Revista Brasileira de
Sexualidade Humana ISSN 2675-1194
DOI: https://doi.org/10.35919/rbsh.v37.1312



**TRABALHO DE PESQUISA**

# TRANSGENDER PEOPLE'S EXPERIENCES IN MEDICAL CARE: A QUALITATIVE STUDY IN A GENDER CLINIC IN SOUTHEASTERN BRAZIL

## AS EXPERIÊNCIAS DE PESSOAS TRANSGÊNERO NOS ATENDIMENTOS MÉDICOS: ESTUDO QUALITATIVO EM UM AMBULATÓRIO DE GÊNERO DO SUDESTE BRASILEIRO

## EXPERIENCIAS DE PERSONAS TRANSGÉNERO EN LA ATENCIÓN MÉDICA: ESTUDIO CUALITATIVO EN UN CONSULTORIO DE GÉNERO DEL SURESTE DE BRASIL

*Karine Schlüter*[1] *Amilton dos Santos Júnior*[2] *Paulo Dalgalarrondo*[3]

**Abstract**: The aim of this paper was to listen to trans people and understand medical care from their perspectives, highlighting both positive and negative aspects. It is a qualitative study based on participants' testimonies regarding their medical care after beginning the gender transition process. The analysis was carried out using the clinical-qualitative research method. The negative aspects were related to the disrespect of their gender identity, lack of knowledge about trans issues, lack of empathy from professionals, discomfort in healthcare settings, and fear of exposure during physical examinations. Positive accounts included respect and empathy from the physician and a perception of the environment as safe. Furthermore, these characteristics of the professional and the setting enabled individuals to experience the physical examination, despite being a vulnerable moment, as something positive that affirms their identities. We conclude that empathetic and competent care for trans people is a fundamental condition in the pursuit of equity in healthcare for this population.

**Keywords**: Transgender people; Doctor-patient relationship; Physical examination.

**Resumo:** O objetivo deste artigo foi escutar pessoas trans e compreender o atendimento médico segundo suas perspectivas, elencando pontos positivos e negativos. É um estudo qualitativo dos depoimentos de participantes sobre seus atendimentos médicos após o início do processo de transição de gênero. A análise foi realizada por meio do método clínico-qualitativo de investigação. Os aspectos negativos foram relativos ao desrespeito a seu gênero, desconhecimento da temática trans e falta de empatia do profissional, constrangimentos nos ambientes de saúde e medo da exposição no exame físico. Relatos positivos incluíram respeito e empatia por parte do(a) médico(a) e ambiente entendido como seguro. Além disso, essas características do profissional e do ambiente possibilitaram vivenciar o exame físico, apesar de ser um momento de vulnerabilidade, como algo positivo e que legitima suas identidades. Concluímos que um atendimento empático e competente às pessoas trans é condição fundamental para buscarmos a equidade na assistência a essa população.

**Palavras-chave**: Pessoas Transgênero; Relação Médico-paciente; Exame Físico.

**Resumen**: Este articulo científico cualitativo escuchou personas trans para comprender la atención médica desde sus perspectivas, enumerando aspectos positivos y negativos. Es un estudio basado en testimonios de participantes sobre su atención médica después de la transición de género. El análisis se realizó mediante el método clínico-cualitativo de investigación. Los aspectos negativos fueran falta de respeto a su identidad de género, desconocimiento sobre la temática trans, falta de empatía del profesional, situaciones incómodas en entornos de salud y el miedo a la exposición durante el examen físico. Relatos positivos incluyeron respeto y empatía por parte del médico y percepción del entorno como un espacio seguro. Además, estas características del profesional y del entorno permitieron vivir el examen físico, aun siendo un momento de vulnerabilidad, como algo que legitima sus identidades. Concluimos que atención empática y competente a las personas trans es essencial para buscar la equidad en la atención a esta población.

**Palabras clave**: Persona transgénero; Relación médico-paciente; Examen físico.

[1]Mestrado em Saúde da Criança e do Adolescente - Faculdade de Ciências Médicas - Universidade Estadual de Campinas - UNICAMP- SP- Brasil. karineschluter@gmail.com
[2]Professor Adjunto - Departamento de Psiquiatria- Faculdade de Ciências Médicas- Universidade Estadual de Campinas- UNICAMP -SP- Brasil. amilton@fcm.unicamp.br
[3]Professor Titular- Departamento de Psiquiatria-Faculdade de Ciências Médicas- Universidade Estadual de Campinas- UNICAMP-SP- Brasil. pdalga@fcm.unicamp.br

Revista Brasileira de
Sexualidade Humana ISSN 2675-1194
DOI: https://doi.org/10.35919/rbsh.v37.1312


## Introduction

Transgender people (those whose gender identity differs from the gender assigned at birth based on genital appearance, hereinafter referred to as trans people) face greater difficulties in accessing healthcare than cisgender people (those whose gender identity matches the gender assigned at birth, hereinafter referred to as cis people) (Brandelli et al., 2018).

In 2008, the Brazilian Unified Health System (SUS) created the Transsexualization Process, which was redefined and expanded in 2013 in order to guarantee trans people's access to procedures involved in gender transition, including psychotherapy, vocal therapy, hormone therapy, and surgeries. In addition, Article 196 of the 1988 Brazilian Federal Constitution establishes health as a right of all citizens and a duty of the State. However, despite the existence of public policies directed at this population, it still faces significant barriers in accessing healthcare, possibly representing the most marginalized group in terms of care at all levels (Rocon et al., 2020).

According to a 2018 Brazilian study, among the determining reasons for negative experiences in medical care are the incorrect use of names and pronouns and physicians' lack of knowledge about the specificities of trans health (Brandelli et al., 2018). Another study, from 2016, showed that trans female patients who had to teach their doctors about their needs were four times more likely to postpone seeking care when they needed it than those who were seen by professionalsalready familiar with their needs (Jafee, Shires, Stroumsa, 2016).

This article addresses how trans patients view medical care, seeking to define what is perceived as positive and negative. With this assessment, we hope to equip physicians and other professionals with approaches and attitudesthat may help in the pursuit of better health outcomes for this population.

Materials and Methods

The study took place at a clinic specifically for trans people, located within a university hospital in a metropolitan region of southeastern Brazil. The service has professionals from several fields, including psychiatrists, psychologists, art therapists, speech therapists, pediatricians, endocrinologists, gynecologists, nurses, and social workers. Patients seek consultations for various reasons, with the search for hormone therapy being the most frequent. Between February 2021 and November 2022, 33 people were seen by the first author. Of these, 13 reported their experiences in writing. Among the 20 people who did not write their accounts were patients who had only one consultation, others who moved to another city, and some who simply did not want to participate. The accounts provided were submitted to clinical-qualitative content analysis.

This method, based on phenomenology, psychodynamics, and the person-centered approach, was created by Dr. Egberto Ribeiro Turato, and because it deeply values subjectivity, it is suitableto the analysis of individual accounts (Faria-Schützer et al., 2021). Through this analytical technique, it is possible to transpose the experience of small groups, or even of a single individual, to the collective, provided that the categories listed have been exhausted. First, the material was prepared by selecting fragments of the discourses related to the triggering question, namely: “Describe your experiences in the medical consultations you have had since the beginning of your transition.” Once the fragments were selected, they were coded, separated into categories, and finally described, discussed, and interpreted.

**Table 1** – Saturation of categories

| | Categories | A | B | C | D | E | F | G | H | I | J | K | l | M |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A Physician | 1. Respect | | | | X | | z | | z | z | | | | z |
| | 2. Knowledge | | | X | | | z | z | | | z | | z | z |
| | 3. Empathy | X | z | z | | z | z | z | z | | | | z | z |
| B Ambiente | 1. Dicomfort | | X | | z | | | z | | | | | | |
| | 2. Safety | | | | | X | | | | z | z | z | | |
| C exame | 1. Fear | | X | | | z | | z | z | | | | z | |
| | 2. Affirmation | | X | | | | z | z | | | z | | | |

**Note**: "X" represents the first occurrence of a category; "z" indicates recurrences.

Analysis of the material showed category saturationthat emerged in the sample, as shown in the table above, where “X” represents the first occurrence of a category and “z” indicates its recurrence. From participant F onwards, no new categories emerged (Fontanella et al., 2011; Faria-Schützer et al., 2021).

This article is the result of a rigorous qualitative analysis of the accounts provided. Category saturation was understood as a gradual analytical process, characterized by the recurrence of patterns without significant interpretive additions to the developing categories. The analysis included the systematic exploration of cases that challenged provisional categories, intentionally delaying analytical closure. The decision to end data collection was based on the recurrence of interpretive cores and the absence of relevant analytical shifts after successive accounts. In line with contemporary approaches to qualitative research, saturation was treated as a heuristic criterion rather than a fixed endpoint.

All people included in the study were over 18 years old and signed a Free and Informed Consent Form. The research was approved by the Research Ethics Committee (CEP). The study uses qualitative analysis of these accounts.

**Results**

The group of 13 participants whose accounts were analyzed comprised 5 trans men, 7 trans women, and one non-binary person who preferred the use of masculine pronouns (Table 2). The population attended was predominantly white and with at least a high school education. Due to the location of the service, far from the city center, access was possibly restricted to people with greater economic resources for commuting.

**Table 2** – Participants’ profile

| Identification | Age | Gender | Skin color | Education | Occupation |
|---|---|---|---|---|---|
| A | 19 years | Trans man | black | High school | None |
| B | 21 years | Trans man | white | High school | None |
| C | 20 years | Trans woman | white | High school | None |
| D | 18 years | Non-binary person | white | High school | Dental assistant |
| E | 30 years | Trans woman | white | Undergraduate (ongoing) | None |
| F | 27 years | Trans woman | white | Higher education | Information technology |
| G | 21 years | Trans man | black | High school | Snack-bar attendant |
| H | 35 years | Trans woman | Black | Undergraduate degree | Civil servant |
| I | 23 years | Trans man | white | High school | None |
| J | 49 years | Trans woman | white | Undergraduate | Musician |
| K | 24 years | Trans woman | white | Undergraduate (ongoing) | None |
| L | 24 years | Trans man | white | Undergraduate | Researcher |
| M | 25 years | Trans woman | white | Undergraduate | Writer |

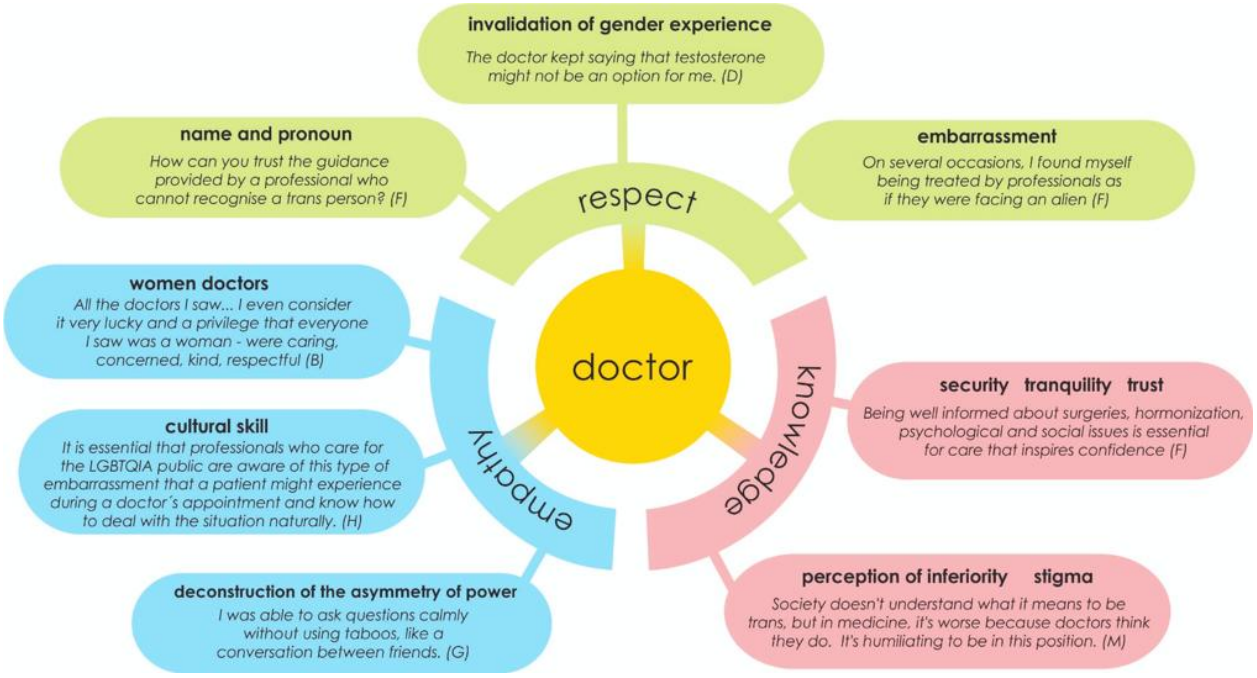
All accounts were submitted to discourse analysis, which identified three major groups determining people's perception of care:

- the behavior of the physician providing the care (Figure 1);
- aspects related to the environment where the care takes place (Figure 2);
- aspects of the physical examination (Figure 3).

Revista Brasileira de
Sexualidade Humana ISSN 2675-1194
DOI: https://doi.org/10.35919/rbsh.v37.1312


**The physician – Respect**

**Figure 1** – Infographic: "The Physician"




Within this subtheme, several accounts describe the incorrect use of name and pronouns, as shown below:

**Pacient Account**

| Patient | Account |
|---|---|
| M | *"I received completely unprepared care. They called me using masculine forms. So I asked. I asked politely to change the pronouns. I asked politely, because that's how we have to speak to cis people, so they don't realize that this is what hurts you. Otherwise it gets worse… The professor asks the students attending the consultation: 'What are you seeing on HIS exam?' Come on! On my chart it says I'm a 'transsexual' person — using the medical and inappropriate term for my identity — but which, in any case, should convey some information to whoever is treating me. It was terrible."* |
| D | *"I had a good experience with the gynecologist, Dr. X. When I needed him to see me, he called me by masculine forms. But now, I don't know why, he only addresses me with feminine forms. I feel like saying, 'Hey! Now that I'm taking testo?!', but I don't say it."* |
| I | *"At the offices (dermatology and gastro) it was quite okay. They called me by my correct name. But I was nervous, thinking it was all going to happen again, like all the other times."* |
| F | *"How can one trust the guidance provided by a professional who cannot recognize a trans person when she literally appears in front of them and declares herself trans?"* |
| K | *"Here at the clinic, a man at the reception insisted on addressing me with masculine forms even when I explained. But I complained during the consultation and it was sorted out."* |

Other accounts refer to the invalidation of the person's gender experience by the attending professional:

| Patient | Account |
|---|---|
| D | *"The doctor kept saying that testosterone might not be the right thing for me."* |

Displays of strangeness towards the people being attended were also a frequently mentioned aspect.

| Patient | Account |
|---|---|
| F | *"I have endured many appointments since I accepted myself and came out as trans. Several times I found myself being treated by professionals as if they were facing an alien."* |
| H | *"We are not always seen with naturalness, and combining the fear we have of this exposure (in the physical examination) with this lack of naturalness, we are left to fend for ourselves because we do not feel comfortable seeking medical help when necessary. Out of fear. Fear of feeling subjugated."* |
| D | *"When I went to the psychiatrist on the health plan, he made a shocked face at what I told him. He only raised his eyes, without lifting his head toward me."* |
| M | *"When I sprained my ankle, I had a consultation through the health plan. There were three doctors. One led the consultation and the other two observed. I know there are visible gender markers. I wear size 44 shoes. It looked like they were disgusted by me, and then they turned me into an ankle to be treated. I was no longer a person."* |

**The physician – Empathy**

From the accounts emerged calm conversations, naturalness, and eye contact — all aspects that can be subsumed under the concepts of cultural skill, preference for female physicians, and the deconstruction of power asymmetry, all viewed as positive aspects of care.

| Pacient | Account |
|---|---|
| J | *"It gives a sense of safety to know that someone who understands what a transgender woman is is treating you. It's a shame this topic still seems to be unknown to many health professionals."* |
| C | *"I was worried and afraid of the possible side effects and the the method of application [of hormone therapy], but the doctor explained everything in a very good and simple way, and in the end I felt completely at ease."* |
| F | *"The doctor's naturalness in dealing with the topic of transsexuality and its health implications is very important. Being well informed about surgeries, hormone therapy, and psychological and social issues is essential for care that inspires trust."* |
| L | *"In general, [doctors] assume that because I am trans I must be hetero, that I play a specific sexual role, but here that was not the case… I never had to explain basic things what a binder or a packer is."* |

Revista Brasileira de
Sexualidade Humana ISSN 2675-1194
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**The setting – Discomfort**

**Figure 2** – Infographic: "The Setting"


One of the factors that constituted a barrier to participants seeking healthcare was the fear of feeling embarrassed in the environment.

| Pacient | Account |
|---|---|
| B | *"Even after two years of hormone therapy, after legally rectifying my documents, after a masculinizing mammoplasty, and being accustomed to being constantly read as a man by those around me, the very idea of a gynecological office waiting room terrifies me. I am afraid of the questions a receptionist might ask about a man going to the gynecologist, of the looks of the patients around me…"* |
| G | *"When you go to a gynecologist outside [a service for trans care], people look at you sideways."* |
| D | *"I felt that people asked things that were not necessary for the consultation. They ask about our intimate life out of curiosity. It happened in a dermatology office where the secretary kept asking who I was hooking up with."* |
| I | *"I am always afraid to seek healthcare services. I have to keep explaining my name. And then, even so, the person calls me by the wrong name… Once I went to the ER because I had a sore throat. I explained that they should call me Paulo (fictitious name), and the woman kept calling me by the wrong name. I explained, but it didn't help. I felt bad there. Then, when it was my turn to go in, she called me by the wrong name again, but she came close to me to call me. At least it was in a way that other people did not hear… When I went into the consultation, I just explained what I was feeling, got the prescription, and left."* |

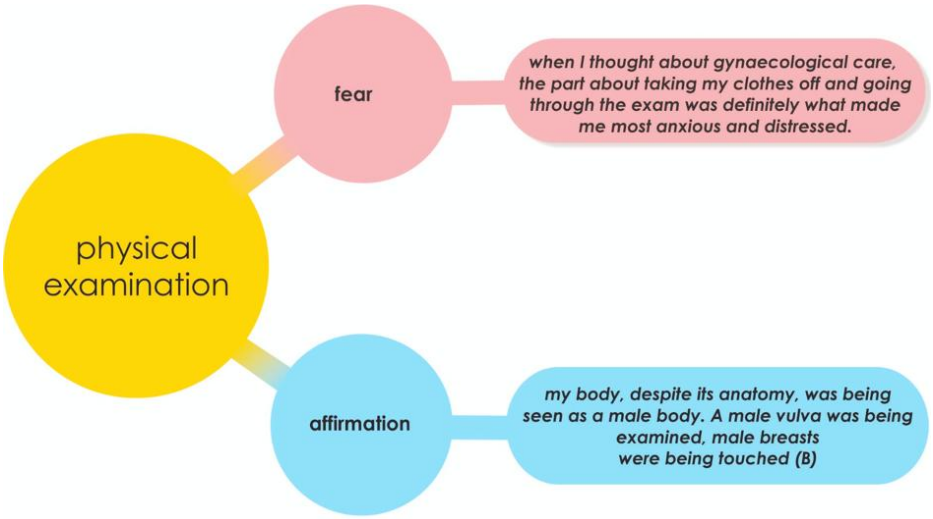
**The setting – Safety**

The participating community described what gave them the perception of a safe and welcoming environment.

| Pacient | Account |
|---|---|
| I | *"Here it's really nice and we are well treated from the moment we walk through the hospital entrance, where they call us by our real names."* |
| E | *"…Above all when we are in an environment where we are not judged, where our identity is respected, and we do not suffer any kind of embarrassment or prejudice for simply being who we are, everything goes as smoothly as possible way."* |

**The physical examination – Fear**

**Figure 3** – Infographic: "The Physical Examination"




People describe the physical examination with ambiguity — it can be either an experience that triggers fear or something positive, experienced as an affirmation of their gender.

| Pacient | Account |
|---|---|
| L | *"I went to the gynecologist when I had a suspected case of genital herpes… I had already changed my name on my documents and was already on hormones, which left me extremely anxious."* |
| H | *"The first contact [with the gynecologist] was somewhat embarrassing… until then I had never been through an evaluation in which my whole body was exposed. This happens because for us, transsexual women, exposing a part of our body that does not match what we present when dressed is… to show a truth that even we do not want to accept when looking in the mirror."* |
| B | *"The mere idea of going to a place where my body could be seen, touched, perceived — while I did not want it to be — terrified me. The gynecological consultation was a source of great fear."* |
| E | *"When I thought about the gynecological consultation, the part of taking off my clothes and going through the exam was without doubt what made me most anxious and distressed, since I don't like being completely naked even for myself, much less touching my genital organ, mainly because I suffer from gender dysphoria."* |

**The physical examination – Affirmation**

Our participants reported that the physical examination can be a gender-affirming experience, evoking feelings of belonging and recognition of their identity.

| Pacient | Account |
|---|---|
| G | *"Before the surgery [masculinizing thoracoplasty] I had dysphoria with my breasts, and even so, because it is a safe space [the person is referring to our service] and because of the way the doctor handles this, I never felt bad or insecure."* |
| B | *"At the clinic, I received care very similar to what I had received before. It was attentive, concerned, kind, and respectful care. But there I realized that one detail kept the experience from being traumatic: my body, despite its anatomy, was being seen as a male body. A male vulva was being examined; male breasts were being touched."* |
| J | *"At the consultation here I felt very comfortable and happy to have my first gynecological consultation."* |

Revista Brasileira de
Sexualidade Humana ISSN 2675-1194
DOI: https://doi.org/10.35919/rbsh.v37.1312


| | |
|---|---|
| F | *"I still remember the positive surprise of my first appointment. The doctor asked me if I had ever had a gynecological exam. I answered no, certain this was impossible without having yet gone through vaginoplasty. The doctor kindly told me it would then be my first time, and instructed me on how to position myself, with my legs in the stirrups, for the exam. What an unprecedented sensation! The embarrassment of having such an intimate exam was overcome by the excitement of anticipating post-sex reassignment care — an exam that would soon become routine."* |

**Discussion**

During this study, the most frequently mentioned word was fear, when participants described their search for medical care. In general, previous healthcare experiences determine whether individuals seek or avoid care, with the doctor-patient interaction being the most relevant among them (Jafee et al., 2016).

The results revealed, in agreement with previous studies, that a therapeutic doctor-patient alliance that leads to optimal health outcomes depends on empathy, knowledge, and non-judgmental communication — identified by the participants as empathy, knowledge, and respect (Zhang et al., 2022; Baker et al., 2014; Murphy et al., 2018; Goldhammer et al., 2018).

The category Physician–Respect focused on three points: the use of name and pronouns; the recognition of the person's gender experience; and the physician's naturalness or strangeness when facing someone of diverse gender. The first contact between physician and patient occurs through gaze and language. The professional who looks the patient in the eye, calls them by their real name, and uses the pronouns by which the person identifies, communicates visibility and respect to the person being treated, facilitating the building of a therapeutic bond. Conversely, addressing patients with incorrect names or pronouns that do not match their identities communicates erasure of the subject, stigma, and discrimination. When this occurs at the very beginning of the contact, there is a great possibility of definitively tarnishing the doctor-patient relationship. It is possible that some healthcare providers think that asking patients how they should be addressed and which pronouns the professionals should usemight sound rude, and so they engage in a behavior that is dangerous for medical practice: making inferences about the person rather than asking them in a respectful and direct manner (Lykens et al., 2018).

People with non-binary trans identities (who identify in a way that dissents from the female/male binary) seem to have even greater difficulty making themselves understood within healthcare, as reported by the only non-binary participant in the sample when he said that the professional who treated him questioned the use of hormone therapy. This finding, also described in the literature, is consistent with daily practice in trans care: non-binary trans people complain that, even in healthcare settings intended for trans people, they have greater difficulty accessing medical procedures for their gender affirmation (Lykens et al., 2018). This is due to multiple factors. Certainly, one of them is that medical education, reflecting the culture in which it is embedded, perpetuates a binary model of care in which patients are divided between men and women.

Knowledge was also a subcategory identified as relevant in patients' experience. The perception of being seen by a professional who understands their demands generates safety, calm, and trust in trans people. However, many people with gender diversity face professionals who are absolutely ignorant about aspects of their health, including those who do not know the meaning of "transgender" (Vermeir et al., 2018). Patients who perceive that their clinicians are unaware of trans health needs are four times more likely to postpone seeking care than people who have not had this experience (Jafee et al., 2016).

The lack of familiarity among professionals with gender transition guidelines and with the specific care to be taken regarding trans health is a significant barrier in the search for care, making it difficult to access hormone therapy procedures and genitourinary and breast health care (Hines et al., 2019; Baldwin et al., 2018). Furthermore, technical ignorance means less possibility of planning actions that might positively impact these people's health.

Our participants reported that their perception of their perception of the physician's lack of knowledge, leads to a sense of inferiority and humiliation. Possibly, the reason for this is stigmatization — a mechanism often unconsciously triggered by the physician when facing a situation that challenges their authority.

According to Le Breton (2017): “The process of discrimination rests on the lazy exercise of classification: it pays attention only to easily identifiable traits (at least from its point of view) and imposes a rectified version of the body. Difference is transformed into stigma.” Stigma reinforces existing power structures and places those who challenge them in a position of inferiority. Stigmatization leads to discrimination. In this way, technical ignorance — something that is easily remediable — creates a context of discrimination that makes the doctor-patient bond unviable, with consequent negative health outcomes (Klein et al., 2020). The professional who is unaware of the nature of trans identity is more prone to stigmatize the patient than one who understands that non-cis people also need to express their true identity (Poteat et al., 2013).

According to patient accounts in other studies, it is not enough for the physician to know about caring for trans people — it is necessary to stay up to date and to understand that following protocols is not enough; rather, one must attend to each person within their unique needs (Sevalho, 2018; Sallans, 2016).

Again, when comparing binary trans people to non-binary trans people, the latter tend to postpone seeking help more often (27% vs. 36%, respectively) after going through care in which the professional provided service without the competence to do so (Hines et al., 2019).

In the subcategory Empathy, participants emphasized the positive force of naturalness, calm conversation, and eye contact during care. This finding has already appeared in previous studies with trans women and trans men who, as also expressed in one of the accounts in this study, revealed a preference for female gynecologists, justified by the fact that women listen more than male gynecologists, have greater acceptance regarding gender identity, and that patients feel more comfortable undergoing pelvic examinations with a female gynecologist (Hines et al., 2019; Lifshitz et al., 2022).

The doctor-patient relationship is built from behaviors deliberately enacted by the physician toward the other, including verbal behaviors, necessary for exchanging information between the parties, and nonverbal ones — such as prosody, gaze, and gestures — which together convey a message of respect, safety, and support (Murphy et al., 2018). Tabaac and colleagues showed, in a recent publication, that improvements in communication practices regarding sexual and reproductive health contribute to adherence to contraceptive methods, illustrating the unequivocal importance of communication when we talk about health outcomes (Tabaac et al., 2022).

The physician’s cultural skill was one of the aspects highlighted in the accounts, presented by patients as knowledge about their experiences beyond just health needs. The term “cultural competence” is understood as the professional’s ability to understand, communicate, and provide appropriate care to diverse populations (Hines et al., 2019). Perhaps the word “competence” is not the most appropriate to describe a knowledge that is alive, changeable, not static, and fundamentally dependent on interaction with the target population (Sevalho, 2018). Thus, considering that it is a skill learned with the other, it may be more accurate to speak of “cultural humility” or “cultural sensitivity” (Baker et al., 2014).

Another aspect of relevance in the analyzed material was the deconstruction of the power disparity between physician and patient as a factor that positively contributes to the therapeutic bond. When this asymmetry decreases, the professional communicates empathy and respect (Vermeir et al., 2018; Ross et al., 2017).

Trans people report that they expect to be treated like any other patient, and that the quality of communication directly influences the quality of care (Hines et al., 2019; Sallans, 2016). Certainly, being treated like any other patient involves all the characteristics listed by patients when referring to good care: knowledge about their needs, respect for their identity, less power disparity, and cultural skill on the part of the physician providing care.

As for the Setting, participants reported fear of embarrassment and of the incorrect use of names by staff — this communicates disrespect and aggressiveness. On the other hand, they praise the service where they are called by their real namesAlthough our participants do not mention it, the literature emphasizes the role of gender-neutral environments as a way of communicating welcome (Baldwin et al., 2018; Dendrinos et al., 2019). With this objective, the restrooms in our service do not have signs identifying them as female or male.

Another category raised in the accounts as defining the experience of medical care for participants was

Revista Brasileira de
Sexualidade Humana ISSN 2675-1194
DOI: https://doi.org/10.35919/rbsh.v37.1312


the Physical Examination. The finding that this moment of care generates fear was already expected. Many trans people experience strong suffering with their bodies. Undressing for the physical examination, especially the genital examination, is a situation of great vulnerability.

On the other hand, the people who participated in the research showed that the genital physical examination can be an experience of gender identity affirmation. The visualization and touch of a body areis a privilege granted to few professions. In addition to the obvious function of providing information that corroborates or rules out diagnostic hypotheses, it can also be seen as a ritual, since it is performed within a specific symbolic environment, such as the examination room with its table, using specific objects, such as the stethoscope or speculum, with a methodology of actions (measuring blood pressure, performing cardiac auscultation, and so on). Two actors structure this ritual: doctor and patient. The doctor looks, listens, touches. The person being attended lends their body to the examination. Rituals symbolize passages, and the physical examination can be seen as a rite of passage from disease to cure or, in the case of the trans patient, can symbolize the rite of passage from invisibility to visibility of their body, which faces the obstacles created by current social and political structures. Thus, it represents an experience of identity validation and inclusion in the logic of health care (Constanzo et al., 2018).

Experiencing the physical examination as something positive is certainly the result of the entire context in which it takes place. Those who reported this fact describe situations experienced in a safe environment, being examined by a professional who has knowledge and cultural skills to care for trans people. Making the physical examination something positive should be one of the physician's focal points. The specificities of the person being examined must be addressed, with respect for the nomenclature they prefer in referring to parts of their body. What will be done must be explained to the patient at the end of the anamnesis, before the examination. The person should have their body covered, with only the part to be examined exposed and we ask the person to let us know if they feel uncomfortable during the procedure. This posture contributes to making the stress generated by the exposure become a positive experience.

The finding that gender-specific health care plays a role in making trans women patients feel accepted as "complete women" has already been described in the literature (Hines et al., 2019). However, we found no study describing this gender affirmation related to the genital physical examination.

Gynecology stands out in this context. Understood as the specialty that cares for women's health, trans people question this concept when they affirm the importance of genital evaluation as a way of feeling seen within a health system that is segregational and heterocisnormative. In this sense, gynecology is placed as a dissident specialty, as it also encompasses health care for trans male, female, and non-binary bodies.

**Limits and strengths of the article**

Although the topic of this article is highly original, we acknowledge that the sample size is small; however, the saturation of categories indicated that the number of participants was adequate for the proposed methodology.

The proposed method involves, as an epistemological condition, the researcher themselvesas an element of the research (action research), and therefore as part of the resulting findings. In this sense, the authors do not position themselves with a fictitious neutrality but as the critical conscience of what is analyzed. Nevertheless, each interpretation was supported by excerpts from the accounts, used consistently to avoid undemonstrated inferences. We acknowledge the interpretive character of qualitative analysis, and for that reason we adopted strategies of reflexivity, audit trail, and empirical anchoring in the written testimonies, in order to make explicit and traceable the influence of the researchers on the findings. The data in this article are situated and interpretive. For this reason, traditional criteria of reliability and reproducibility, conceived for experimental and quantitative studies, are not appropriate for the chosen method. The criteria of rigor widely recognized for qualitative research, such as credibility, dependability, and confirmability, were mobilized here, always sustained by analytical reflexivity, documentation of the interpretive process, and empirical anchoring of the findings.

**Final considerations**

According to Paulo Freire, one cannot know the reality of a population without those people being active subjects in the process (Sevalho, 2018). Based on the results of this study, we can suppose that the most important skills for trans care are knowledge, empathy, the ability to observe the other, and non-judgmental communication. These changes imply the deconstruction of the hierarchy and medical power in consultations, which may lead to a more flexible and efficient approach to healthcare. It would be the place of listening, of observation, and of the humility to recognize that one must learn from the other. The physician's role is to contribute to the possibility of building autonomy from the vulnerability of the people who seek care. In this way, barriers to care and their consequences may be minimized.

The professional's place is not to lead the consultation but to offer their knowledge in the service of the patients' needs, who are the protagonists of this delicate encounter that is a medical consultation. If this applies to healthcare practice as a whole, it should be done especially for trans people, both because of the barriers they face in accessing care and because of the scarcity of knowledge among health professionalsregarding their demands.

Our article used qualitative analysis of testimonies to identify relevant aspects of healthcare for transgender people. Future studies analyzing the impact of medical knowledge on the subject and of improvements in care environments on the health outcomes of this population may help to provide solid foundations for the implementation of continuing education programs for health professionals.

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Revista Brasileira de
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DOI: https://doi.org/10.35919/rbsh.v37.1312


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Recebido em: 01/07/2025
Aprovado em: 12/04/2026