Canadian studies.

Summary of Included Literature

Quantity of Research Available

A total of 354 citations were identified in the literature search. Following screening of titles and abstracts, 323 citations were excluded and 31 potentially relevant reports from the electronic search were retrieved for full-text review. One potentially relevant publication was retrieved from a hand search the for full-text review. Of these potentially relevant articles, fifteen publications were excluded for various reasons, and 17 publications met the inclusion criteria and were included in this report. Appendix 1 presents the PRISMA[9] flowchart of the study selection.

Summary of Study Characteristics

Study Design

Seventeen studies were included in this review. Three of these studies were mixed method designs, in which both qualitative data and quantitative data were collected.[10-12] One study used a phenomenologic approach,[6] two studies used an ethnographic approach.[5,13] and one study used both critical phenomenology and ethnographic description.[14] One study used constructivist grounded theory.[15] One study used a feminist, participatory action research framework.[16] One study used an approach based on social constructivism.[17] The other studies did not specify their approach, but they used in-person semi-structured interviews.[18-22] One study used focus groups [23] and another study used secondary data from another qualitative study that was based on in person interviews.[24]

Country of Origin

Eight of the studies were conducted in Canada[5,6,10,14-17,20] and nine of the studies were conducted in the United States.[11-13,18,19,21-24]

Patient Population

Of the eight studies examining the health care experience of transgender individuals within Canada,[5,6,10,14-17,20] two included youth aged 14-18 years old[15] and 12-17 years old.[16] These two studies also described the experience of parents of transgender youth. Nine studies explored the health care experience of transgender individuals within the United States.[11-13,18,19,21-24] One of these studies was based on transgender youth (13-21 years old).

Three studies explored the experience of treating transgender individuals from the perspective of health care providers in Canada.[5,14,20] These studies explored the experiences of general practice physicians in Halifax or Vancouver,[14] and of nurse practitioners from either New Brunswick, Nova Scotia or Prince Edward Island.[20] Two studies explored the experience of treating transgender individuals from the perspective of health care providers in the USA.[11,13] One of these studies interviewed a range of health care providers (internist, endocrinologist, pediatrician, medical director, herbalist).[13] The other study interviewed primary care providers or specialists in oncology (nurses or physicians).[11]

Interventions (and Comparators)

This review examines the experience of gender affirming therapy for gender dysphoria, and reports the experiences of those who experience gender dysphoria as well as the experiences of the clinicians who treat those individuals.

Gender affirming care includes treatments that are specifically used to treat gender dysphoria such as hormone treatments and gender reconstruction surgeries (GRS). However, many of the participants expressed the view that gender affirming care goes beyond the application of these treatment modalities.[19] For transgender patients, every encounter in the health care space can be either gender affirming or gender denying. For this reason, this broader understanding of the term “gender affirming” care is used in this review.

Summary of Critical Appraisal

All studies identified for this review used qualitative methods appropriately. The study design, the data collection methods and the data analytic strategies were all appropriate for qualitative research.

In one of the studies, the researcher explicitly discussed how her expressed gender identity, social class and education were in some ways similar, and in other ways different from those of her study participants.[22] Furthermore, the researcher discussed how she addresses the differences to help generate detailed accounts from her study participants and generate rich data.[22] In the other studies, the relationship between the study participants and the researcher was not described.

In four studies the authors explicitly described their theoretical orientation.[5,6,21,22] These studies therefore tended to provide a more detailed theoretical explanation for the results that they generated.[5,21,22]

Additional details regarding the strengths and limitations of included publications are provided in Appendix 4.

Results

The results are presented in two parts. The first part presents the experience of transgender patients and their interactions with the health care system. The second part describes the experience of clinicians who treat individuals with gender dysphoria.

The experience of transgender patients with the health care system can be categorized into four themes: the process of discovery and decision-making regarding treatment for gender dysphoria; navigating the health care system to access treatment; a preference for family physicians providing the bulk of care and being treated as a whole person and searching for culturally sensitive care.

The health care experiences of people with gender dysphoria

The process of discovery and decision-making regarding treatment for gender dysphoria

This review identified one study that described youth’s reflections on gender dysphoria and on their subsequent decisions to seek treatment.[15] This study of youth residing in British Columbia, Canada revealed that the first aspect of this journey was a discovery phase, in which youth began to develop awareness of the transgender experience and found language to describe their own gender and experiences. This growing awareness was supported by the participants' own research – that was "primarily conducted independently and online" (p.139)[15] and focused on accurate medical information and personal narratives.

Individuals weighed several factors before deciding to come out and seek hormone therapy. The individuals considered the fear of treatment of transgender people in public spaces and stigma – ranging from internalized stigma to cues from parents about gender acceptance. Sometimes, these fears made youth hesitate before coming out.[15] However, in other cases, the stigma helped the youth decide to initiate hormone therapy because it could help them pass more successfully as the other gender and avoid being subject to violence. In addition, the intensity of distress caused by their feelings about their body propelled them to seek treatment.[15]

Those who came out to parents and declared their need for hormone therapy encountered a range of supportive and unsupportive reactions related to their health care goals.

Navigating the health care system to access treatment

Before initiating hormone therapy in Canada, individuals are required to undergo a hormone readiness assessment, which is typically conducted by a psychiatrist or psychologist.[15] Sometimes, primary care physicians are also qualified to provide this service. Some youth navigated this system with the support and help of their parents, youth workers support groups and youth clinicians, while others explained that the process was challenging because they received little support.[15] Some youth appreciated health care providers who assisted in explaining gender health needs to their parents. However, other youth were frustrated that the provider-imposed requirements to involve parents in the process delayed treatment because their parents were not on board.[15]

For some Canadian youth, there were financial and travel barriers. In Canada, health care provider costs are paid for, but a funded hormone readiness assessment service may not be available to all youth.[15] In the American context, financial barriers for HRT were more extensive and included such costs as doctor visits, lab work and of therapist to provide a letter of support for initiating hormone therapy.[12,13]

Advocacy, persistence, presentation

Studies of both transgender youth and transgender adults revealed that the process of obtaining treatment for gender dysphoria requires a substantial amount of persistence, and self-advocacy beyond what would be considered typical in a patient-health care practitioner encounter.

Lack of knowledge about HRT among primary care physicians

Participants from both Canada[6,15-17] and the United States[18,19,23] thought that the knowledge of primary care practitioners about hormone therapy for gender dysphoria was often lacking. A study conducted in Kingston, Ontario concluded that participants perceived that few family physicians had a baseline understanding of the initiation, dosing, and monitoring protocols for HRT.[6]

Participants reported educating their physician about transgender health needs.[6,17,18] Some participants described how they brought in resources[17] such as copies of transgender hormone guidelines to their primary care provider or referred them to local education events.[6] Some participants reported that primary care physicians, although initially not knowledgeable about relevant protocols, were perceived by participants to provide appropriate care after a brief educational intervention.[6] However, some patients reported that it was emotionally exhausting to be constantly educating health care professionals.[6]

Other participants reported that some primary care physicians were unwilling to provide transgender health care services[6,16] despite being given educational materials.[6] This led to specialist referrals, delayed access for HRT and sometimes transportation costs, as specialists were often in different communities.[6,15] Some parents of youth in a study conducted in Newfoundland expressed frustration that it was difficult to find appropriate services for their child, as expressed by the parent of a 15-year-old boy: "[It is] very frustrating to try to get services. [I am] only aware of services through friends I have developed throughout the journey. Healthcare not adequate!" (p.21)[16]

In some cases, participants whose primary care physicians were not willing to provide health care services led the participant to lose faith in family physicians and the health care system, and some patients chose subsequently to limit interactions with physicians with little attention paid to preventive care.[6] In addition, some study participants expressed the view that the exclusion of transgender issues in health provider curriculums may contribute to the interpersonal discrimination that they experienced because the exclusion signifies to clinicians that transgender patients do not matter.[17]

Studies conducted in the United States also reveal that transgender patients struggled with clinicians who lacked knowledge about transgender health needs, and in some cases, denied care. In one study, clinicians who were "willing to learn" and "educate other health care providers were viewed very positively by participants. One participant remarked: "I inherited a doctor who was a god-send. He knew nothing about me or transgender women, but took it upon himself to learn." (p.e85)[24]

Participants from the United States often reported significant difficulties in accessing care. In one study, some patients reported that some endocrinologists would refuse to provide hormone treatment to transgender patients.[12] In another study in New Orleans, USA, most respondents described obtaining gender affirming care through alternative routes. They travelled abroad for surgical procedures, and ordered hormones online, sharing among friends, or via international pharmacies. They did this because of cost difficulties or because they did not want to interact with the healthcare system.[13] They also discussed the use of street silicone injections which they used to help achieve their gendered body.[13] In another study, many participants stated that they drove to nearby cities or places with gender clinics in to get hormone treatment.[12]

Presentation of self as a means to access to care

In the North American context, clinicians' assessment of gender dysphoria are guided by two assessment standards: the DSM and the WPATH-SOC (World Professional Association for Transgender Health Standards of Care).[5] Some Canadian participants explained that they felt they had to present in a certain way[6] or become an expert in transition readiness assessment[5] to access treatment. For instance, one participant noted:

"[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" (p. e151)[6]

Another participant explained that he was a member of a transgender support group where they would discuss the script that you would present to your physician to get hormone treatment.[6] Other participants described strategies such as displaying complete confidence in their desire to transition rather than acknowledging that they might have some hesitations. For instance, one participant felt compelled to check off "yes" for all potential transgender procedures on a medical form, as a means of downplaying any possible uncertainty.[5]

Some features of this narrative, such as an expressed desire for gender reassignment surgery, may have been shaped by earlier versions of the WPATH-SOC as previous versions did not recommend the administration of hormones to patients who were not interested in subsequent gender reassignment surgery.[5]

The challenge of individuals with complex mental health problems, financial insecurity; HIV positive

Gaining access to hormones and gender affirming surgery appears to be particularly challenging for those with complex mental health problems and for those experiencing financial insecurity. Some patients in a study conducted in Canada described the delicate balancing act that they had to achieve to present sufficient distress indicative of gender dysphoria, but at the same time convey that they were mentally healthy enough to transition:

"When I first stated transitioning, I was experiencing a lot of issues with …mainly depression and a lot of thoughts of suicide…I didn't want to say anything that would potentially be a barrier to me starting hormones…So I remember at the time thinking, how do I convey to the doctor…that I identify with these symptoms [of gender dysphoria] without appearing…mentally unhealthy" (p.63)[5]

Both patients and clinicians noted that how much "significant distress" is appropriate for gender dysphoria as opposed to an uncontrolled mental disorder that could complicate a patient's transition was ambiguous.[5] Transgender participants who were considered to have complex mental health problems described having to prove to clinicians that the issue was controlled by describing their therapy, and how they were "doing everything they were asked" (p.65) such as taking medications.[5] Transgender patients who disclosed mental health or substance use issues, could lead providers to determine that they were not ready to transition.[5] Gaining access to hormones or surgeries for this group required significantly more time and resources.

Two studies conducted in Canada found that financial instability could also lead to delays in treatment. Unstable housing or lack of financial resources to take time off paid work could lead providers to conclude that transition needed to be delayed.[5] Another study of HIV positive transgender women found that factors such as lack of financial resources, housing instability, and precarious immigration status served as barriers to accessing gender affirming care.[10] In addition, those who were able to access medical transition reported HIV related stigma when interacting with service providers.

The challenge of non-binary individuals in accessing GAT

The studies indicate that non-binary transgender people experienced additional challenges in obtaining the care that they needed.[6,12] A study conducted in Canada suggests that non-binary youth may experience lower levels of parental support for hormone therapy and higher barriers to care.[15]

American studies offered more detail about the experience of non-binary individuals in the health care context.[12,19] Participants explained that not all non-binary individuals are interested in surgery, and some may want reduced hormones or no hormones at all.[12,19] Non-binary individuals explained that they needed to educate their providers, and sometimes they were unable to obtain care that met their needs.[12] For instance, some participants reported that mental health therapists would provide hormone therapy only for binary transgender patients and deny it to non-binary transgender patients.[12]

In one study conducted in San Francisco of nonbinary transgender young adults (23-33), nearly all participants encountered providers whom they perceived were reframing their needs into a binary perspective of transgender care, even within transgender clinics. For instance, one two-spirit study participant explained that they ceased medical care because the health care provider assumed that they wanted surgery:

> "I remember that she [the provider] thought that I hated my penis. This was so bizarre to me, you know, because I used it. I was fine with it. …she was seriously convinced by all this shit that [because] I said I was non-binary that I hated my penis. She told me on- well she told me like three separate times […] to consider removing it, to consider bottom-surgery…I left after the third time. I couldn't take it anymore" (p.193)[19]

Other participants avoided care because the treatments that they desired did not fit into a standard transgender binary framework. Some participants explained that they modified the treatment prescribed based on the use of the "transgender label". For instance, a genderqueer participant explained that they took a lower dose of masculinizing hormones than prescribed to achieve the effect they wanted: "So, what I do is get the full dose by saying I'm transgender, But I don't take the full shot every week because I want less effects from T". (p.194)[19]

This account illustrates that some non-binary individuals are making decisions on their own without guidance from medical professionals. This introduces the possibility of potential health risks because medication is not taken as prescribed, and there is lack of open discussion with the medical provider about the medication that is taken.[19]

A preference for primary care physicians providing the bulk of care being treated as a whole person

Generally, participants stated a preference for having primary care physicians provide HRT and referrals for surgery: "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". (p.e152)[6] While participants did not expect their primary care physicians to have a deep understanding of transgender health needs, they did hope for "some basic knowledge around hormone initiation and where to access further resources." (p.e153)[6]

While they recognized the occasional role of specialists providing care, participants wanted to have their care centralized with their primary care physicians. They thought that the primary care physician knew more about their medical, psychological and social needs and therefore would be better suited to deliver holistic care.[6] The need for being viewed as a whole person with a full range of health needs, roles, identities and experiences was emphasized by participants in numerous studies[18,23]: “I really appreciate when people can see me as a whole person. Like being transgender is part of me, but I’m also a parent, and I- there’s a lot of other parts of me that come into play” (p. 79)[23] This view was corroborated by other participants who felt as though their clinician had reduced them to set of organs and genitals.[13]

Participants explained that primary care physicians are more accessible than specialists, thus wait times are shorter and transportation costs are reduced.[6] Greater accessibility of care is an important concern for this group, because studies have found that anxiety, depression and suicide attempts are highest when care has been sought but transition has not yet started.[6] Some study participants reported that denial of gender affirming care led to distress and suicidality.[10]

Searching for culturally-sensitive care

In addition to the technical aspects of providing gender affirming care, such as appropriate HRT dosages, the research reveals the relevance of social and environmental factors in participants’ quest for gender affirming care. There was the expectation among study participants that they could find a supportive primary care physician who could provides a positive space for transgender identities.[6] Furthermore, transgender individuals who experience discrimination and negative interactions in the health care setting are more likely to delay care or forgo health care such as mental health care, physical health care and gender affirming therapies.[25]

Discriminatory practices include misgendering or deadnaming patients and outing patients in the health care setting. By contrast, positive interactions include such practices as being sensitive during the physical exam and the naming of genitalia and providing symbols and information in the health environment that indicate acceptance of transgender identities. These are described in greater detail below.

Discrimination and the incorrect use of pronouns

In one study conducted in Canada, many participants reported that they frequently encountered health care providers with negative or uncomfortable attitudes, leading the transgender patients to feel disrespected.[17] A few participants stated that the health care providers were colder and shorter with them compared to before they came out as transgender.[17]

All three studies of transgender adults had some participants who reported that they were frequently misgendered or called by their previous name during a health care encounter.[6,10,17] In one of these studies the participants thought that this misgendering was purposeful and avoidable.[10] In another study, the participants attributed the misgendering to a limited understanding of how to interact with transgender patients.[6]

Studies conducted in the United States appear to reveal more serious examples of health care providers misgendering or dead-naming their patients. Some participants reported being misgendered[23,24,26] or deadnamed even after they had legally changed their name.[21] In one study, the participant explained that her health care provider attempted to correct her and claim she was not a woman, she was “really a man” because she had male genitalia.[21].

As another example, a participant explained being purposefully misgendered during a health encounter.

> "The nurse practitioner told her student nurse that even though I had [GCS] surgery, I was still male. I thought: 'oh my God, I've done all this and I'm still a man?...I could have gone and killed myself, or something like that. That could have been the adverse effect. Afterwards, I walked away and never went back." [58 years old] (p.e87)[24].

Many participants thought their health care providers were "aloof, uninterested, uncomfortable with transgender identities" (p.e85).[24] They did not use names or pronouns correctly and they did not take participant health needs seriously.[24]

Participants in one study emphasized that even milder forms of discrimination such as accidental misgendering can cause great distress for some people.[6] In addition, these forms of discrimination can result in health care avoidance.[10]

Lack of privacy and discrimination in the health care setting

Some participants noted that the physical environment of a health care environment, such as waiting rooms, emergency rooms and changing rooms are often not conducive to privacy.[17] While privacy is an important consideration for all patients, transgender patients pointed out that as opposed to cisgender patients, lack of privacy could lead to violence for them. Lack of privacy constitutes a barrier that could lead to health care avoidance.[17]

Participants feared violence within the health care setting from health care workers, or other patients, or outside in the community, as a consequence of being "outed" within the context of the health care setting.[17] Outing could occur as a result of having office staff use incorrect names and pronouns.[18] This could lead to distress and to medical care avoidance in the future.[18]

Participants in one study thought that rural health care providers within Nova Scotia were less tolerant of transgender individuals than those from urban centers.[17] Furthermore, in a small town, patients feared that eventually their gender identity would not stay confidential, once it was revealed in the health care setting:

"I live in a town of 15,000 people. Everyone knows everyone…I'm really reluctant [to disclose that I'm transgender] because I might know the nurse. …I know that sooner or later, that information is going to get out there…I've been outed on more than one occasion because I went into a hospital or clinic space" (p.239)[17]

The physical exam as dysphoric

Participants expressed the desire to have clinicians who were sensitive about physical exams and the naming of genitalia. The research reveals that for some transgender patients, physical examinations regarding genitals can be uncomfortable: "examinations 'involving the genitals should be as quick as possible because you tend, people tend to feel kind of dysphoric when those are brought up." (p.347)[18]

For some transgender and non-binary people, using the anatomically terms for genitalia can be very distressing.[17,18] One participant explained: "Your doctor knows what your biological sex is. But I do not know, just hearing it can be really uncomfortable and like stressful". (p.347)[18]

Signifiers of a positive space

Some participants commented that having a rainbow flag or sign would help them to feel safer in the health care setting and could cause them to access health care more frequently.[6,17] Such signs can convey to the transgender patient that the environment understands and is knowledgeable about transgender identity. [6,17,18,21]

Some participants reflected on the apparent lack of posters, pamphlets relating to transgender health in health care settings.[17] Such an omission served as a barrier to learning more about their own health care needs.

Gender-neutral bathrooms were an important feature of the physical environment.[17,18] Participants noted it was very stressful to have to choose between male and female washrooms. They noted that while gender-neutral washrooms are often found in hospital settings, they had not seen them in doctor's offices or walk-in clinics.[17]

Participants suggested that altering medical paperwork so that gender was not just a choice between male and female would be very appreciated and for some it would increase their use of healthcare.[17-19,23] In addition, nonbinary individuals stated a need for nonbinary options on forms.[23]. However, in one study, some youth noted that some parents might not be supportive of their transgender identity and therefore transgender identity intake forms would be best completed when alone in the doctor's office.[18]

The experience of health care providers

The experience of clinicians who treat clients with gender dysphoria can be categorized into the following themes: lack of formal education concerning transgender health; fostering a positive patient-provider relationship; using patient's preferred names and pronouns vs misgendering and deadnaming; clinicians as gate keepers?; treating the transgender-patient the same or different: social identities vs. individualism.

Lack of formal education concerning transgender health

Studies of Canadian nurse practitioners and physicians[14] revealed that these clinicians felt that they lacked foundational knowledge regarding the LGBTQ community and particularly with respect to transgender health. The clinicians stated that their training for LGBTQ issues, and particularly transgender health, within nursing schools or medical schools was either non-existent or insignificantly short. These views about lacking training in LGBTQ health were echoed American clinicians.[11,27] The nurse practitioners compensated for this lack of knowledge by learning from their patients, from the internet, and by helping their patients to navigate the system to help them get the help that they needed even if they were not able to care for them directly.[20] The hysicians stated that they had learnt from their colleagues and patients, occasionally continuing education, such as conferences and reading and a few learnt from selected electives, or strong mentors.[14]

Fostering a positive patient-provider relationship

In several studies, both Canadian and American, nurse practitioners and clinicians (physicians, mental health workers) expressed the need to establish a good relationship with their patients as an important component of providing good treatment to their transgender patients.[14,20,27]

For nurse practitioners, establishing a good relationship meant being open and non-judgmental, and ensuring that they demonstrate respect for a group that have sometimes been treated disrespectfully.[20]

Some clinicians explained that they tried to remain non-judgmental even when it challenged and contradicted their own personal views:

> "I am not comfortable with any decisions made to change one's body using hormones and surgical treatments, I try not to let any prejudices get in the way….I don't see that half hearted mutilation is any benefit. I don't want to share these feelings…as I…don't appreciate the benefits attained by these patients…I will be non-judgmental treating them, But at the same time wondering why." (p.e17)[14]

Some clinicians noted that establishing a trusting relationship is crucial to providing treatments.[27] However, clinicians noted that sometimes they felt that patients were presenting in a way that aligns with current medical guidelines, and that this practice could undermine a trusting provider-patient relationship. "Yes, and well I can't blame them. They are creating a story of themselves that they believe fits with the identity. They read the literature and they knew back then that they were aroused or used to cross dress as a kid in adolescence than they might not get surgery." (p.1515)[27] Some clinicians suggested that if they did not trust their patient, then they had the opportunity to deny treatment.[27]

Using patient's preferred names and pronouns vs misgendering and deadnaming

Some nurse practitioners clearly expressed the importance of using the patient's correct pronoun.[20] Nurse practitioners understood that slipping up in this respect could be seen as insensitive or insulting and undermine the nurse-patient relationship: "[I had] anxiety about what if I slip up and use the wrong pronoun? Yes. I don't want them to see, I didn't want (her) to see it as insensitive or purposeful." (p.162)[20]

One barrier to the use of appropriate pronouns that nurse practitioners explained that the intake forms for new patients provided only a binary option for gender (male vs female).[20]

However, in a study in rural and Appalachian Tennessee, health care providers (nurses and physicians) described a completely different approach to addressing their transgender patients. They described consciously choosing not to use the preferred names or pronouns of their patients: "I ask the patient if I can call them by their [birth/legal] name because of my beliefs. I do not care – if I know it's a male and he still has a penis. I do not care to call him Margaret or say she" (public health nurse). (p. 2084)[11]

Clinicians as gatekeepers?

Clinicians explained that one of their challenges is to differentiate between transgender people who would benefit from medical treatment and those patients who experience gender identity issues that may be caused by other diagnoses such as bipolar disorder, psychosis, schizophrenia or transvestic disorder.[5] In addition, clinicians explained that transgender people who present with co-occurring mental health issues may not be ready for surgeries and hormones. This relates to the WPATH-SOC guideline that mental health problems need to be 'well controlled" before initiating treatment.[5] They also considered whether the psychiatric condition could limit the patients' decision-making capabilities and thus may lead to transition regret.[5]

In one study, a clinician expressed a sense of responsibility for the treatment of transgender patients: "…we do take the responsibility of irreversibly altering somebody and from our own ethical perspective we want to make sure that we are doing the appropriate thing…the right thing for that individual." (p. 1512)[27]

Many clinicians did not feel comfortable making the definitive decision that a patient had or did not have gender dysphoria, nonetheless they did feel a sense of responsibility in ensuring that patients were capable and mentally competent enough to make a decision: "…essentially that if someone comes into my office and as long as they are mentally competent to make decisions about their life…It is their choice as to what they do." (p. 1512)[27]

Clinicians also noted that there were certainly subjective elements of the assessment process:

> "Its [Mental health readiness assessments] subjective, there's no doubt about it…There's the piece about, you know, do they meet all the criteria in the standards of care?...and then the diagnosis of gender dysphoria. So, if all of those pieces are in place, then yeah. We make a referral." (p. 68)[5]

In one study, American clinicians noted that treating transgender patients could possibly threaten their medical license because if a patient sues the doctor due to the transgender treatment, the medical board would be unlikely to support the medical doctor [27]. For that reason, making a distinction between a "true transgender" and "someone who is confused or has some psychosis or something else going on" (p.1514)[27] was particularly important to those clinicians. Furthermore, stricter adherence to the medical guidelines regarding treatment can offer protection in a count of law.[27]

Treating the transgender-patient the same or different: social identities vs. individualism

The tension between treating LGBTQ patients the same as or differently than other patients was a key theme.[14] Some health practitioners stated that they did not treat LGBTQ patients differently because they believed that the health care needs of their LGBTQ patients were the same as those of non-LGBTQ.[14,20]

Some physicians noted that the only way that transgender issues would have them treat the patient differently was very specific and biological, such as physical examination, blood test results and cardiac monitoring would be affected if a transgender patient were on hormone therapy.[14] Some participants noted that sexual identity and gender orientation of the patient do not matter, because they strive to treat each patient as an individual. They noted that it was important not to make assumptions about people based on these categorizations.

A different perspective was offered by a few clinicians who suggested that sensitivity training to group membership may alert clinicians to issues so that they can ask the right questions, but at the same time not assume that all people within a group are the same.[14] In keeping with the view that transgender patients may have distinct needs in two Canadian studies, some NPs and physicians declared that they were aware that LGBT are more likely to experience bullying, stigma and discrimination and that this can lead to mental health issues such as anxiety, depression and suicidal ideation.[14,20] Therefore some clinicians described how they assessed mental health problems and addressed those either through counselling and medication,[20] or by referring their patient to support groups.[14]

Limitations

Only one study was identified that explored the discovery phase of individuals who decide that they would like to undergo hormone treatment for gender dysphoria.

There was very little from the perspective of endocrinologists. Only one study, included one study participant who was an endocrinologist.[13]

Conclusions and Implications for Decision or Policy Making

The research describes the long journey that patients travel to receive gender affirming care and to be treated respectfully by their health care practitioners. Transgender individuals tended to characterize the discovery of their transgender identities as a discovery of finding the language to describe their own gender and experiences. This discovery phase occurred primarily independently and online. Next, was the process of seeking gender affirming care. Transgender youth and adults faced numerous obstacles in having their health care needs met. Therefore, their journey required **self-advocacy**. There is the process of navigating the health care system to find a clinician who is knowledgeable and willing to provide care. Participants expressed a preference for primary care physicians for gender affirming care, because of their greater accessibility, and because they are better positioned to address holistic aspects of care, including social, psychological and medical needs. However, study participants explained that primary care physicians often lacked knowledge about HRT. Sometimes, family physicians would refer the individual elsewhere. This was problematic as it could lead to treatment delay and could result in increased levels of anxiety and suicidality. Other times participants described educating their family physician through providing them with resources or information about continuing education. There was also the process of “presenting” in such a way as to ensure that they satisfied the criteria for gender dysphoria, as the assessment criteria is highly subjective. Those with complex mental problems, financial insecurity or non-binary individuals appeared to face particular challenges in accessing gender affirming care.

Aside from the technical aspect of gender affirming care, participants also sought a supportive physician who could provide a positive space for transgender identities. This could be a challenge, because transgender individuals often had to contend with the stigma or discrimination within the context of the health care encounter, such as being “outed” or misnamed. Many study participants reported that they frequently encountered health care providers with negative or uncomfortable attitudes. These practices led the transgender patient to feel disrespected[17] and avoid or delay care.

Primary care clinicians in both the Canadian and American context reported that they had received virtually no formal education regarding transgender health. They learnt on the job through courses, through resources and through their patients. For the treatment of transgender patients, clinicians emphasized the importance of fostering a positive patient-provider relationship built on trust. Some clinicians recognized that using the patient’s preferred name and pronoun is an important aspect of building a respectful relationship with their patients. However, some clinicians noted that the intake forms for new patients present only binary options (male or female), and thus impeded their ability to use the correct pronouns for their patients. Furthermore, some American clinicians stated that they refused to use the patient’s preferred name and pronoun and instead opted to use the patient’s birth name and sex at birth.

The view that the hormone assessment readiness tool is highly subjective was noted by some clinicians. Therefore, some clinicians noted that they although they did not think they could judge absolutely whether or not their patient had gender dysphoria, they did feel responsible for ensuring that the patient had the mental state to make a sound decision and they did feel a sense of responsibility for the patient's decision to change their body irrevocably. Some clinicians reported that they tried to treat all their patients the "same". Others noted that certain groups, such as transgender patients, were subject to higher levels of stigma and discrimination and therefore mental health issues need to be explored for this population.

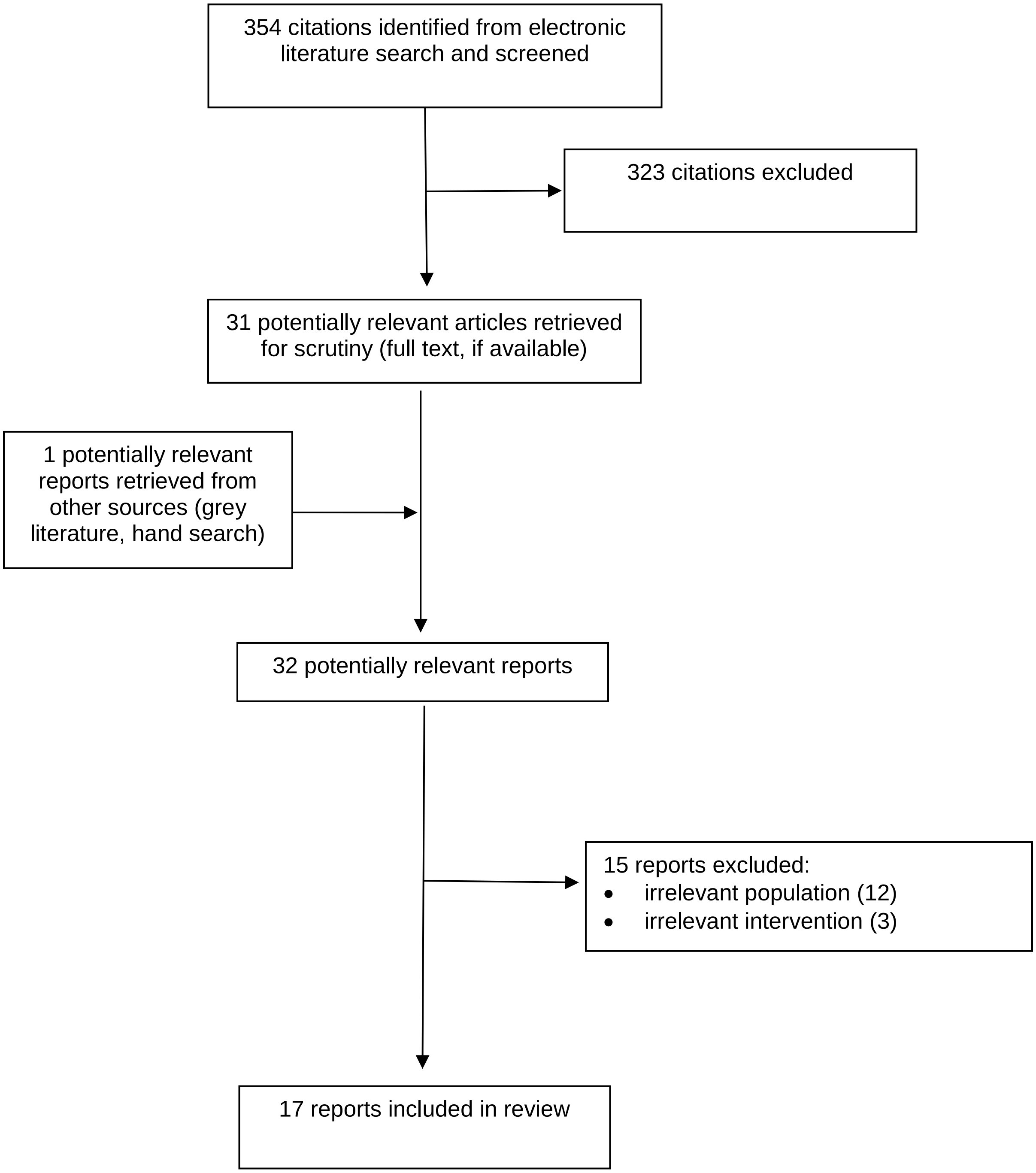
Both transgender patients and their primary care physicians explained that clinicians lack foundational knowledge about transgender health issues. A more comprehensive understanding of transgender health issues at medical schools and nursing schools was recommended by transgender patients in the studies reviewed. Transgender health issues could address the physical health needs of transgender individuals, such as the possibility of hormone treatment and of surgeries, as well as the notion that transgender individuals' needs vary in terms of hormone therapy and surgery. Not all transgender individuals who need hormone therapy will pursue surgery. Some transgender individuals, such as non-binary, may require different hormone therapy dosages. Furthermore, there is a need to explore ways of reducing barriers to care for those with limited financial resources and complex mental health problems. It is important to emphasize that delayed access to care for those suffering from gender dysphoria can lead to increased levels of distress and suicidality.

In addition, such training could also emphasize the social, psychological and cultural needs of transgender patients. Discriminatory practices such as misgendering or deadnaming patients, or outing patients due to lack of privacy can lead to health care avoidance or delayed treatment. This can result in increased levels of distress and suicidality. Altering medical intake forms, beyond the binary option, may be one way to facilitate the proper use of pronouns. Understanding the sensitivities regarding aspects of care such as the physical exam, and providing symbols and information in the health care space that indicate acceptance of transgender identities could increase the use of health care and increase access to gender affirming care.

References

1. 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.
2. 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):118-122.
3. An Act to amend the Canadian Human Rights Act and the Criminal Code. Bill C-16. Ottawa (ON): Government of Canada; 2017: https://laws-lois.justice.gc.ca/eng/annualstatutes/2017_13/FullText.html. Accessed 2020 Jun 5.
4. Bauer G, Pyne J, Francino M, Hammond R. Suicidality among trans people in Ontario: implications for social work and social justice/La suicidabilité parmi les personnes trans en Ontario: implications en travail social et en justice sociale. *Service social.* 2013;59(1):35-62.
5. MacKinnon KR, Grace D, Ng SL, Sicchia SR, Ross LE. “I don’t think they thought I was ready”: how pre-transition assessments create care inequities for trans people with complex mental health in Canada. *Int J Ment Health.* 2020;49(1):56-80.
6. Bell J, Purkey E. Trans individuals' experiences in primary care. *Can Fam Physician.* 2019;65(4):e147-e154.
7. CASP qualitative checklist. Oxford (UK): CASP UK; 2018: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf. Accessed 2020 Apr 17.
8. Strauss A, Corbin J. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Newbury Park (CA): Sage Publications; 1990.
9. Liberati A, Altman DG, Tetzlaff J, et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *J Clin Epidemiol.* 2009;62(10):e1-e34.
10. Lacombe-Duncan A, Newman PA, Bauer GR, et al. Gender-affirming healthcare experiences and medical transition among transgender women living with HIV: a mixed-methods study. *Sex Health.* 2019;16(4):367-376.
11. Patterson JG, Jabson Tree JM, Kamen C. Cultural competency and microaggressions in the provision of care to LGBT patients in rural and appalachian Tennessee. *Patient Educ Couns.* 2019;102(11):2081-2090.
12. Puckett JA, Cleary P, Rossman K, Newcomb ME, Mustanski B. Barriers to gender-affirming care for transgender and gender nonconforming individuals. *Sex.* 2018;15(1):48-59.
13. Glick JL, Andrinopoulos KM, Theall KP, Kendall C. "Tiptoeing around the system": alternative healthcare navigation among gender minorities in New Orleans. *Transgend Health.* 2018;3(1):118-126.
14. Beagan B, Fredericks E, Bryson M. Family physician perceptions of working with LGBTQ patients: physician training needs. *Can Med Educ J.* 2015;6(1):e14-22.
15. Clark BA, Marshall SK, Saewyc EM. Hormone therapy decision-making processes: transgender youth and parents. *J Adolesc.* 2020;79:136-147.
16. Newhook JT, Benson K, Bridger T, Crowther C, Sinnott R. The TransKidsNL study: healthcare and support needs of transgender children, youth, and families on the island of Newfoundland. *Can J Commun Ment Health.* 2018;37(2):13-28.
17. Vermeir E, Jackson LA, Marshall EG. Barriers to primary and emergency healthcare for trans adults. *Culture, Health & Sexuality.* 2018;20(2):232-246.
18. Guss CE, Woolverton GA, Borus J, Austin SB, Reisner SL, Katz-Wise SL. Transgender adolescents' experiences in primary care: a qualitative study. *J Adolesc Health.* 2019;65(3):344-349.
19. Lykens JE, LeBlanc AJ, Bockting WO. Healthcare experiences among young adults who identify as genderqueer or nonbinary. *Lgbt Health.* 2018;5(3):191-196.
20. Manzer D, O'Sullivan LF, Doucet S. Myths, misunderstandings, and missing information: experiences of nurse practitioners providing primary care to lesbian, gay, bisexual, and transgender patients. *Can J Hum Sex.* 2018;27(2):157-170.
21. Meyer HM, Mocarski R, Holt NR, Hope DA, King RE, Woodruff N. Unmet expectations in health care settings: experiences of transgender and gender diverse adults in the Central Great Plains. *Qual Health Res.* 2020;30(3):409-422.
22. Paine EA. Embodied disruption: "sorting out" gender and nonconformity in the doctor's office. *Soc Sci Med.* 2018;211:352-358.
23. Hinrichs A, Link C, Seaquist L, Ehlinger P, Aldrin S, Pratt R. Transgender and gender nonconforming patient experiences at a family medicine clinic. *Acad Med.* 2018;93(1):76-81.
24. Hines DD, Laury ER, Habermann B. They just don't get me: a qualitative analysis of transgender women's health care experiences and clinician interactions. *J Assoc Nurses AIDS Care.* 2019;30(5):e82-e95.
25. Lacombe-Duncan A. Understanding access to HIV-related and gender-affirming healthcare for trans women with HIV in Canada: a mixed methods study. *Diss Abstr Int.* 2019;80(4-A(E).
26. Meyer G, Mayer M, Mondorf A, Herrmann E, Bojunga J. Increasing normality-persisting barriers: current socio-demographic characteristics of 350 individuals diagnosed with gender dysphoria. *Clin Endocrinol (Oxf).* 2020;92(3):241-246.
27. Dewey JM. Challenges of implementing collaborative models of decision making with trans-identified patients. *Health Expect.* 2015;18(5):1508-1518.

Appendix 1: Selection of Included Studies



Appendix 2: Characteristics of Included Publications

Table 2: Characteristics of Included Publications

Study Citation, Country	Study Design	Study Objectives	Inclusion Criteria	Data Collection Strategy
MacKinnon, 2020, Canada[5]	Qualitative (institutional ethnography)	To understand how standardized readiness assessments coordinate access to hormones and surgeries for transgender people in Canada.	Transgender people who had accessed mental and/or transition related care in the past year, clinicians or clinician-educators with at least one year experience in transgender health care and hospital administrators currently working on transgender health programming	Semi-structured interviews, observation of two clinical-education workshops in the area of transition-related medicine and mental health, documents and tests pertinent to transition-related medicine such as relevant clinical guidelines, and provincial funding policies for transition medicine
Meyer, 2020, United States[26]	Qualitative	To document and categorize the types of unmet expectations that are common in the Transgender patient-health care provider dynamic in the Central Great Plains of the United States	19 years of age or older, identifying as transgender or gender diverse	In-depth semi-structured interviews
Bell, 2019, Canada[6]	Qualitative phenomenologic approach	To explore past experiences and describe the expectations of the transgender community regarding the delivery of primary care by their family physicians	Older than 18 years, Self-identification as transgender	Semi-structured interviews
Clark, 2020, Canada[15]	Constructivist grounded theory	To understand youth hormone therapy initiation decision-making processes	Transgender youth aged 14-18 (and their parents) who were receiving or who were considering receiving hormone therapy, or who had chosen not to have hormone therapy or who had barriers for hormone therapy	Transcripts and life-line drawings obtained through semi-structured interviews

Study Citation, Country	Study Design	Study Objectives	Inclusion Criteria	Data Collection Strategy
Guss, 2019, United States[18]	Qualitative (not otherwise specified)	To learn about transgender adolescents' experiences in primary care and their recommendations for primary care offices and clinicians	To identify as transgender, speak English, adolescent	In-person semi-structured interviews
Hines, 2019, United States[24]	Qualitative (secondary analysis of another qualitative study that explored coping strategies following an HIV prognosis)	To explore the health care experiences of transgender women living with HIV.	Transgender women, living with HIV, residing in Indiana, 18 years of age or older, received services at an agency that provides primary medical services to transwomen living with HIV within the last 12 months	Face to face qualitative interviews.
Lacombe-Duncan, 2019, Canada[10]	Mixed method design	To understand barriers and facilitators to access to medical transition among transwomen living with HIV	Completed the survey: Canadian HIV Women's Sexual and Reproductive Health Cohort Study. Verbally proficient in English.	Qualitative component: open-ended semi-structured individual interview
Patterson, 2019, United States[11]	Multi method (surveys _ interviews)	To understand LGBTQ cultural competence among primary and oncology providers in rural and Appalachian Tennessee	Currently practice in primary care or oncology, identify as a physician or nurse, be able to read and speak English, 18 years of age or older	Semi-structured telephone interviews
Puckett, 2019, United States[12]	Survey with some open-ended questions (qualitative)	To explore the barriers to gender affirming care for transgender and gender non-conforming individuals	Aged 16 years and older, reside in the United States, and identify as transgender/gender non-conforming	Survey with open ended questions for qualitative component
Glick, 2018, United States[13]	Qualitative (targeted ethnography)	To explore the alternative navigation strategies used by Gender Minority individuals to access care.	Transgender and gender nonconforming individuals aged 18 years or more, residing in the New	Semi-structured in-depth interviews

Study Citation, Country	Study Design	Study Objectives	Inclusion Criteria	Data Collection Strategy
			Orleans, Louisiana area	
Hinrichs, 2018, United States[23]	Qualitative (focus groups)	To learn about the experience of primary care among transgender nonconforming patients and to learn about how to improve care for this patient group.	18 years or older, spoke English, were patients at one urban clinic in Minneapolis	3 focus groups
Lykens, 2018, United States[19]	In depth qualitative interviews	To understand the health care experiences of gender queer/non-binary individuals	Self identify as gender queer/non-binary, 18 years age or older, speak English, live in San Francisco bay area, have accessed health care at least once in the last 6 months	Semi-structured in depth qualitative interviews
Manzer, 2018, Canada[20]	Qualitative descriptive design	To explore the practice experiences of Nurse Practitioners in providing primary health care to LGBTQ patients	Nurse practitioner with license to practice in New Brunswick, Nova Scotia or Prince Edward Island, indicated that they had provided care to at least one LGBTQ patient in the past 3 years, understood and spoke English.	One-on-one semi-structured qualitative interviews. Eleven interviews were conducted in person, and eleven interviews were conducted over the phone at the participant's request
Newhook, 2018, Canada[16]	Qualitative (feminist participatory action research framework)	To understand the health care needs and concerns of transgender children, youth and their families.	Transgender and gender questioning youth (12-17 years) and parents of transgender and gender-questioning children and youth up to 17 years	Open ended electronic questionnaire
Paine, 2018, United States[22]	Qualitative	To understand what happens during health encounters with gender non conforming people	LGBQ cisgender women who are gender non-conforming or transgender men or non-binary.	Semi-structured narrative interviews
Vermeir, 2018, Canada[17]	Qualitative methods (social constructivism, queer theory, risk	To explore the barriers transgender adults encounter	At least 18 years old, live in Nova Scotia, English speaking,	One on one qualitative interviews

Study Citation, Country	Study Design	Study Objectives	Inclusion Criteria	Data Collection Strategy
	environment framework)	when pursuing primary and emergency care in Nova Scotia, Canada	identify as transgender, experienced or tried to experience primary and/or emergency care in the last two years	
Beagan 2015, Canada[14]	Qualitative (draws on critical phenomenology and ethnographic description)	To understand the experience and understandings of general practice physicians about their work with women patients who identify as LGBTQ	General practice physicians, with experience working with LGBTQ patients, located in Halifax or Vancouver	One on one semi-structured interviews

HIV = human immunodeficiency virus; LGBTQ = lesbian, gay, bisexual, transgender and queer

Appendix 3: Characteristics of Study Participants

Table 3: Characteristics of Study Participants

Study Citation, Country	Sample Size	Gender	Age range in years	Other relevant variables
MacKinnon, 2020, Canada[5]	9 transgender people 11 clinicians and clinician-educators 2 hospital administrators.	Not reported	Not reported	Clinicians and clinician-educators were trained in the specialties of family & emergency medicine, psychiatry, psychology, and social work.
Meyer, 2020, United States[21]	27 transgender and gender diverse individuals	14 transgender women 10 transgender men 3 nonbinary	22-64	48% reported living in a rural area
Bell, 2019, Canada[6]	11 transgender individuals	6 transfeminine 4 transmasculine 1 nonbinary	24-64	10 taking hormones 1 not taking hormones 6 completed surgery 4 awaiting surgery 1 not seeking surgery
Clark, 2020, Canada[15]	21 transgender youth 15 parents	8 female or transfeminine 8 male or transmasculine 5 non-binary or gender fluid	14-18 for the youth	14 on hormones 1 in the process of starting hormones 3 undecided 3 experienced barriers to care (re: hormones)
Guss, 2019, United States[18]	20 transgender adolescents	4 transgender women 12 transgender men 4 non-binary/non-conforming	13-21	70% had doctor visit in the last year, 85% had primary care visit in the last year.
Hines, 2019, United States[24]	18 transgender women	18 transgender women	21-60	All participants were living with HIV.
Lacombe-Duncan, 2019, Canada[10]	11 transgender	11 transgender women	39-44	All are HIV positive Half of participants had accessed one or more gender affirming medical procedures
Patterson, 2019, United States[11]	4 nurses 2 physicians	Not reported	Not reported	Clinicians worked in a local health department, a rural medical service, community based

Study Citation, Country	Sample Size	Gender	Age range in years	Other relevant variables
				practices in primary care and oncology, and a local hospital system.
Glick, 2018, United States[13]	18 gender minority individuals 5 health care providers	6 genderqueer / gender non-conforming 5 Transgender male 7 Transgender female	23-64	All gender minority respondents had experience using health care within New Orleans, LA. 5 The health care providers were: 1 internist, 1 endocrinologist, 1 pediatrician, 1 medical director (LGBT), 1 rural herbalist.
Hinrichs, 2018, United States[23]	22 transgender	10 transgender male/man 5 transgender female/woman 4 gender nonconforming / both 3 female	18-65+	All attend one clinic in urban Minneapolis
Lykens, 2018, United States[19]	10 transgender	10 genderqueer/ fnonbinary/two spirit	23-33	Had experienced health care in the last 6 months Nearly all had health insurance
Manzer, 2018, Canada[20]	22 Nurse Practitioners	All identified as cisgender female, none self-identified as LGB to the researcher	14% < 40 years 73% 40-59 14% > 60	All identified as Caucasian, all had at least a Masters' degree and three had a doctoral degree completed or in progress. 82% had completed a Canadian based nurse practitioner program and 18% were educated in the United States.
Newhook, 2018, Canada[16]	24 transgender youth 21 parents	9 transfeminine 22 transmasculine 1 two-spirit 13 non-binary	12-17 for the youth	
Paine, 2018, United States[22]	34 transgender	LGBQ 34 cis women who are gender non-	21-46	All participants had at some time assessed health

Study Citation, Country	Sample Size	Gender	Age range in years	Other relevant variables
		conforming, or transmen, or nonbinary.		care at an organization purposed specifically for the LGBTQ community.
Puckett, 2018, United States[12]	201 transgender and gender non-conforming	30.1% transgender men 23.4% transgender women 13.7% genderqueer 10.9% non-binary	16-73 years	78.9% white 45.3% had an income <$10,000/year.
Vermeir, 2018, Canada[17]	8 transgender adults	3 transwoman 1 transman 1 transgender-masculine guy 1 transsexual man 2 gender-queer/non-binary	18-44	
Beagan, 2015, Canada[14]	24 physicians	18 heterosexual women 5 heterosexual men 1 gay man	Not reported	In practice for 7-40 years.

HIV = human immunodeficiency virus; LGBTQ = lesbian, gay, bisexual, transgender and queer

Appendix 4: Critical Appraisal of Included Studies

Table 4: Strengths and Limitations of Included Studies

Strengths	Limitations
MacKinnon, 2020[5]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • data was collected in a way that addressed the research issue • ethical issues were adequately addressed • data analysis was adequate • statement of findings is clear • research has some value. • strong theoretical foundations for the work are clearly elaborated and are consistent with their data collection, and data analysis and interpretation	• the relationship between the researcher and the participants was not discussed.
Meyer, 2020[21]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • data was collected in a way that addressed the research issue • good explanation of theoretical background (organizational behaviour literature on unmet expectations) that framed and helped with interpretation of results • ethical issues were adequately addressed • analytic themes are well developed • statement of findings is clear • research has some value	the relationship between the researcher and the participants was not discussed
Bell, 2019[6]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • data was collected in a way that addressed the research issue • ethical issues were adequately addressed. • data analysis was adequate • statement of findings is clear • the author explicitly states his previous experience with the transgender community • theoretical stance was stated explicitly (phenomenological) • research is valuable to understand expectations of transgender community regarding primary care by their family physicians	the relationship between the researcher and the participants was not discussed

Strengths	Limitations
Clark, 2020[15]	
- clear statement of the aims of the research - appropriate use of qualitative methodology - research design is appropriate to address the aims of the research - data was collected in a way that addressed the research issue - ethical issues were adequately addressed. - data analysis was adequate - statement of findings is clear - research is valuable to understand decision making process of youth regarding hormone therapy	- the relationship between the researcher and the participants was not discussed
Guss, 2019[18]	
- clear statement of the aims of the research - appropriate use of qualitative methodology - research design is appropriate to address the aims of the research - data was collected in a way that addressed the research issue - ethical issues were adequately addressed - data analysis was adequate - statement of findings is clear - research is valuable	- Theoretical orientation is not specified - the relationship between the researcher and the participants was not discussed
Hines, 2019[24]	
- clear statement of the aims of the research - appropriate use of qualitative methodology (secondary analysis) - despite the fact that this was a secondary analysis, the interview questions were directly relevant to this study. - research design is appropriate to address the aims of the research - data was collected in a way that addressed the research issue - ethical issues were adequately addressed - data analysis was adequate - statement of findings is clear - research is valuable	- the relationship between the researcher and the participants was not discussed, although the researcher did explain that she was cis - Theoretical orientation is not specified
Lacombe-Duncan, 2019[10]	
- clear statement of the aims of the research - appropriate use of qualitative methodology - research design is appropriate to address the aims of the research - data was collected in a way that addressed the research issue - ethical issues were adequately addressed. - data analysis using framework analysis was appropriate.	- the relationship between the researcher and the participants was not discussed

Strengths	Limitations
• theoretical approach was explicit (social ecological and intersectional) • statement of findings is clear • research is valuable	
Patterson, 2019[11]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • data was collected in a way that addressed the research issue • ethical issues were adequately addressed. • data analysis was appropriate • statement of findings is clear • research has value for understanding the perspective of clinicians in rural and Appalachian Tennessee in treating the LGBT community	• data for the qualitative component is a little bit sparse, perhaps because the article also includes the quantitative results. • the relationship between the researcher and the participants was not discussed • theoretical orientation is not specified
Puckett, 2019[12]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • data was collected in a way that addressed the research issue • ethical issues were adequately addressed. • data analysis was appropriate • statement of findings is clear	• the relationship between the researcher and the participants was not discussed • theoretical orientation is not specified
Glick, 2018[13]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • data was collected in a way that addressed the research issue • ethical issues were adequately addressed. • data analysis was adequate • statement of findings is clear • research is valuable to understand how gender minorities navigate and pursue alternative strategies to access care	• the relationship between the researcher and the participants was not discussed
Hinrichs, 2018[23]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • the theoretical perspective is explicit: social constructivist version of grounded theory.	• the relationship between the researcher and the participants was not discussed • Theoretical orientation is not specified

Strengths	Limitations
- data was collected in a way that addressed the research issue - ethical issues were adequately addressed. - data analysis was adequate - statement of findings is clear - research is useful, in particular with regards to ideal care for transgender patients	
Lykens, 2018[19]	
- clear statement of the aims of the research - appropriate use of qualitative methodology - research design is appropriate to address the aims of the research - data was collected in a way that addressed the research issue - ethical issues were adequately addressed - data analysis was adequate - statement of findings is clear - research has some value	- the relationship between the researcher and the participants was not discussed - Theoretical orientation is not specified
Manzer, 2018[20]	
- clear statement of the aims of the research - appropriate use of qualitative methodology - research design is appropriate to address the aims of the research - data was collected in a way that addressed the research issue - ethical issues were adequately addressed. - data analysis was adequate - statement of findings is clear - research has some value	- theoretical stance was not specified - the relationship between the researcher and the participants was not discussed
Newhook, 2018[16]	
- clear statement of the aims of the research - appropriate use of qualitative methodology - research design is appropriate to address the aims of the research - data was collected in a way that addressed the research issue - ethical issues were adequately addressed - statement of findings is clear - research has some value	- data analysis was sparse and undertheorized. Direct quotes were placed under subject headings - the relationship between the researcher and the participants was not discussed
Paine, 2018[22]	
- clear statement of the aims of the research - appropriate use of qualitative methodology - research design is appropriate to address the aims of the research - data was collected in a way that addressed the research issue - ethical issues were adequately addressed.	- None found

Strengths	Limitations
• data analysis was appropriate • statement of findings is clear • research has value • excellent discussion of the relationship of the researcher to the participants in terms of their social position LGBT status, social class education. How these similarities and differences were addressed during data collection. • good discussion of theoretical influences	
Vermeir, 2018[17]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • data was collected in a way that addressed the research issue • ethical issues were adequately addressed • data analysis was based on framework on the constant comparative method and framework analysis and is appropriate • statement of findings is clear • research has value	• the relationship between the researcher and the participants was not discussed
Beagan, 2015[14]	
• clear statement of the aims of the research • appropriate use of qualitative methodology • research design is appropriate to address the aims of the research • data was collected in a way that addressed the research issue • ethical issues were adequately addressed. • data analysis was adequate • statement of findings is clear • research findings are useful	the relationship between the researcher and the participants was not discussed

LGBTQ = lesbian, gay, bisexual, transgender and queer