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Health care for transgender people in the hospital context: health workers' discourse

Atenção à saúde de pessoas trans no contexto hospitalar: discurso dos trabalhadores da saúde

Atención a la salud de personas trans en el contexto hospitalario: discurso de los trabajadores de la salud

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ABSTRACT

Objective: to understand the knowledge, based on health workers' discourse, regarding health care for transgender individuals in the hospital context. **Method:** descriptive study with a qualitative approach conducted at a federal university hospital in Alto Sertão Paraibano, Brazil. Data collection was carried out through semi-structured interviews with 19 health workers between September and November 2023. Data analysis was performed using the Collective Subject Discourse method. The research protocol was approved by the ethics committee. **Results:** four central ideas were identified: misconceptions about the concept of Gender Identity; sexual orientation as a synonym for sexual education; limited knowledge about transgender people; and a narrow view of the relationship between transgender individuals and physical body modifications. **Conclusion:** health workers' knowledge regarding the transgender population reveals significant weaknesses that can negatively impact the provision of qualified care, thereby exacerbating barriers to access to health services for this social group.

Descriptors: Transgender Persons; Hospital Care; Integrality in Health; Health Personnel.

RESUMO

Objetivo: compreender os conhecimentos, a partir dos discursos dos trabalhadores da saúde, acerca da atenção à saúde de pessoas trans no contexto hospitalar. **Método:** estudo descritivo com abordagem qualitativa desenvolvido em um hospital universitário federal do Alto Sertão Paraibano, Brasil. A coleta de dados se deu por entrevistas semiestruturadas com 19 trabalhadores entre setembro e novembro de 2023. Análise dos dados desenvolvida por meio do Discurso do Sujeito Coletivo. Protocolo de pesquisa aprovado pelo comitê de ética. **Resultados:** foram identificadas quatro ideias centrais: concepções equivocadas acerca do conceito de Identidade de Gênero; orientação sexual como sinônimo de educação sexual; conhecimento limitado sobre pessoas trans e visão restrita da relação entre pessoas trans e modificações físicas do corpo. **Conclusão:** os conhecimentos dos trabalhadores quanto à população trans demonstra significativas fragilidades que podem impactar negativamente a oferta de cuidados qualificados e consequentemente, potencializar a dificuldade ao acesso desse segmento social aos serviços de saúde.

Descritores: Pessoas Transgênero; Assistência Hospitalar; Integralidade em Saúde; Pessoal de Saúde.

RESUMEN

Objetivo: comprender el conocimiento de trabajadores de la salud, a partir de sus discursos, sobre la atención a la salud de personas trans en el contexto hospitalario. **Método:** estudio descriptivo con enfoque cualitativo desarrollado en un hospital universitario federal del Alto Sertão Paraibano, Brasil. datos recopilados a través de entrevistas semiestructuradas a 19 trabajadores entre septiembre y noviembre de 2023. El análisis de datos se desarrolló por medio del Discurso del Sujeto Colectivo. Protocolo de investigación fue aprobado por el comité de ética. **Resultados:** se identificaron cuatro ideas centrales: concepción errónea sobre el concepto de Identidad de Género; orientación sexual como sinónimo de educación sexual; conocimiento limitado sobre las personas trans y visión acotada sobre la relación entre las personas trans y las modificaciones corporales. **Conclusión:** el conocimiento de los trabajadores sobre la población trans tiene muchas falencias que pueden afectar negativamente la prestación de atención calificada y, aumentar la dificultad de acceso a los servicios de salud de este segmento social.

Descriptores: Personas Transgénero; Atención Hospitalaria; Integralidad en Salud; Personal de Salud.

INTRODUCTION

Among the numerous factors that can negatively influence the health, illness, and care processes of the Lesbian, Gay, Bisexual, Transvestite, Transsexual and Transgender, Queer, Intersex, Asexual, and Pansexual (LGBTQIAP+) population, the impact of various forms of discrimination stands out, especially practices of LGBTQIAP+phobia[1]. This type of violence is amplified against transgender individuals, who daily experience transphobia and transvestiphobia in various social settings, including within health services. By not conforming to cisgender norms, they become more susceptible to negative experiences[2].

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These acts of violence sometimes originate from professionals within health service teams, creating significant barriers to providing qualified care for this group. Such interpersonal barriers may arise from a lack of knowledge about the needs and specificities of this population, refusal to provide care, and even moral and/or sexual harassment[3].

As a result, this social segment faces intense health inequalities and difficulties accessing these spaces[4]. This issue resonates in the challenges transgender individuals face in receiving effective care within health services[5]. Consequently, it may lead this population to seek clandestine services—that is, those without legal and technical conditions to meet health needs.

This panorama of obstacles and violence is present across different health care settings; however, the transgender population's search for specific services tends to be concentrated in the hospital settings. In this context, a Brazilian study conducted with transgender women in a teaching hospital revealed that all participants primarily used hospital services, generally lacking an effective connection with Primary Health Care (PHC)[6]. It is believed that this disconnect can exacerbate the fragility of health care for transgender individuals, as failing to establish a link with PHC leads to significant losses in providing longitudinal care with an emphasis on health promotion and disease prevention.

Still within the context of tertiary care, research conducted in a Canadian hospital highlighted structural problems affecting health care for transgender individuals, such as outdated systems that restrict entries to only binary genders—female or male—and difficulties in including preferred pronouns in these documents. The same study also demonstrated professionals' insecurity in providing care due to fear and/or lack of knowledge[7], situations that can lead binary or non-binary transgender users to feel embarrassment and discomfort in the hospital environment.

Given this scenario, access to hospital care for transgender individuals is becoming yet another barrier faced by this social segment, which already experiences constant marginalization and invisibility in various social settings. As a result, this social segment remains disconnected from equitable, sensitive, and ethical health care—rights that have been hard-won through their struggles and advocacy.

Deepening the understanding of issues concerning transgender people's access to hospital care, the research guiding question emerges: What knowledge do health workers have about the health of the transgender population in the hospital environment?

Thus, this study aimed to understand, based on health workers' discourse, their knowledge regarding health care for transgender individuals in the hospital context.

METHOD

This is a descriptive study with a qualitative approach, focusing on health care for transgender individuals in the hospital context, conducted at a federal university hospital in Alto Sertão Paraibano, Brazil. Despite offering medium- and high-complexity services, the hospital does not yet have specialized outpatient clinics for transgender population care.

The research constituted the situational diagnosis phase, part of the first stage of a protocol for developing and validating a care-educational technology aimed at improving the quality of transgender care. Data collection occurred between September and November 2023, conducted by a nursing undergraduate student under the supervision of the lead researcher, both affiliated with the proposing Higher Education Institution (HEI).

Inclusion criteria for interviews were: being a health worker (including administrative, reception, and health professionals) employed at the mentioned hospital for six months or more, and having regular direct contact with the flow of individuals served at the health facility. Those on health leave or vacation during the data collection period were excluded.

Semi-structured interviews were conducted, comprising four items that explored the phenomenon of interest in this study, aiming to understand the knowledge presented regarding health care for transgender individuals in the hospital context. The interviews, which lasted an average of 15 minutes, were conducted in person and individually, with audio recordings carried out in private areas within the hospital. Before each recording began, the researcher explained the purpose of the interview and the possibility of withdrawal; however, no participants declined, and all chose to proceed.

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Participants were selected using convenience sampling and the snowball sampling technique. Interviews concluded upon reaching theoretical saturation, when the contributions of interviewees no longer introduced new insights into the phenomenon under study[8]. After transcription, participants were contacted individually and given access to their transcripts for validation.

Prior to data collection, the researcher had no prior relationship with the interviewees; their first contact occurred during the interviews. To enhance the robustness of the research methodology, the Consolidated Criteria for Reporting Qualitative Research (COREQ)[9] were utilized to support the study's framework and credibility.

Data were analyzed using the Collective Subject Discourse (CSD) methodology, grounded in the concept of Social Representation (SR). This methodology aims to construct representations that preserve both individual and collective perspectives. Opinions and expressions with similarities in participants' statements were grouped into categories to form these SRs[10]. In this framework, individual speech segments, termed Key Expressions (KE), were grouped based on semantic similarity to create Central Ideas (CI), culminating in the development of the CSD[11].

This study is part of the umbrella project "Development and Validation of Care-Educational Technologies in the Field of Interdisciplinary Health" and commenced following approval from the Research Ethics Committee (REC) of the proposing institution. It was conducted in compliance with Resolution 466/2012 of the National Health Council, which establishes guidelines and regulations for research involving human subjects[12]. Participation of health workers began after reading, understanding, and signing the Free and Informed Consent Form (FICF). The form was completed in duplicate, with one copy retained by the participant and the other by the researcher.

To ensure anonymity, codes were created using the first three letters of participants' occupations at the health institution, followed by numerical identifiers corresponding to the order of interviews within each category. Participants were thus identified as ENF01, ENF02, ENF03, ENF04, ENF05, ENF06, TEC01, TEC02, TEC03, TEC04, MED01, MED02, FIS01, FIS02, NUT01, NUT02, REC01, REC02, and REC03.

RESULTS

The study included 19 health workers employed in the referenced health care service. Participants represented various occupational categories: six nurses, four nursing technicians, two nutritionists, two physiotherapists, two physicians, and three receptionists.

Of the 19 respondents, 14 identified as female and five as male. The age range varied between 22 and 50 years, with a predominant age group of 35 to 39 years (47.3%). Educational levels also varied, with 14 participants (73.7%) having completed higher education; of these, 71.4% held advanced qualifications such as residency, master's, doctoral, or lato sensu postgraduate degrees. Most health workers had been employed at the institution for over a year (78.9%). Regarding ethnicity, 63.1% self-identified as white, 31.5% as mixed-race (pardo), and 5.2% as Black.

Based on the analysis of the interviews, and in line with the grouping of the CSDs, four CIs were identified: (1) Misconceptions about the Concept of Gender Identity, (2) Sexual Orientation as Sexual Education: A Misstep in Health Workers' Discourse, (3) Limited Knowledge About Transgender Individuals, and (4) A Narrow View of the Relationship Between Transgender Individuals and Physical Body Modifications.

IC01 - Misconceptions About the Concept of Gender Identity

CI01 explores health workers' knowledge about gender identity, based on contributions from six participants: TEC01, ENF04, REC02, FIS01, NUT01, and MED01.

> *CSD01: What I know about this topic is really very limited, very little… I think it is a concept that, in people's minds, is still very vague, but socially it seems to imply a choice regarding the sexuality each person wants to assume, right? There are matters related to the particularities of sexual orientation. That is my understanding! There is the LGBT issue, homosexuals, transsexuals… So, I do not understand if the person is a lesbian, or not… if they are gay, or not… I do not get it, you know? I do not understand this… Let's say a trans man… he wants to be in a woman's place. In the same way that a homosexual man also wants to be in a woman's place, and a trans woman may need to be in a man's place. So [...] it has to do with the sexuality the person identifies with, right? With their sexuality.*

In *CSD02*, participants reveal, through their discourse, misconceptions in addressing Gender Identity, with a noticeable intertwining of divergent concepts such as Sexual Orientation and Sexuality. Additionally, they exhibit confusion regarding the "choice" of spaces associated with trans women, trans men, and cisgender homosexual men.

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CI02 - Sexual Orientation as a Synonym for Sexual Education

In CI02, health workers discussed their understanding of the definition of sexual orientation. Five participants contributed to this category: ENF01, REC01, ENF04, REC03, and TEC03.

> *CSD02: My knowledge about sexual orientation is limited. In a way, it caught me off guard, but in my view, it might refer to what users or patients consider as guidance from the external environment, right? It might also stem from the education a person receives, right? Let's put it that way. Parents can guide their children… It depends both on the guidance from parents and on the individual, on what they truly feel. It is about providing the best possible guidance, with the best practices, ensuring safety and health for this person, in the way they want to manage their sexual life. So, orientation would mean information; we need information to guide ourselves and understand what gender identity is, what the LGBTQI+ community is—plus something else that I do not know the differences of, which is something we need to understand, right?!*

In *CSD02*, health workers limited the concept of sexual orientation to aspects of sexual health practices, linking it to educational guidance provided by families on issues related to sexual life, gender identity, and the LGBTQIAP+ community.

IC03 - Limited Knowledge About Transgender Individuals

CI03 explores the participants' knowledge about transgender individuals. Five participants contributed to this category: ENF03, ENF04, REC02, TEC04, and MED01.

> *CSD03: I understand that they are people just like heterosexuals, like… anyway, people who have the same rights. They are only different because of their sexual orientation. They do not identify with that, for example… I think it is not just about the body but also about relationships—sexual, emotional. I get confused about these things, to be honest with you. I have never been able to understand this myself. I have read, re-read, looked up definitions, but when I observe it in practice, I cannot understand what it means to be trans. Some say being transgender means one thing, while others say it is something else…*

In *CSD03*, participants share their perceptions of the concept of transgender individuals, revealing difficulty distinguishing between Sexual Orientation and Gender Identity.

CI04 – Narrow View of the Relationship Between Transgender Individuals and Physical Body Modifications

CI04 focuses on health workers' understanding of gender-affirming procedures in the context of transgender individuals. Four participants contributed to this category: TEC01, REC03, FIS02, and NUT02.

> *DSC04: When I think about transgender individuals, what immediately comes to mind is someone going through a radical transformation, right? Someone who has undergone some kind of physical alteration hormonally, a bodily change… sex change, right? I understand it as a total modification from what they were when they came into the world, so to speak. It would be people who totally change their sex.*

In CSD04, participants restrict their understanding of transgender individuals to radical bodily modifications achieved through gender-affirming practices, such as hormone therapy or sex reassignment surgeries.

DISCUSSION

In CSD01, participants highlighted weaknesses in their understanding of the concept of gender identity, leading to confusion with terminologies that have distinct definitions, such as "Sexuality" and "Sexual Orientation."

Gender identity is related to an individual's self-identification with a particular gender—female, or male—and is distinct from sexual orientation, which refers primarily to affective and sexual desires[13].

Although the two concepts are interconnected, they are fundamentally different[14]. Confusing them as synonymous can result from a lack of reflection and in-depth exploration of these topics in professional development settings. Such misconceptions can lead to negative outcomes, for example, inadequate care for LGBTQIAP+ populations, particularly transgender individuals.

For instance, a study conducted in a Spanish hospital examined the case of an individual who underwent gender detransition, possibly influenced by internal conflicts stemming from confusion between gender identity and sexual orientation[15]. This highlights the importance of hospital teams having a clear understanding of these differences to provide accurate information to patients who often arrive with uncertainties and a lack of knowledge. Clarifying these concepts can prevent patients from making definitive decisions that may lead to future distress.

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Failing to understand these distinctions increases the likelihood of gaps in clinical practice. Scientific literature documents instances where health workers make premature assumptions about a patient's sexual orientation or gender identity, presuming alignment with their assigned sex at birth or heterosexuality[16]. These assumptions hinder inclusive care. Therefore, it is not enough to merely understand the terminology; it is crucial to integrate this knowledge into care practices, recognizing the patient holistically.

In CSD01, participants also demonstrated confusion regarding the spaces occupied by transgender individuals, including the suggestion that homosexual patients might wish to occupy spaces designated for women. The term "spaces" here seems to refer to sex-segregated (female or male) areas within the hospital, such as wards and restrooms. A more accurate understanding would clarify that sexual orientation does not define gender identity. Thus, a cisgender homosexual individual would not wish to be in a woman's space but rather in one that aligns with their gender.

However, this misunderstanding, as observed in CSD01, can result in stereotypes among health workers, potentially causing discomfort for patients accessing hospital services. Participants also mentioned that trans men might wish to occupy women's spaces, and trans women could be placed in men's places.

This demonstrates a lack of knowledge about gender identities. Transgender individuals, whether binary or non-binary, should receive care aligned with their current gender identity and specific needs. A Brazilian study with four trans women reported experiences of distress caused by health workers' refusal to use their social names, placing them in male wards to sleep, and prohibiting them from using women's restrooms[6]. These situations lead to trauma and discomfort due to the violence experienced in health services.

The concept of Sexual Orientation, as defined by participants in CSD02, was limited to the idea of information shared between individuals as guidance on sexual practices, gender identity, and knowledge about LGBTQIAP+ communities. This interpretation diverges from the true meaning of sexual orientation and aligns more closely with sexual education. Sexual education aims to broadly address topics related to the human body, pleasure, violence, gender identity, and other areas[17].

One goal of sexual education is to expand and enhance knowledge[18]. While sexual orientation may be a topic within sexual education, it is neither limited to this field nor synonymous with it.

This context of lack of knowledge can be explained by the fact that, despite the importance of sexual education as a means to expand understanding, health workers may operate in care environments that do not promote practices addressing specific issues related to sexual orientation. This further hinders the delivery of care tailored to the needs of sexual and gender minorities who use these services.

Although participants expressed confusion in CSD02 when defining sexual orientation, by the end of the discourse, health workers acknowledged the necessity of understanding the subject, despite their lack of knowledge. Contrasting this finding, a study involving LGBTQIAP+ people and health workers across six European countries found that some professionals considered sexual orientation a low-relevance topic in most specialties, emphasizing its importance primarily in psychiatry[19].

From the perspective of sexual and gender minorities in a study conducted in England, within a European context, some participants from the LGBTQIAP+ community who accessed health services, including hospitals, viewed the inclusion of information about sexual orientation at the beginning of care as positive[20].

Similarly, nurses in the United States working in pediatric hospitals and other health services recognized the importance of including sexual orientation as part of clinical information to facilitate practice. This inclusion in updated electronic medical records, alongside gender identity, enables the promotion of inclusive care by health workers, ranging from direct care providers to those outside the immediate scope of health assistance[21]. Therefore, it is emphasized that understanding the terminology can enhance the care provided to patients, as culturally sensitive care should align with the comfort and preferences of users.

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In turn, in CSD03, the health workers who participated in the study demonstrated confusion not only between the terminologies “Sexual Orientation” and “Gender Identity” but also exhibited limited knowledge about the concept of transgender individuals. Although this topic has gained more visibility in recent years due to social deconstructions, concepts such as “transgender,” “transsexuality,” and “transvestility” do not share the same definition.

In this context, a lack of understanding of this gender identity may also indicate insufficient awareness of the specific needs and characteristics of this population within health services, particularly in hospital settings. Supporting this, data from an Australian study involving health professionals specializing in oncology services indicated greater difficulty in providing care for transgender and intersex individuals within the broader LGBTQIAP+ population[22].

Aligned with the limited knowledge observed in CSD03, a study in the Netherlands revealed that transgender individuals with a history of suicidal ideation encountered health professionals who were unfamiliar with transgender identity. Some of these individuals even had to educate their health providers on the topic[23]. Such situations can amplify feelings of insecurity and mistrust toward clinical care.

Adding to this discussion, research conducted at a university hospital in France found that health professionals expressed discomfort when providing care to transgender persons. This discomfort was apparently linked more to a lack of knowledge about engaging with this social group than to a refusal to offer services[24]. Such gaps may contribute to uncomfortable experiences for patients. A study involving 21 transgender individuals with perioperative care experiences reported negative feelings associated with having to educate health professionals about their gender identity[25].

This lack of understanding can reflect gaps in academic training, as evidenced by a Brazilian study involving 28 nursing undergraduates. Some participants reported believing that specific care tailored to the transgender population was unnecessary, justifying their stance with arguments about equality with other populations. These participants felt confident in providing care for this population, assuming it would not differ from the care provided to other people[26].

This emphasis on equality creates a false sense of inclusion for the transgender population, fostering barriers that prevent health workers from delivering equitable care plans. This approach leaves transgender and transvestite individuals vulnerable to neglect and uncomfortable situations in environments dominated by cisheteronormative practices.

Building on the low level of knowledge about transgender individuals noted in CSD03, CSD04 reveals further misconceptions among health professionals. Participants discussed transgender identity in terms of the necessity of radical bodily modifications, such as hormone therapy or gender-affirming surgeries, to validate an individual's transgender status. Both procedures are available free of charge in Brazil through the Unified Health System (SUS), following Ordinance No. 2,803, established on November 13, 2013, which ensures gender affirmation through the transsexualization process[27].

There were no findings in the reviewed literature regarding health professionals’ perspectives on the topics addressed in CSD04. However, transgender poersons’ accounts suggest that this scenario extends to other countries. For example, a study on the gestational experiences of transgender individuals described a participant being led to believe that a hysterectomy was necessary. This decision stemmed from a health professional’s assumption that it was the appropriate choice given the patient’s gender identity[28]. These practices must be individualized based on the person’s needs and should not be used to define who belongs to the population segment.

Although personal desires may align with available health services, transgender individuals often face additional barriers, including difficulty accessing specialized gender-affirming care. This is partly due to the limited number of hospitals offering outpatient services tailored to these specific needs.

In Brazil, for instance, research shows that only five hospitals provide transgenitalization procedures through SUS[5]. This situation complicates access for transgender individuals seeking to begin specific aspects of the transsexualization process, as financial factors influence their ability to reach these facilities.

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A study in China involving 2,060 transgender individuals (including trans men and women) found that 868 expressed a desire for gender-affirming surgeries. However, more than half (53.1%) reported difficulty obtaining information about hospitals or doctors performing these surgeries within the country[29]. This highlights a global problem with the limited availability of services capable of meeting these demands.

The same study also revealed that most participants who had used hormone therapy did so without a medical prescription, acquiring the medications through unregulated sources, including individuals or companies[29]. This reflects a disconnect between health services and transgender individuals, endangering their physical well-being.

It is worth emphasizing that monitoring in hospital outpatient settings is essential to ensure coherent and guided decision-making. However, health professionals must move beyond the stereotype that transgender identity is solely defined by gender-affirming procedures. Only then can they provide competent care for this population. Social transitioning and gender affirmation have life-long impacts on transgender people and their families[30].

In this regard, a study conducted in Andalusia, Spain, involving 18 transgender individuals (both men and women) revealed that some participants experienced health professionals attempting to coerce them into undergoing hormone therapy or surgical procedures for gender affirmation, even when such interventions were not desired by the health service users[31]. This practice imposes measures that violate the autonomy of transgender individuals and demonstrates the stigma among professionals regarding the relationship between transgender people and gender-affirming procedures.

Such procedures must be presented respectfully and sensitively, highlighting the diversity of pathways that can be explored while dismantling limited notions about individuals living with gender dysphoria[15]. Achieving this requires not only knowledge on the part of professionals about various methods but also the involvement of multidisciplinary teams to ensure qualified and empathetic listening for transgender individuals undergoing bodily changes—or not.

Gender dysphoria itself can lead to emotional and physical stress[32]. Thus, it requires the preparation of professionals to provide care to the transgender population. This preparation is often lacking, due to the persistence of a biomedical model that inadequately addresses this social segment.

In such context, barriers to ensuring fluid and comfortable care for the transgender population create a growing disconnect between this population and hospital services, perpetuating the invisibility of their needs and characteristics. The absence of ongoing professional education hinders the development of a welcoming culture for transgender people within health services.

Study limitations

The study's limitations stem from the fact that it was conducted exclusively in a single federal university hospital setting, without addressing the characteristics of care provided to transgender persons in other health care facilities within Brazil's Health Care Network.

CONCLUSION

The hospital context, as a key player in the transsexualization process and a provider for non-specific needs of the transgender population, still presents numerous barriers that hinder equitable, sensitive, and qualified care for this social segment. Health workers' knowledge regarding the LGBTQIAP+ population, particularly transgender individuals, continues to reveal significant weaknesses. These shortcomings negatively impact the provision of qualified care, furthering invisibility and perpetuating prejudiced and stigmatizing behaviors toward transgender individuals within hospital health care services.

It is suggested that future research focuses on developing technologies to improve care for transgender individuals in various healthcare settings, thus fostering opportunities to transform a stigma- and prejudice-laden environment. Additionally, new investigations could analyze how the topic of sexual and gender minorities, particularly transgender individuals, is addressed in Pedagogical Course Projects within health programs nationwide. These studies could contribute to rethinking and reshaping curricula to include this vital topic.

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Author's contributions

Conceptualization, A.K.C.G.A. and M.C.F.; methodology, A.K.C.G.A. and M.C.F.; validation, M.C.F., J.P.S., F.A.P.S., T.N.G.V. and I.L.A.B.; formal analysis, R.C.A.T., C.R.D.V.S. and M.C.F.; investigation, A.K.C.G.A.; resources, A.K.C.G.A.; data curation, A.K.C.G.A.; manuscript writing, A.K.C.G.A.; writing – review and editing, A.K.C.G.A., R.C.A.T., C.R.D.V.S. and M.C.F.; visualization, J.P.S., F.A.P.S., T.N.G.V. and I.L.A.B.; supervision, M.C.F.; project administration, M.C.F.; acquisition of financing, A.K.C.G.A. All authors read and agreed with the published version of the manuscript.