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Factors Associated with Medical Doctors' Intentions to Discriminate Against Transgender Patients in Kuala Lumpur, Malaysia

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Abstract

Purpose: Transgender people are frequent targets of discrimination. Discrimination against transgender people in the context of healthcare can lead to poor health outcomes and facilitate the growth of health disparities. This study explores factors associated with medical doctors' intentions to discriminate against transgender people in Malaysia.
Methods: A total of 436 physicians at two major university medical centers in Kuala Lumpur, Malaysia, completed an online survey. Sociodemographic characteristics, stigma-related constructs, and intentions to discriminate against transgender people were measured. Bivariate and multivariate linear regression were used to evaluate independent covariates of discrimination intent.
Results: Medical doctors who felt more fearful of transgender people and more personal shame associated with transgender people expressed greater intention to discriminate against transgender people, whereas doctors who endorsed the belief that transgender people deserve good care reported lower discrimination intent. Stigma-related constructs accounted for 42% of the variance and 8% was accounted for by sociodemographic characteristics.
Conclusions: Constructs associated with transgender stigma play an important role in medical doctors' intentions to discriminate against transgender patients. Development of interventions to improve medical doctors' knowledge about and attitudes toward transgender people are necessary to reduce discriminatory intent in healthcare settings.

Keywords: delivery of healthcare, discrimination, Malaysia, stigma, transgender persons

Introduction

Worldwide, transgender people face systematic oppression and devaluation as a result of stigma,[1,2] which is a social process involving social devaluation and discrediting of individuals whose assigned sex at birth (i.e., male or female) differs from their current gender identity or expression.[3] The total worldwide population of transgender people is unclear; however, estimates suggest that worldwide 0.5%–1.3% of birth-assigned males and 0.4%–1.2% of birth-assigned females identify as transgender.[4] The World Health Organization has identified transgender people as a key population with high vulnerability and specific health needs that should be addressed.[5] Ensuring that transgender people receive equal access to high-quality healthcare is critical to improving health outcomes for this community. Yet, stigma represents a significant barrier to this goal.

Stigma manifested at the structural level includes laws, policies, and cultural standards that criminalize aspects of transgender experience. Laws that criminalize or fail to protect certain aspects of being transgender (e.g., cross-dressing and using a public restroom labeled differently compared with sex

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assigned at birth) negatively affect public opinion of the criminalized group.[6] At the interpersonal level, transgender individuals regularly experience discrimination from others, which is poor or unfair treatment that results from stigma. For example, transgender individuals report significant verbal and physical harassment from cisgender (i.e., non-transgender) individuals.[2,4,7] Transgender people who face discrimination from others are at an increased risk of poor health outcomes, including depression, suicidality, substance use, and HIV.[8–11]

Although discrimination against transgender people is an issue across the globe, Malaysia is unique in that it has a sizable transgender population. Based on worldwide estimates,[4] Malaysia would have between 151,500–424,200 transgender individuals. Yet, many aspects related to being transgender are criminalized in Malaysia. ''Cross-dressing'' remains a criminal offense in Malaysia for men who wear stereotypically female clothing.[12] Furthermore, Muslims, who make up 60% of Malaysia's population, are subject to state-level Sharia (Islamic law) ordinances, in addition to the federal criminal law.[13] In 1994, the government banned anyone who is homosexual, bisexual, or transsexual from appearing in the state-controlled media, and in 2010, the Film Censorship Board of Malaysia announced it would only allow depiction of homosexual characters as long as the characters ''repent'' or die.[14] Criminalization and incarceration lead to worse health outcomes[15,16] and may, therefore, undermine the well-being of LGBT Malaysians. Moreover, these laws may increase discrimination among the general public, including healthcare providers. In a recent Pew survey, Malaysia was identified as one of the least accepting countries in terms of LGBT rights, with 86% of Malaysian respondents believing that homosexuality or identifying as transgender should not be accepted by society.[17] To best serve Malaysian transgender people in healthcare settings, it is important to understand stigma-related barriers to care among healthcare providers.

Discrimination from healthcare providers and transgender health

There is growing evidence that stigma from healthcare providers, including discriminatory behaviors, leads to negative health outcomes for patients.[18,19] Discrimination by healthcare providers, which is characterized by the poor or unfair treatment of certain groups of patients, may manifest as providers being unsupportive of the patient's condition, having a poor quality of communication relative to how they interact with patients, and ridiculing, coercing, or otherwise harassing the patient.[20] Indeed, stigma among healthcare providers has been found to be a barrier to care for multiple vulnerable populations, including people living with HIV (PLWH), people who inject drugs (PWIDs), and men who have sex with men (MSM).[21–23] A study on healthcare providers in Malaysia found that physicians' decisions to defer antiretroviral therapy for HIV patients may be due, in part, to prejudice toward these patients.[24]

Transgender people may need to access medical care for general and transition-related healthcare needs, including hormone therapy or gender-affirming surgeries. Due to prior and anticipated experiences of discrimination, many transgender people are unable to access care.[25] For transgender people who are able to access healthcare services, the care they receive is often inadequate and of poor quality.[10] The U.S. Transgender Survey, which surveyed over 27,000 transgender and gender nonconforming people throughout the United States, found that almost a third of participants had experienced both discrimination in a medical setting *and* had postponed their medical care because of discrimination.[26] Other research suggests that the prevalence of mistreatment among transgender respondents is approximately twice that of non-transgender lesbian, gay, and bisexual respondents.[27]

Research involving healthcare providers provides further evidence of stigma toward transgender people in healthcare settings. In general, there are very few studies that focus on the discrimination intent of healthcare workers toward transgender people.[10,28,29] The work that has been done is qualitative in nature and suggests that providers feel uncertainty about the nature of transgender identity and those who disagree that transgender people are natural and that it is not a choice are more likely to express stigmatizing attitudes toward transgender patients.[10] This research has focused largely on provider-level healthcare barriers for U.S. transgender patients. More nuanced research on discrimination toward transgender people in international healthcare settings, including correlates of discrimination, may strengthen efforts to address this discrimination and improve the health of transgender people.

Sociodemographic correlates of discrimination

Although research on transgender stigma in Malaysia is limited, there has been some research examining sociodemographic correlates of intent to discriminate against PLWH in Malaysia. Yet, the relationship between sociodemographics and HIV discrimination intent has differed across studies.[30–32] For example, one study found that being male and being Malay were positively associated with discrimination intent toward PLWH,[31] whereas another study found Malay ethnicity to be negatively associated with discriminatory attitudes toward PLWH.[32]

The frequency and nature of clinical encounters between physicians and transgender people may also be related to the discriminatory treatment of transgender people. Studies of the contact hypothesis suggest that interpersonal contact, under appropriate conditions, effectively reduces prejudice between majority and minority group members.[33] Physicians who have interacted with transgender people in a clinical setting may, therefore, be less likely to discriminate against transgender people. Moreover, certain specialties that have more exposure to medical issues unique to transgender people may express less discriminatory attitudes than those who have no exposure at all.

Stigma-related correlates of discrimination

Stigma-related constructs may also be correlated with discrimination toward transgender people. Previous work on PLWH suggests that five stigma-related constructs—internalized shame, belief in good care, fear, prejudice, and stereotypes—play roles in physicians' intentions to discriminate against PLWH.[34,35] For example, prior research in Malaysia among medical and dental students showed greater intention to discriminate against PLWH to be associated with more negative attitudes toward PLWH, greater levels of HIV-related shame,

higher levels of HIV-related fear, and disagreement that PLWH deserve good care.[35] Other research demonstrates that these constructs are also related to discrimination against other populations (e.g., racial/ethnic minorities in the United States)[36] and are applicable to transgender people.[37,38] Due to transgender stigma, physicians may feel shame as a consequence of having a transgender patient or transgender colleague. Physicians may also believe that transgender people do not deserve good care, leading to poor delivery of care. Given the high global burden of HIV among transgender women (i.e., high prevalence of HIV compared to other at-risk groups, including MSM and PWID),[39] providers may be prejudiced against transgender women and be afraid of contracting HIV from transgender women, which may in turn contribute to discriminatory treatment.[40] Physicians may also hold stereotypes about transgender people, such as the belief that all transgender people are promiscuous and do not care about their health, which could further contribute to discriminatory treatment. It is important to understand the factors that contribute to discriminatory treatment of transgender patients by medical providers to improve health outcomes for transgender patients.

Study rationale

Transgender people face significant stigma globally, including discrimination within healthcare settings. The 2016 special issue of *The Lancet* on transgender health highlights the critical need for examination and understanding of how stigma and discrimination manifest in physicians[41] and specifically calls for more research on the intersection of transgender people and the healthcare system. A concentrated study of issues in this area is critical to addressing health disparities for transgender people and improving the quality of healthcare they receive.[10] To date, no published literature has explored the role that physicians' attitudes play in determining discrimination against transgender people in Malaysia. This quantitative study was conducted to address this gap.

In this study, we examine sociodemographic and stigma-related correlates of healthcare providers' intentions to discriminate against transgender patients in Malaysia. The scope of this study was not focused on intent to discriminate in transgender-specific care—the study examined transgender discrimination within general and primary care. We also examined the variance in intent to discriminate accounted for by sociodemographic versus stigma-related constructs to determine which suite of constructs may be related more strongly to discrimination in healthcare settings. Documenting stigma-related correlates of discrimination intent among providers in Malaysia can pave the way for targeted educational interventions to improve the quality of care and ultimately the health of transgender people in Malaysia.

Methods

Study procedures

Between May and July 2016, we conducted an online survey of medical doctors employed at two major university medical centers in Kuala Lumpur, Malaysia—University of Malaya (UM) and Universiti Teknologi MARA Malaysia (UiTM). A total of 1307 medical doctors ($N_{UM} = 870$; $N_{UiTM} = 437$) were emailed an invitation to participate in the survey containing a link to the survey. The email contained an information sheet that detailed the purpose of the study, some basic definitions about transgender people, their rights as participants in a research study, a confidentiality statement, and instructions on how to complete the survey. The survey was self-administered by Qualtrics (Qualtrics, Provo, UT) and required approximately 20 minutes to complete. A total of 648 (49.6%) doctors accessed the link and 436 (33.4%) completed the survey. Participants were also given the option of entering a drawing to win one of two tablet computers or an electronic fitness tracker.

Ethics

The study was approved by the institutional review boards of the University of Malaya Medical Centre, Universiti Teknologi MARA Malaysia, and Yale University. Participants reviewed all study-related risks and benefits and provided their informed consent before taking the survey by clicking a checkbox that indicated their agreement to participate in the study.

Sociodemographic characteristics

Survey questions included participants' age, sex, ethnicity, religion, country of medical training, and area of medical specialization. Current clinical status was measured by their rank as house officer, medical officer, registrar, specialist, or consultant. These clinical ranks are listed in order from most junior to most senior position.

Intention to discriminate

The dependent variable, intention to discriminate against transgender people, was measured using a modified version of the discrimination intent at work construct of the Stein and Li multidimensional HIV stigma scale.[34] This scale has been previously used in the context of discrimination toward PLWH among medical and dental students in Malaysia[35] and healthcare providers in China.[34] We adapted the scale by substituting the term ''transgender patients'' for ''patients living with HIV/AIDS'' for all items. The scale included four items, which participants rate on a Likert-type scale ranging from *strongly disagree* (1) to *strongly agree* (5). The four items were as follows: (1) ''I am willing to provide the same quality of care to transgender patients as other patients,'' (2) ''I am willing to work with transgender patients,'' (3) ''I am willing to do physical exams on transgender patients,'' and (4) ''I am willing to interact with transgender patients the same way I interact with other patients.'' The measure showed good internal consistency (Cronbach's $\alpha = 0.72$).

Stigma-related constructs

The following five stigma-related constructs were measured: prejudice toward transgender people, internalized shame related to interacting with transgender people, fear of transgender people, belief that transgender people deserve good care, and transgender-related stereotypes. These constructs were identified in previous work by Stein and Li as particularly important predictors of discrimination toward PLWH in healthcare settings based on HIV stigma theory and research.[34] Other work further suggests that these five constructs play key roles in discrimination toward people living with a wide range of stigmatized identities in healthcare settings.[36,42]

Scale items were adapted from the Stein and Li stigma scale[34] to refer to transgender patients using the methods of Earnshaw et al.[34,35] Each construct was measured on a Likert-type scale ranging from 1 (*strongly disagree)* to 5 (*strongly agree*). The prejudice construct consisted of seven items, including ''Transgender individuals do not belong in society'' (Cronbach's $\alpha = 0.76$). In the prejudice construct, items specific to the transgender patient population such as ''It is unnatural to be transgender'' and ''Being transgender is a choice'' were included. These items were adapted from a previously published model of constructs of anti-transgender prejudice.[43] The internalized shame construct consisted of five items, including ''I would be ashamed if I had a friend who was a transgender individual'' (Cronbach's $\alpha = 0.75$). The fear construct consisted of four items, including ''I am afraid that transgender individuals will give me communicable diseases if I treat them'' (Cronbach's $\alpha = 0.74$). The belief in good care construct consisted of two items, including ''Transgender individuals deserve good care'' (Cronbach's $\alpha = 0.74$). Finally, the stereotypes construct consisted of four items, including ''Transgender individuals are promiscuous'' (Cronbach's $\alpha = 0.80$).

Analysis

Associations between stigma-related constructs and discrimination intent were explored using bivariate Pearson correlations. Scores for discrimination intent and each of the stigma-related constructs were calculated as a composite score. Bivariate and multivariate linear regressions were used to evaluate the association between sociodemographic characteristics, the five stigma-related constructs, and discrimination intent. All covariates were evaluated for multicollinearity; any variable exceeding a variance inflation factor of 7 was removed from the model.[44] Hierarchical linear regression, using the same variables as the multivariate regression, was also used to evaluate the percentage of variance in discrimination intent accounted for by the sociodemographic characteristics and stigma-related constructs. Discrimination intent was regressed onto the sociodemographic characteristics (age, sex, religion, and specialty) in step one of the analysis, followed by stigma-related constructs (prejudice, internalized shame, fear, belief in good care, and stereotypes) in step two. All analyses were conducted in R Studio version 3.2.3.[45]

Table 1. Sociodemographic Characteristics of the Sample ($N = 436$)

Characteristics	*% (n) or Mean (SD)*
Age	34.7 (6.7)
Sex	
Male	47.2 (206)
Female	52.8 (230)
Ethnicity	
Malay	41.3 (180)
Chinese	37.8 (165)
Indian	14.2 (62)
Other	6.7 (29)
Religion	
Muslim	45.0 (196)
Buddhist	21.3 (93)
Christian	16.3 (71)
Hindu	11.5 (50)
Other	5.9 (26)
Country of medical training	
Malaysia	62.6 (273)
Other	37.4 (163)
Clinical status	
House officer	0.7 (3)
Medical officer	37.4 (163)
Registrar	17.9 (78)
Specialist	28.4 (124)
Consultant	14.7 (64)
Other	0.9 (4)
Area of specialization	
Internal medicine	25.2 (110)
Primary care medicine	11.9 (52)
Surgery	9.9 (43)
Emergency medicine	7.8 (34)
Radiology	7.3 (32)
Psychiatry	6.7 (29)
Anesthesiology	5.5 (24)
Obstetrics and gynecology	5.0 (22)
Orthopedics	4.6 (20)
Rehab medicine	4.6 (20)
Ophthalmology	3.4 (15)
Ear nose and throat	3.0 (13)
Pathology	2.1 (9)
Sport medicine	2.1 (9)
Oncology	0.9 (4)
Surgical specialty	
Nonsurgical based	89.4 (390)
Surgical based	10.6 (46)

Results

Participant characteristics

Characteristics of the sample are summarized in Table 1. Participants were mostly female (52.8%), Malay (41.3%), and Muslim (45.0%). Participants' mean age was 34.7 years ($SD = 6.7$) and most had completed their formal medical education in Malaysia (62.6%). Medical officer (37.4%) was the most common clinical rank, followed by specialist (28.4%), registrar (17.9%), consultant (14.7%), other (0.9%), and house officer (0.7%).

Correlation between stigma-related constructs and discrimination intent

Bivariate correlations between the stigma-related constructs and discrimination intent, along with means and standard deviations, are presented in Table 2. Stigma-related constructs were all significantly correlated with each other and with discrimination intent. Belief in good care was negatively correlated with the other four stigma-related constructs and intention to discriminate. Internalized shame was positively correlated with prejudice ($r = 0.67$), stereotypes ($r = 0.66$), and fear ($r = 0.64$). Discrimination intent was most strongly correlated with internalized shame ($r = 0.57$), fear ($r = 0.56$), and belief in good care ($r = -0.54$).

The mean score for discrimination intent was 1.81 ($SD = 0.58$), indicating that on average, doctors reported themselves as ''disagreeing'' with the intent to discriminate against transgender patients. The scores for discrimination intent ranged from 1 to 5, with 26.8% of participants scoring higher than

Table 2. Bivariate Correlations Between Stigma-Related Constructs and Discrimination Intent

	Mean (SD)	*[1]*	*[2]*	*[3]*	*[4]*	*[5]*
[1] Transgender prejudice	2.82 (0.60)					
[2] Transgender internalized shame	2.37 (0.63)	0.67*				
[3] Transgender fear	1.95 (0.59)	0.44*	0.64*			
[4] Transgender belief in good care	4.26 (0.84)	−0.35*	−0.47*	−0.32*		
[5] Transgender stereotypes	2.06 (0.66)	0.55*	0.66*	0.63*	−0.36*	
[6] Transgender discrimination intent	1.81 (0.58)	0.36*	0.57*	0.56*	−0.54*	0.47*

*$P < 0.05$; correlation values are Pearson correlation coefficients.

3, indicating that doctors had reported ''agreeing'' or ''strongly agreeing'' with discrimination intent against transgender patients.

Bivariate and multivariate linear regression

Results of the bivariate and multivariate regression analysis are shown in Table 3. For the bivariate analysis, participants of Muslim religion had greater discrimination intent, while those of Hindu religion were less likely to show discrimination intent. Psychiatrists reported lower discrimination intent than doctors from other specializations. Age and sex, however, were unrelated to discrimination intent. Of the stigma-related constructs, prejudice, internalized shame, fear, and stereotypes showed a strong positive association with discrimination intent. Conversely, belief in good care was negatively associated with discrimination intent.

Associations between sociodemographic characteristics and stigma-related constructs with intention to discriminate against transgender patients changed slightly in the final multivariate analysis (Table 3). Ethnicity and religion were found to be collinear, resulting in the removal of ethnicity from the model. All sociodemographic factors–age, sex, religion, and specialty—were unassociated with the intention to discriminate in the final model. Of the stigma-related constructs, both stereotypes and prejudice became nonsignificant; however, the direction of association remained the same. Internalized shame and fear remained significantly positively associated, and conversely, belief in good care remained negatively associated, with discrimination intent. Collectively, the multivariate model demonstrated that stereotype and prejudice constructs were positively associated with discrimination intent.

Results of the hierarchical linear regression are shown in Table 4. In step 1, sociodemographic characteristics accounted for 8% of the variance in discrimination intent. In step 2, with the five stigma-related constructs added to the equation, an additional 42% of the variance in discrimination intent was explained.

Discussion

This study is the first in Malaysia to examine attitudes of healthcare providers toward transgender people and, to our knowledge, the first to evaluate discrimination intent toward transgender people in a Malaysian healthcare setting using a standardized stigma and discrimination intent scale. Medical doctors in this study expressed relatively low intent to discriminate against transgender patients, although a minority of participants did express a moderate to high level of

Table 3. Bivariate and Multivariate Linear Regressions with Transgender Discrimination Intent as the Dependent Variable

	Bivariate regression				*Multivariate regression*			
	B	SE	t	p	*B*	SE	t	p
Sociodemographic characteristics								
Age	−0.02	0.01	−1.34	0.18	0.005	0.003	1.55	0.12
Male	−0.01	0.22	−0.06	0.96	0.02	0.04	0.52	0.60
Muslim	0.52	0.23	2.33	0.02*	−0.04	0.09	−0.40	0.69
Hindu	−1.31	0.34	−33.79	0.001**	−0.16	0.10	−1.5	0.13
Christian	−0.16	0.30	−0.54	0.59	−0.04	0.09	−0.44	0.66
Buddhist	0.10	0.27	0.35	0.72	0.04	0.09	0.43	0.67
Psychiatric specialty	−1.81	0.44	−4.12	0.001**	−0.11	0.05	−1.72	0.18
Internal medicine	0.09	0.26	0.34	0.73	0.01	0.05	0.18	0.85
Stigma-related constructs								
Transgender prejudice	1.41	0.17	8.15	0.001**	0.09	0.05	1.87	0.08
Transgender internalized shame	2.13	0.15	14.65	0.001**	0.25	0.06	4.25	0.001**
Transgender fear	2.19	0.16	14.03	0.001**	0.27	0.05	5.34	0.001**
Transgender individuals deserve good care	−1.49	0.11	−13.27	0.001**	−0.24	0.03	−8.75	0.001**
Transgender stereotypes	1.65	0.15	11.10	0.001**	0.04	0.05	0.78	0.44

*$P < 0.05$.
**$P < 0.01$.

Table 4. Hierarchical Regressions with Transgender Discrimination Intent as the Dependent Variable

	R	R^2	R^2 *Change*	*F Change*
Step 1: Sociodemographic characteristics	0.28	0.08	0.08	4.36***
Step 2: Stigma-related constructs	0.71	0.50	0.42	70.63***

Sociodemographic characteristics include age, sex, religion, and specialty; Stigma-related constructs include transgender prejudice, transgender internalized shame, transgender fear, transgender individuals deserve good care, and transgender stereotypes.
***$P < 0.001$.

discriminatory intent. Our findings also illustrate that medical doctors' intention to discriminate against transgender patients is explained primarily by the stigma-related attitudes they hold about transgender people. Indeed, our multivariate model shows that, when controlling for all factors, discrimination intent is driven by internalized shame, fear, and belief in good care.

Stigma is a multilevel phenomenon that affects transgender experience at the structural, interpersonal, and individual levels.[1,2] This study used a nuanced scale that distinguishes between multiple stigma-related constructs at the interpersonal level, which is critical to identifying specific intervention targets that are highly associated with healthcare providers' intentions to discriminate against transgender people. Our findings suggest opportunities for intervention in at least two settings: early medical education and continuing medical education (CME) for healthcare providers.

Implementation of education about transgender health can be introduced as early as medical school. In a recent study of North American medical school curricula, it was found that a median of only five hours was dedicated to LGBT topics across all years of medical school training.[46] Although transgender health training has not been specifically examined in Malaysia, our findings indicate that a significant portion of doctors are uncomfortable with providing care to transgender patients, indicating a need to build provider competency.[47] Unlike the United States, medical education in Malaysia starts at the undergraduate level[48] and continues into graduate-level medical education. This longer period of training allows Malaysian trainees more opportunity to be exposed to transgender healthcare training and learn to become comfortable and able to cater to the specific needs of transgender patients. Clinical cases related to transgender patients can be integrated within lectures and problem-based sessions during the didactic years, and specific efforts should be made to expose students to transgender patients during clinical rotations.[48]

Evidence from this study additionally justifies the implementation of CME to address how physicians' own beliefs can subconsciously influence judgment of and delivery of healthcare to marginalized patients. The implementation of a CME session based on the theory underlying the contact hypothesis[33]—bringing transgender people to present to physicians or a community physician who specializes in transgender-specific care—could reduce feelings of shame and fear among physicians about transgender people.[2] Integration of the basic tenets of medicine—the Hippocratic oath and the duty to provide nondiscriminatory care to all of their patients[49]—within these CME sessions may address the belief among some physicians that transgender people are not as equally deserving of good care as other patients.

Furthermore, transgender people will often seek medical services for both general and transgender-specific medical care. Given the size of the transgender population in Malaysia and the wide range of healthcare needs, it is important that primary healthcare providers and others be trained in the basic clinical standards of transgender-specific healthcare, including protocols for referral to specialists where available.[4] Cultural and clinical competency training may be best implemented at the early stages of medical education. Nonetheless, continuing education training is also needed, particularly for providers who have not received prior training in transgender health.

Findings from this research are also meaningful for the transgender community. Discriminatory attitudes from healthcare providers might lead transgender people to not seek healthcare when they need it[4] and lack of access to medically necessary transition-related care is associated with depression and suicidality among transgender patients.[47,50] In addition, transgender women in particular have one of the highest HIV burdens of any at-risk group.[39] Thus, ensuring access to good-quality healthcare for all transgender people is an important public health issue for this population. If we are to solve this issue, identification and elimination of discriminatory behavior among physicians is an important first step.

Limitations

There are limitations to this study that must be considered. We did not explore differences in the intention to discriminate against transgender men versus transgender women, which is an important next step in this analysis. Issues of gender stereotyping and discrimination may create different perceptions of transgender men versus transgender women among medical providers. The survey is based on self-reported data, which introduces the possibility of a social desirability bias that may be causing providers to report less discriminatory intent toward transgender patients than they actually feel.[51] Self-reporting also limits generalizability of the results to other situations.

Although examining healthcare providers' attitudes toward transgender people is a crucial step in understanding the inequities of transgender healthcare, there is a wider array of issues that transgender people face before even stepping into a physician's office. External forces, such as punitive laws and lack of legal recognition, marginalize transgender people and make it increasingly difficult for them to access basic healthcare services.[41]

Our sample of physicians was recruited from the two largest academic universities in the largest urban center (Kuala Lumpur) in Malaysia. This cross-section of the physician community most likely represents the most favorable picture of providers' discrimination intent toward transgender people, as participants in this setting tend to have greater exposure to transgender people than do physicians in other settings.

Exploring these issues in a semiurban or rural setting is important, as transgender people access healthcare in all of these settings.[52] In fact, in most semiurban or rural settings, the clinic is the sole source of healthcare and medical advice for transgender people.

Conclusion

In addressing transgender-related healthcare inequities, it is vital to recognize that it is the responsibility of the healthcare provider to serve the health of transgender patients. Achieving health equity for the global transgender community is a multifactorial process that will require advances in medical education and training at all levels coupled with advances in legal and political safeguards.[41] Our study, which represents the first attempt to document the presence of stigma and discrimination toward transgender people in a large sample of Malaysian healthcare providers, represents an important preliminary step in understanding and ultimately reducing stigma so that transgender people can access their full rights to healthcare.

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