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Transgender Health - Eliminating Inequalities and Strengthening Clinician-Patient Relationships

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ABSTRACT

This article considers healthcare experiences of transgender patients on their transition journeys. One case illuminates ways in which binary-dominance—the prevailing assumption that a person must be either male or female to be normal—is a species of cultural imperialism that can influence the quality of clinical encounters. We focus specifically on clinicians' affective orientation toward a transgender patient and how it can influence the patient's general and mental healthcare experience. When expressed in healthcare contexts, binary dominance exacerbates the vulnerabilities of transgender patients and reinforces trends of underservice to members of this community. Generally, clinicians tend to lack knowledge about the medical and mental health needs of transgender patients, and clinicians and office staff tend to lack cultural humility regarding the multi-dimensional challenges of being transgender in a binary-dominant society. We suggest a five-point model of foundational clinical and ethical competencies related to different patients' transition experiences, which can help clinicians and organizations identify and eliminate binary dominance expressions from their practices and policies.

Key Words: clinician-patient relationship, disparities, ethics, health justice, inequalities, physician-patient relationship, standard of care, transgender health

The term transgender is used to characterize people whose *gender expression*—the way a person communicates their gender—is considered nontraditional for their sex or gender and to characterize people whose *gender identity*—a person's psychological identification of gender—is different from their sex assigned at birth. Importantly, a transgender identity can differ from a person's sexual orientation; one can be gay, lesbian, or heterosexual, for example, and also have a transgender identity.

In 2011, healthcare inequalities for transgender people were acknowledged as a critical area of research by the Institute of Medicine (Institute of Medicine of The National Academies, March 2011, p. 3). In 2014, the *Hastings Center* Report published a supplement further documenting these inequalities and analyzing, from an ethics point of view, some model progress in access and healthcare infrastructure innovation (Davis & Berlinger, 2014, p. S45). Also in 2014, the *American Journal of Public Health* featured numerous articles illuminating inequalities in health status and access to healthcare suffered by transgender patients in the United States's healthcare system. One of those articles issued "a call to action" (Conron, Stewart, Reisner, & Sell, 2014, p. 970), citing risks for suicide, depression, and violence as "commonplace" (Conron et al., 2014, p. 970) vulnerabilities of transgender people. The response we contribute here is intended to problematize binary dominance as a culturally imperialistic expression common in clinical practices and to motivate deeper understanding of trends of underservice by focusing on one set of clinical encounter experiences of transgender patients.

Clinical Encounters as One Micro-Level Support for Macro-Level Inequalities

One important question to explore is, *How can macro-level, systems-based inequalities be addressed by focusing on micro-level clinical encounters*? First, we consider that one reason why transgender people are vulnerable in healthcare settings is that, for many transgender patients, pursuing, exploring, fulfilling and maintaining physical expressions of authenticity over time demands deep personal reliance and dependence on healthcare professionals. Second, clinical standards that promote the clinician's stance as the one who surveys and verifies the authenticity of a transgender person's identity are ethically problematic. These standards place clinicians in positions to reinforce binary dominance and to be the primary enforcers of this species of cultural imperialism. These standards also divert clinical attention away from responding to a

patient's needs, generate anxiety for patients in clinical encounters, and undermine trust and potential therapeutic capacity of the clinician-patient relationship (WPATH). Consider the following case as an example of some of the typical dynamics in transgender patients' healthcare experiences.

> Aidan, a transgender male (born assigned female, transitioning to male) is ready to start cross-sex hormones to induce male secondary sex characteristics, but he is having difficulty finding a physician willing to prescribe and monitor his hormone therapy regimen. After calling several offices, where staff members hang up on him or ask invasive questions about what his body looks like, he finally finds a willing physician who has treated transgender patients in the past.
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> Ten minutes into Aidan's first appointment, he quickly begins to realize that this physician does not seem familiar with how to start a transgender patient on hormone therapy. The physician asks, "So, you've already been living as a man?" Aidan asks why this information is relevant to beginning a hormone regimen. The physician responds, "I've read that patients seeking hormones should undergo a 'real life experience' before undergoing a medical transition." Aidan, mindful of his tone despite his growing feelings of discomfort, politely reminds the physician that the language of "the real life experience" does not appear in the recent literature on transgender clinical care standards. Aidan offers to send the physician an article or two documenting current clinical standards.
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> The physician seems taken aback by the suggestion that his practice and protocol need updating. He states curtly, "Look, if you don't want to follow my advice, I'd be happy to refer you to someone else." Knowing that this physician is the only one in his area willing to work with transgender patients, Aidan says, "I'm sorry. I wasn't trying to offend you. I just felt like I needed to inform you about this important change." The physician ends the medical consult requesting a letter from a therapist and stating that he would like to wait three months before Aidan's next appointment.

A number of things seem to go wrong during this clinical encounter, some of which seem to stem from the physician's affective orientation to Aidan. Affective orientation can be an important means of expressing culturally imperialistic tendencies in clinical contexts; in this case, the clinician's response to Aidan's resistance to binary dominance is key. This physician, for example, is open to working with transgender patients, but he is threatened by the patient's knowledge, has little empathy with the cluster of stressors Aidan must navigate in his everyday life, and his response places Aidan in the position of having to capitulate to the advice of someone he doesn't trust or go without timely care. Emotionally, Aidan may not feel like he can speak up or advocate for his health, due to the fear of being denied care or being subject to delays. These feelings might increase his anxiety, frustration, and fears. Not being able to trust his physician, Aidan might even withhold clinically relevant information (about depression, thoughts of suicide, fear, anxiety, and self-injurious behaviors, for example). Aidan leaves this clinical encounter, perhaps, feeling hopeless about getting help with his deepest concerns.

Because many transgender patients rely on healthcare professionals for authentic identity expression, they are particularly vulnerable to particular experiences of medicine as an enforcer of cultural imperialism. For example, Jacob Hale's chapter "Tracing a Ghostly Memory in My Throat" in "*You've Changed*" *Sex Reassignment and Personal Identity* (2009) problematize use of the clinical specialty of psychiatry as the permission-granting authority of gender transitioning. He argues that placing psychiatry in charge of certifying transgender patients' needs can co-opt patients into self- pathologization and feigning "symptoms" of pathology that don't correspond well to transgender patients' actual needs. He also argues that placing psychiatry in charge of certification of need relies upon essentialist conceptions of gender that reinforce binary-dominance.

Also, because so many health professionals lack education and training in transgender medicine, transgender patients far too often are pressed into the stressful triple role of being patient, advocate, and educator during clinical encounters like the one in this case. This dynamic can also be awkward and a potential source of strain and frustration for clinicians, as it upsets "traditional" distribution of power in clinician-patient relationships, in which clinicians wield knowledge and power and patients are ill and objectified. Despite that the triple role of transgender patient-advocate-educators during clinical encounters can be threatening to some clinicians, it's important to remember that patients like Aidan are still far more vulnerable than their clinicians.

Just as this case illustrates the importance of clinicians' affective orientations to transgender patients, it also illuminates micro-level challenges of their individual clinical encounters and suggests how macro-level inequalities in health status, access to care, and quality of care develop and persist.

Common Inequalities

Improving clinical encounters for transgender patients first requires healthcare professionals' cultivation of awareness that three kinds of inequalities—in health status, in access to care, and in the quality of care received—matter for transgender patients. Transgender community members' self-reports consistently suggest that health inequalities experienced by these patients are a function of stigma from broader society expressed within clinical settings (Poteat, German, & Kerrigan, 2013, p. 22).

Stigmatization is always morally problematic when it reinforces cultural imperialism, and has special capacity to incur harm in clinical settings. Stigmatization works via cultural, economic, political, and social means (Link & Phelan, 2006, p. 528), which, in clinical settings, is magnified by healthcare professionals' social power and cultural authority. So, processes of discrimination and marginalization extant in the broader social sphere, such as "othering, blaming and shaming" (Deacon, 2006, p. 418; Poteat et al., 2013, p. 27) can be experienced by transgender patients as especially poignant and damaging expressions of devaluation when they happen in clinical settings.

"Othering" is, perhaps, most clearly defined by the philosopher Iris Marion Young in *Justice and the Politics of Difference* (1990).

"Othering" happens when a group "different from the dominant group" is "defined by the dominant culture as deviant" (p. 60). For gender, "othering" is a species of stigma that works by endorsing binary-dominant identities. It happens in clinical settings, for example, when a clinician states that she works with patients who are *transgender men*, but not with patients who are *transgender women*—born assigned male at birth, transitioning to female—as they are sometimes alleged to be "difficult" or noncompliant (Poteat et al., 2013, p. 27). When clinicians' affective orientations to transgender patients reinforce this kind of devaluation of transgender patients, health inequalities are likely to be exacerbated. Transgender patients who feel that they are viewed with contempt by healthcare professionals or their office staff, for example, can be unlikely to feel incentivized to return to that environment to meet their healthcare needs. This is one important link between macro- and micro-level trends in healthcare service delivery for members of transgender communities.

Health Status Inequalities

Transgender patients often present with multiple health concerns and critical risks including: suicide, depression, anxiety, posttraumatic stress disorder, increased risk of being a victim of violence, substance abuse, and sexually transmitted infections (Conron et al., 2014, p. 970; Grant, Mottet, & Tanis, 2010, p. 1; HealthyPeople.gov; Liu & Mustanski, 2012, p. 221; Stroumsa, 2014, p. 32). Transgender women are at high risk for HIV infections, and black transgender women have the highest risk for new HIV infections (CDC, 2013). Transgender women of color are also at the highest risk for being victims of violence (CDC, 2013; Grant, Mottet, Tanis, Harrison, Herman, Keisling, 2011).

The risk for suicide and substance abuse are also disproportionally high among transgender patients. According to a survey of almost 6500 transgender respondents, an alarming 41 percent reported attempting suicide at least once in their past. If we look specifically at transgender youth, one study documents that nearly half of young transgender people have seriously considered suicide and one quarter report having made a suicide attempt (Grossman & D'Augelli, 2007, p. 535). Twenty-six percent of transgender adults reported using drugs or alcohol to cope with stress and discrimination, which is higher than the general population (Grant et al., 2010, p. 14).

Inequalities in Access to Care

The numbers just mentioned suggest the obvious need for general medical and mental health care for transgender patients. As the case above suggests, members of transgender communities also experience transition-related health needs that deserve responsive, professional care. Access to competent transition-related care and insurance coverage for such care is scarce for this population. For example, transgender community members are less likely than members of the general public to have health insurance (Grant et al., 2010, p. 8). In part, this is due to over-reliance in the United States's healthcare system on employer-sponsored healthcare; rates of unemployment among transgender community members are also high (Grant et al., 2010, p. 15). Furthermore, state and federal policy restrictions on name changes and other legal document amendments can exacerbate battles transgender patients have to fight with insurers over inclusions and exclusions of services under a policy's coverage.

Additionally, transgender patients are frequently denied clinical services. Such denials can take several forms. For example, in the experience of one of the authors (Sallans), some clinicians simply refuse to work with transgender patients. Another expression of an outright denial was rendered by a receptionist in a medical office, who hung up on a transgender man when he asked to schedule a pap smear. Transgender patients also experience varying degrees of verbal abuse—ranging anywhere from rudeness to overt harassment—in clinical offices (Grant et al., 2010, p. 76).

Care Quality Inequalities

When transgender patients can access care, they often receive substandard care from a professional (Grant et al., 2010, p. 1; Poteat et al., 2013, p. 23). The physician in the case lacks knowledge about transgender patients' needs. Sadly, this lack of knowledge and training is sometimes a function of some healthcare professionals' negative attitudes (Dorsen, 2012, p. 18) and ambivalence (Poteat et al., 2013, p. 25) about learning transgender medicine.

Half of transgender respondents reported having to teach their medical professionals about how to care for them (Grant et al., 2010, p. 6). In the case, the physician is uninformed about current standards of care related to managing a patient's hormone regimen. Hormone care, for example, requires knowledge of appropriate screening techniques, formulations and dosing, and monitoring lab values over time.

Particularly complex barriers to good care arise when professionals who do work with transgender patients overemphasize a patient's experience of mental illness as a strategy for undermining the patient's knowledge or pathologize transgender patients' desires (Nelson, 2012, p. 252). For example, a patient with depression might be questioned about their "real" intent behind transitioning, as if a person's desire for gender transition could only be rationally explained by mental illness. For another example, a patient with a history of eating disorders might be told that a desire to transition is a product of their disorder and negative body image, and thus cannot be addressed until the eating disorder is addressed. In these cases, mental illnesses are used as diversions from addressing a transgender patient's desires about their own identity expression; this is a fundamental way in which clinical interrogations can undermine patients' cultural resistance to binary dominance and their assertions and explorations of their own conceptions of authentic realization of what it means to inhabit their bodies.

Ironically, another neglected source of complexity regarding barriers to good care is revealed in cases in which transgender patients must present themselves as mentally ill (Nelson, 2012, p. 252) in order to be seen as eligible for transition-related services. Those unwilling to do so might go without care rather than capitulate to presenting themselves as mentally ill. So the irony here, and another byproduct of binary dominance as an expression

of cultural imperialism, is that transgender patients are pressed into situations in which they must feign a mental illness they don't have while their real mental health issues go unrecognized and untreated.

Additionally, some transgender patients might feel that they need to be selective and careful about the information they disclose to clinicians about their identities. For example, clinicians who judge transgender patients' desires to change their physical gender expressions can sometime impose their own ideas of what it means to be a man or woman or what it means to assume men's or women's roles. As a result, transgender patients can feel pushed into fitting the labels, constructs, and categories as assumed (rightly or wrongly) by their clinicians. Specifically, a transgender patient who wants to express some of the physical characteristics of an anatomically typical male, such as facial hair, a more squared jaw, and prominent shoulders, might not be interested in expressing all of the physical characteristics of an anatomically typical male, such as having a penis. Such a patient needs hormones, but not lower surgery. Clinicians trapped in the cultural norm of binary-dominant thinking will be ill equipped to be responsive to transgender patients. The variations of gender expression are numerous, and many clinicians have never been prepared to think of these variations before in their professional preparation and training.

Resisting Cultural Imperialism in Clinician-Patient Relationships

Though little is known empirically about how discrimination functions in clinical encounters (Poteat et al., 2013, p. 23), the case above suggests the multi-dimensional challenges Aidan faces as a transgender person in a socially and culturally binary-dominant society. Healthcare professionals' lack of knowledge, sex and gender labeling, and a lack of cultural humility, for example, are three important byproducts of binary dominance and expressions of cultural imperialism related to gender in society-at-large that importantly influence the nature and quality of transgender patients' clinical experiences. Transgender patients will have a sense of the care they will be provided at a clinic immediately when they walk through the office doors. They will be assessing how they are treated by the front-desk staff, the presence of gender neutral or gender segregated restrooms, and how questions are worded on patient intake forms. Specifically, forms that reinforce "Male-Only" and "Female-Only" sections reiterate binary-dominance, as do forms that have places only to mark whether you are "male" or "female." These features of the clinical environment express whether and how aware, knowledgeable, and respectful a healthcare institution is about transgender patients' needs.

Social and Cultural Situatedness of Clinical Encounters

Binary dominance in the broader society and culture is expressed as imperialistic in numerous ways, but two of substantial importance have to do with common policies and our everyday environments, both of which are created by and sustained as macro-level social and cultural structures. First, government policy restrictions on name changes and other legal document amendments sustain structural barriers that disproportionately harm transgender community members. Such policies limit a transgender persons' moral and legal agency and abilities to direct and exercise control over their own futures and life paths.

Second, media representations of transgender people and their lives far too often endorse public ignorance about the concept around being transgender and reinforce harmful stories and stereotypes about transgender people. Misrepresentations are harmful when they negatively bias our perceptions of transgender people, their characters, and their strivings. Specifically, media representations tend to emphasize transgender people as threatening (as in transgender adults or students needing to access restrooms that align with their transgender identity), as dishonorable (as in stories of transgender members of the military who are discharged due to their transgender identity), and as victims (as in stories of transgender individuals being victims of hate crimes).

Finally, transgender community members' everyday experiences of microaggressions also deserve consideration here. For example, transgender patients need protections from employment discrimination and organizational structural accommodations that make it difficult or awkward for transgender people to use facilities that align with their gender identity. Gender-neutral restrooms, for example, can substantially reduce the frequency, and perhaps the impact, of everyday microaggressions. In the chapter "The Education of Little Cis," Professor A. Finn Einke relates an experience of this kind of microaggression when their University department moved into a new space with new wheelchair accessible restrooms, which clearly defined the restrooms as male-only and female-only spaces. Einke writes, "I go there, braided and bearded, and am furious to discover the options," (Einke, 2012, p. 73). If the building would offer a gender-neutral option, it could easily avert Einke's (and fellow non-binary presenting and transgender individuals') anger and discomfort.

Another way to reduce microaggression in clinical settings is by creating more inclusive language in patient intake forms. For example, The Fenway Institute and the Center for American Progress (2013) and the Center for Transgender Excellence (Cahill, 2014, p. 37) suggests that all healthcare settings use a "two-step gender identity and birth sex question" (p. 10). Two questions include "What is your current gender identity?" and "What sex were you assigned at birth on your original birth certificate?" (The Fenway Institute, 2013, p. 11). The Centers for Disease Control and Prevention (CDC) suggests a strategy for clinicians and healthcare facilities to recognize a patient's current gender identity while also honoring their past and potential healthcare needs that might not align with their current gender. For example, a patient who has a current gender identity of female, but was assigned male at birth, might need testicular cancer screenings if they have not undergone an orchiectomy. Also, a patient that identifies as male, but was assigned female at birth, requires cervical screenings if they have a cervix. Having both items listed, and having clinicians educated on what to be aware of, allows for more comprehensive, better informed, and more compassionate care of transgender patients.

Recommendations for Eliminating Inequalities in Transgender Health: A Five Point Model

What follows is an example of one set of key transition points—not necessarily sequential—that could be adapted to clinical work with a variety of transgender patients.

1. **A patient "comes out" as transgender to a healthcare professional.**

When a patient comes out as transgender, clinicians need to be sensitive to how the patient is feeling (Mayer et al., 2008, p. 991) and be able to identify common clinically relevant challenges such as biological puberty, signs of emotional distress, lack of social and cultural support, risks of being harassed or abused in schools, homes, or other community-based environments. Clinicians should be motivated to and should know how to create an environment during clinical encounters that is inclusive towards and supportive of transgender patients. One important feature of the environment during clinical encounters that can confer caring and respect is the use of appropriate language. For example, if a client informs a clinician that they are now going by the name "John," the clinician can respond by saying, "Thank you for letting me know. Are there different pronouns that you prefer I use?"

2. **A patient is in need of general healthcare in a medical setting.**

When we discuss transgender medicine, we often forget to acknowledge that transgender patients need general medical care like any other patient, however many transgender patients will avoid accessing general medical care because of previous negative experiences in medical settings (Grant et al., 2010, p. 76). Clinicians should be aware of current risks affecting transgender community members. (For example, high rates of depression, anxiety, eating disorders, substance abuse, and HIV infections were cited earlier in this article.) Many transgender patients fear disclosing their own risk behaviors or emotions to clinicians. This can happen for a number of reasons, including the patient's distrust of a clinician who does not appear caring or knowledgeable about the stressors affecting transgender community members. Clinicians have obligations to help patients avoid delaying transition-related care, particularly in the absence of a medical indication for delay.

3. **A patient is ready to begin cross-sex hormone therapy.**

It is beyond the scope of this paper to discuss the justifiability of clinicians' conscientious objection or "ambivalence" (Poteat et al., 2013, p. 26) to working with transgender patients; we assume for sake of exploring the quality of clinical encounters between clinicians and patients that clinicians have, at the very least, an obligation to treat all transgender patients with care and respect. Additionally, clinicians have general obligations to be up-to-date and versed in current standards of care and practices affecting transgender patients. When clinicians are not competent to execute standards of care themselves, they have obligations to make timely and actionable referrals to clinicians who can. Standards of Care from the World Professional Association for Transgender Health (WPATH), currently in its seventh version (WPATH) are the most commonly used guidelines for the care of transgender patients. All clinicians should be prepared to talk with their patients in order to determine their current transition-related goals and assess any concerns.

4. **A patient requests a physician's letter to enable changing legal documents, such as driver's licenses, birth certificates, and passports.**

Clinicians should educate themselves on their state's current policies related to changing legal documentation. Continuing education modules for clinicians should be developed to inform clinicians about the nature and scope of their roles in assisting patients with these kinds of document changes. One helpful organization for advocacy and education about current state and federal laws is the National Center for Transgender Equality (NCTE) (National Center for Transgender Equality).

5. **A patient requests a physician's referral and/or a letter for a transition-related surgery.**

Clinicians should be able to describe comprehensive clinical care and treatment options to transgender patients and their loved ones or provide referrals and additional information when necessary. One resource for clinicians in need of one-on-one consultation with someone knowledgeable about transgender medicine is TransLine through Project Health (TransLine).

Conclusion

Responding well to transgender patients' general medical and mental health needs include understanding the patients' current support systems and fractures in those support systems, employment status, income streams, and legal protections in the region or state in which that patient lives. For example, a transgender patient who has a supportive family or partner, is steadily employed, and lives in a state where gender identity is protected by nondiscrimination language in statutes, regulations, or court holdings, might very well be in a better state of health than patients who have been kicked out of their homes, unable to maintain steady employment at an income level that allows coverage of basic living needs, and lives in a region or state where marginalization is commonplace and tolerated. Clinicians should also take into account the additional effect of "structural and interpersonal acts of racism" (Harrison-Quintana, Lettman-Hicks, & Grant, p. 1) on patients of color.

The analysis and recommendations we offer in this article focus on nourishing the therapeutic capacity of the clinician-patient relationship and on generating improvements in general and mental health outcomes for transgender patients. We hope to have illustrated the numerous ways in which micro- and macro-levels connect, as quality clinical encounters are critical for eliminating transgender health inequalities.

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