

Improving Services to Transgender Students, Improving Services to All Students

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Editor's Note: Cultural competence is a process which requires opening many doors — the door of personal prejudice, values and attitudes, the door of institutional values and structures, the door of community values and traditions. This important case history from Dr. Smith and Ms. Walter makes a terribly important, but often missed point. Open doors allow all manner of change to occur. What started as an effort to be more responsive to a very small community of students created a process for successful self-examination and personal and institutional change which has benefited all of the Wesleyan community.

Two years ago, our University Health Center began a series of initiatives aimed at improving quality of services for transgender students. We did so in response to student advocacy and with administration support. We have made significant inroads toward understanding transgender issues and improving quality of care for transgender students, but surprisingly, these efforts on behalf of a small group of students have led to even more meaningful changes in the services for all students. We removed previously unrecognized barriers to care and improved the breadth, depth and relevance of sexual health services. We worked as a group through an intellectually-challenging frame of reference realignment. Through the process of designing, evaluating, testing, modifying and marketing these changes, we modeled a system which can be applied to other clinical initiatives.

Initial Student Inquiry

In the Fall of 2004, a student contacted the Director of our Health Service and asked if we would be willing to meet to discuss care of transgender students. We arranged a meeting attended by our Director, Medical Director and Assistant Medical Director. During the meeting the student asked if we would prescribe hormones to aid in gender transition. We responded that we didn't feel that initiating such a prescription was within our

scope of practice as Internists, but would gladly refer to someone who would (an Endocrinologist). We further offered to provide support in the form of evaluating side effects, monitoring blood work, etc. We also stated that we might be able to take over the prescribing once levels were stable, doses constant, etc. We felt this was in keeping with our standard of care for other hormone therapies, e.g. insulin and thyroid hormone. The student expressed great dissatisfaction with our response and left the meeting abruptly. We were surprised and confused by this response.

Soon after this meeting, we discovered that our usually cordial relations with several of the student advocacy groups addressing Gay, Lesbian, Bisexual, Transgender¹ issues were strained. Moreover, in at least one setting, a statement was made that, "The Health Center does not provide care to Transgender students." This statement was not in accord with our experiences. Attention to health center use patterns reassured us that some transgender students on campus did utilize us for routine primary care services. We struggled to clarify the exact nature of the dissatisfaction and repair the relationship. We also reviewed our environment and made a number of small but significant changes to the Health Center. We reviewed all documents for questions about gender. When such questions were unnecessary, we removed them entirely. Elsewhere we replaced the options of female or male with a blank space. We designated one of our bathrooms as gender-neutral, placed rainbow stickers on our main doors, and put up a poster supporting respect for transgender people.

After further communication with student advocacy groups, we agreed to produce a list of transgender resources, including providers of hormone therapy, support groups, and sensitive counseling resources "from Boston to New York." As we researched these resources, we took the opportunity to establish contact with individuals involved in care of and advocacy for transgender individuals. Despite efforts, we were unable to connect with a

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representative of any primary care health center or facility that had integrated transgender patients into its population or made special accommodations for transgender people.

We did, however, get a reliable snapshot of the state of transgender services, advocacy, and, perhaps most importantly, history. We also took the opportunity to review the Harry Benjamin International Gender Dysphoria Association, Inc. Standards of Care.² These were developed to “articulate...consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders.” They represent a response to historically widely divergent thresholds for medical intervention for transgender patients. These standards are frequently cited as supporting a style of care whereby medical intervention to accomplish gender reassignment will not be initiated without the patient first being cleared by a psychological professional. We also learned that from the perspective of some patients, this narrow reading of the standards could represent a significant, if not insurmountable, cost burden.³

Through our review process we formed a group of six transgender advocates from the community. These contacts, in addition to the material we found regarding the history of transgenderism in America,⁴ were enormously helpful in understanding the context in which medical care of transgender patients exists. In particular, they helped us understand that much of the best quality medical contact information was still underground because many doctors preferred not to publicize that they welcomed transgender patients or that they were willing to provide hormone therapy.

A Request We Could Fulfill

As we worked on developing the resource list, a third inquiry trickled down from one of the student groups: “You offer Women’s Health and Men’s Health,” they asked, “Why not Transgender Health?” This, at last, was a concept we felt qualified to address.

We were reasonably sure no campuses offered Transgender Health clinics as such, and our research had yielded relatively little helpful information from non-University Health arenas either. We attempted a more

conventional search of the medical literature. This also proved disappointing (although there have been several very helpful articles published since that time⁵). Most of the literature is of the “Creating a caring and safe environment” ilk or limited to glossaries of transgender terminology. These were helpful to a degree, but didn’t answer our root question: What new services need to be offered and what existing services need to be modified to optimally provide care for transgender students?

We decided to start from scratch. We reviewed the content and root philosophy of our Men’s Health and Women’s Health clinics, each developed to address issues of insufficient service. In the case of Women’s Health, the clinic was a product of a movement associated with feminism’s “second wave” in the late 1960s.⁶ Reacting to the paternalism and institutionalized disempowerment of women in the traditionally-male medical hierarchy, this movement sought to return the locus of control to the individual, specifically to females. This was especially the case with regard to reproductive health. The demystification and demedicalization of normal anatomy, sexual function and endocrine function was a central goal of the movement as epitomized in books such as *Our Bodies, Ourselves*.⁷ From this movement came the development of medical services philosophically in line with these priorities, and college health centers were fertile ground for such experiments. As with many others, our Women’s Health clinic focuses on explaining and normalizing reproductive health function and empowering women to have control over fertility, to protect themselves against sexually-transmitted diseases and to have physically and emotionally rewarding sex lives (irrespective of partner’s gender).

The history of Men’s Health is more fragmentary. The roots of the movement germane to our clinic were in academic medicine, as opposed to a grassroots patient advocacy movement. Recognizing that young men were rarely to be seen in doctors’ offices except in the case of musculoskeletal injury, illness or sexually-transmitted infections, the idea was developed to maximize the opportunity of such visits to deliver preventative messages. The messages were targeted public health messages such as summarized by the U.S. Preventive Services Task

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Force.⁸ In Dr. Smith's case, the training in this approach to young males occurred simultaneous with volunteering in the sexual health section of the Cleveland Free Clinic. There he found that respectful, responsible attention to young men's sexual health complaints was a powerful means of building rapport, and frequently led to requests for counseling in very intimate arenas of patient's lives. It was here that he began to think about addressing as medical issues the interplay between emotional and physical intimacy as well as the role of alcohol and other substances in sexual decision-making. He also began to develop skills in delivering accessible teaching about normal sexual anatomy and function. These topics parallel many of the Women's Health Movement ideas by making such concepts appropriate topics for young men to explore for themselves and with their partners with their health care provider as a valuable reference.

We based our Men's Health clinic on models graciously shared from several sites including Tulane and San Francisco State University, as well as Dr. Smith's own experiences at the Cleveland Free Clinic. At the time of scheduling an appointment, we sent students a pre-visit survey. This document screened for areas of concern to the student, past medical history, and age-specific public health issues (substance use, seatbelt wearing, sunburns, etc.). It further prepared students to discuss sexual history. The visit itself comprised a careful (and carefully assumptions-free) sexual history, sexually-transmitted infection counseling, physical exam, testing and treatment when indicated. Because we have the luxury of working on a campus at which men take an impressive degree of responsibility for assuring good sexual health, the clinic is well used. In consequence, the visit instruments have been honed and tailored to a high degree of efficiency and efficacy.

We quickly recognized that Transgender Health could not be viewed simply as a combination of the issues and services delivered in Women's Health and Men's Health visits. Transgender students are clearly subject to unique issues that not only lead to very individual needs and priorities but which can easily manifest in their being marginalized and underserved. This led us to explore

what was unique about the medical needs of transgender students. We settled on three key topics: the social and emotional content of coming out/transitioning, the existence of black market treatments, and the limits of dichotomous gender organization.

In the context of transgenderism, coming out refers to the process of coming to terms with one's gender identity. For some this may yield a sense of being "the opposite" of one's assigned gender. For others it may be an unwillingness to fit neatly into a gender role. For everyone it is unique. Some transgender people are transitioning. This refers to actively addressing the mismatch between internally- and externally-perceived genders. While much popular literature as well as medical scholarship focuses on the process of "changing" gender, is important to recognize that for some, the endpoint may not be so much to change perceived gender as to challenge or obfuscate the very notion of gender.

Black market treatments are, at least according to some sources, a special concern of clinicians caring for transgender individuals. Hormones can be obtained while abroad or via the Internet, which abounds with advice and recommendations about self-medication with such agents. It is further reported that some individuals will pursue silicone breast implantation via sources other than licensed surgeons. The Internet also contains links to sexual reassignment surgical services offshore. Approaching the issue from the patient's side, it is not unusual, per our sources, for people taking hormones without a doctor's prescription to avoid medical care altogether. There exist worrisome publicized cases of catastrophic outcomes for transgender individuals who encountered the medical system unintentionally.⁹

Dichotomous gender organization is the notion that there is only male and female and that one is the opposite of the other. A quick reflection on one's daily activities or group of friends readily reveals that stereotypical notions of what is masculine and feminine are not particularly predictive of gender or partner gender. While it may be said that, biologically, procreation requires the presence of a male element, the sperm, and female element, the ova, there are individuals born sterile or,

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more confusingly, intersex. Even at the core biological level of XY vs. XX there are exceptions such as Klinefelter’s Syndrome (47 XXY). In short, there are cogent arguments against the notion that there is only male and female. Gender Studies¹⁰ has become an academic discipline by which the interplay of the personal, political and societal concepts of gender identity are explored.

From Research to Clinical Change

Our research was beginning to yield results in defining the shape of the Transgender Health clinic we planned to offer. We concluded that in keeping with our Women’s Health and Men’s Health services, sexual health should be the focal point of our Transgender Health services. We knew that sexual health was mostly about counseling and education, but that these are only as effective as they are relevant. They must be shaped and informed by the patient’s actual risks. Most of us had been taught to ask, “Are your partners men, women, or both?” But this assumed that we could meaningfully infer risk by knowing partner gender(s). A service tailored to transgender students had to be designed with great attentiveness to language and assumptions inherent in certain terms or lines of inquiry. To offer sexual health services to transgender students in a meaningful, accessible way, we would do better to strip away all assumptions and language about patient and partner gender and instead assess risk by focusing on the essential issues. This yielded a reductionistic, but very helpful core question: “What are you putting where?”¹¹ Re-conceptualizing the risk assessment by inquiring into behaviors became the key original point from which the rest of the concept flowed.

We developed a pre-visit survey that allowed entry of preferred name, did not ask gender, addressed age-specific public health, inquired into gender identity history via a long list of options, and asked students to be prepared to answer explicit questions about sexual history. We also developed a form to be used by the clinician during the visit. This began with a sexual history that asked the number of sex partners, and then accounted for the specific sexual contacts, e.g. number of partners for protected vaginal sex, number for unprotected vaginal sex, etc. The education segment of the visit addressed the

specific risks associated with the identified practices. The exam section allowed for documentation of findings for breast and either vaginal or penile/scrotal exam as well as anal verge. The assessment and plan section likewise allowed for a variety of tests and interventions. The form was, in short, as multipurpose as our exam rooms.

Once we had the core documents in advanced drafts, we circulated them among our clinicians, our “trans” team and several interested students. The feedback we received was helpful, but left us feeling the concept had not been given enough of a test drive. We decided to make a public event of rolling out this new service and called a campus-wide forum to introduce it. We sent a press release to the school paper, invited any interested students, administration, faculty and staff, and welcomed our community “trans” team for a mid-day two-hour session in a central location on campus. The turnout was terrific. We shared with the group the history of the project, and then began to walk them through the documents we had produced. Before long, this turned into a massive group-editing project. We were delighted. We had never considered ourselves expert on the subject and had always wanted the process to be as transparent and community-driven as possible. What better way to do this than to edit the document line by line with a large group of interested individuals?

After 90 minutes of editing, the group concluded that there was nothing special enough about transgender sexual health to warrant its own clinic. Instead, they recommended we adapt the existing document to meet the needs of all students. This way, there would be no need for students to identify themselves or be identified as male, female or transgender at the time of scheduling a visit.

We invited all interested participants of this large group to a follow up meeting in two weeks. In the interim we incorporated the ideas and edits from the large group meeting. The follow up group included 6-10 students who were vocal advocates for transgender and queer issues on campus as well as all of the Class Deans. Over the course of a semester this working group helped us to finalize the main documents. They also helped us work through some other aspects such as planning for bringing a transgender educator to campus to work with our providers

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and staff as well as to meet with students and run a session for other members of the campus community.

The Wellness and Sexual Health Clinic

In keeping with the altered mission, we changed the name of the new clinical offering from Transgender Health Clinic to Wellness and Sexual Health clinic. This name change addressed the two key components: age-appropriate public health screening and education, and risk-based education and evaluation for sexually-transmitted infections. The Wellness and Sexual Health clinic is a significantly more accessible and effective clinical tool than its predecessors. At its heart is a focused and powerful approach to the issues at hand: a behavior-centered risk analysis.

At the time of making an appointment, students are given or instructed how to download the pre-visit survey. They are asked to complete it and bring it with them to the visit. The modified pre-visit survey begins by asking for preferred name and pronoun. It then inquires about specific concerns. (We repeat this question at the beginning of each visit. Experience has taught us that in the setting of a new skin lesion or other symptom, discussion of or inquiry into unrelated topics is viewed as irrelevant and annoying. Ideally such a student would have been scheduled for a briefer “GU/GYN Problem Visit.”) Next is a Wellness Inventory that asks if a student wishes to discuss any of a number of common health concerns. After this comes a general medical history. The next session is titled “Gender Identity History” and states, “If you feel it would contribute to the quality of care we provide, please describe your gender identity history,” followed by several blank lines. Finally, the form inquires into sexual health history. This form is intended partly to gather information, but at least as much to communicate to students the range of acceptable topics of discussion.

The visit itself begins with reviewing the demographic information and pre-visit survey. We then ask the following sequence of questions: How many partners have you had, grand total, including for oral sex only? How many of these were oral sex only? We then fill in the following table:

	PERFORMER		RECIPIENT	
	PROTECTED	UNPROTECTED	PROTECTED	UNPROTECTED
VAGINAL				
ANAL				
ORAL				
OTHER				

After another set of more typical history questions (bumps, sores, rashes on self? Partner? Personal history of STI or abnormal Pap? Partner history of same?), we deliver a risk-based education component tailored to the individual’s reported sexual history. We then advise on testing appropriate to their risk and educate them in risk reduction. Students regularly express satisfaction with the form and style of the visit.

Why Do So Much for So Few?

Even at our very diverse University, only a handful of students self-identify as transgender. We had a sense that this initiative would come to be meaningful for all students, but it wasn’t until much later in the process that we fully understood the extent to which this would be true. Some benefits, however, were clear from the outset. A major focus of the intervention was decreasing barriers to care. By abandoning or neutralizing gender language, we made ourselves more welcoming to students attentive to the issue without irritating students for whom the issues are less important. Along the same lines, training our providers to a broader range of gender identity dynamics promised to increase the sophistication of our interactions with students. While we can’t (and don’t need to) manifest expertise in every nuance of gender dynamics, it is inviting that we are willing to meet part way so that students for whom these issues are central don’t have to feel the need to constantly teach and explain. It is useful that the Health Center be recognized as “for us, too” by as many students as possible.

Beyond the patient care aspects of this initiative is the important opportunity to display responsiveness to student inquiries and needs. It is also the case that rethinking health care delivery care through the lens of the needs of

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transgender students offers an intellectual challenge to our whole staff. It challenges us to rethink approaches that may have become static or stale with repetition.

An early outgrowth of our project was the recognition that (for all our services) there wasn't always good concordance between a student and provider regarding the objectives of a given visit type. Providers don't like having a short visit for a big problem and students with a single problem are impatient with history taking or exam elements they perceive as marginal to the issue at hand. To address this we prepared a document for our Web page in which we described every type of visit we provide [www.wesleyan.edu/healthservices/services/visitdescriptions.html]. It includes the types of practitioner that provides the services, the duration of the visit, what a student needs to bring with them to the visit and the anticipated duration of the visit. This allowed a better match between patient and provider for a given type of visit and increased the likelihood of common expectations of appointment content and intent.

Conclusions

The process of responding to the students' requests for health services for transgender students was challenging and at points frustrating, but as a whole enormously satisfying and valuable. What started as an attempt to clarify a response to an unusual inquiry grew into a reevaluation and redefinition of how we provided sexual health services to all students. By rethinking the concept of sexual health, we had the opportunity to establish the core tasks for our own practice: risk assessment, risk-based education and testing appropriate to real risk. What works best for our campus is essentially a gender-blind sexual health clinic.

The process of responding to this issue has turned out to be at least as valuable as the product. The way in which we investigated and defined the question and refined our response through meeting alternately with clinicians and clinic staff and campus community members both underscored the transparency of the process as well as ensuring ownership and buy-in from and relevance to all involved parties. It was particularly instructive to learn the extent to which meaningful criticism depends on an

actual document. What people had to say about the idea in the abstract was very different from how they felt about actually using clinical materials as patient or provider.



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Notes:

1. On our campus the group has referred to itself as the “Endless Acronym” (in place of GLBTQQFAGPBDSMI) and now usually uses the term “Queer”.
2. Available at www.hbigda.org/soc.cfm.
3. Reviewing critiques of the Standards of Care is a valuable means of exploring a number of currents of thought within the transgender community.
4. See www.symposion.com/ijt/gilbert/bullough.htm, www.transhistory.org/history/index.html, and www.cinematter.com/tshistory.html.
5. Notably Moore, E, Wisniewski, A and Dobs, A, “Endocrine Treatment of Transsexual People: A Review of Treatment Regimens, Outcomes, and Adverse Effects,” *Journal of Clinical Endocrinology and Metabolism*. 88(8): 3647-3473, 2003.
6. Swenson, Norma. “Women's Health Movement,” in *Reader's Companion to U.S. Women's History*, Wilma Mankiller ed., Houghton Mifflin Co. 1998. Obtained at http://college.hmco.com/history/readerscomp/women/html/wh_000101_publicationd.htm. See also www.womenshealthnetwork.org/about/overview.php.
7. *Our Bodies, Ourselves For The New Century*. Boston Women's Health Book Collective. New York: Simon and Schuster, 1998.
8. *USPSTF Guide to Clinical Preventative Services*. Age-Specific Charts for the Periodic Health Exam in “Guide to Clinical Preventive Services,” Second Edition, Report of the U.S. Preventive Services Task Force, 1996. <http://odphp.osophs.dhhs.gov/pubs/guidecps/PDF/Frontmtr.PDF>.
9. www.gender.org/remember/#.
10. See, for example, <http://humanities.uchicago.edu/orgs/cgs/mission.htm> and <http://eserver.org/gender/> and www.indiana.edu/~gender/html/index.html.
11. The corollary question: “Where has it been before?” is at least as significant, but much harder to evaluate.