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Improving interactions between gender-diverse persons and the healthcare system

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Introduction

Individuals who do not identify with their normative gender expectations set by society often suffer significant negative health disparities when compared with their binary counterparts. These disparities are often hard to identify and quantify due to a paucity of evidence specific to these individuals. This article reviews current interactions between gender-diverse individuals and healthcare systems with reference to the available literature. The article explores barriers faced by gender-diverse patients, as well as gender-diverse healthcare professionals in forming a part of the health workforce. We conclude that the primary barrier is a lack of knowledge about the gender-diverse experience, which leads to discrimination, inadequate or even inappropriate healthcare, and a consequent withdrawal from the mainstream healthcare system. Structural factors such as the binary description of gender used by medical systems leads to a lack of visibility of these individuals, both within healthcare organisations and research. For gender-divergent healthcare professionals, there are actual or perceived potential professional ramifications of expressing their gender. We propose that the identification and understanding of these barriers will assist healthcare workers and organisations in Australia to begin to address these disparities.

Terminology

To accurately and respectfully interact with issues about gender and healthcare, it is important to use terminology that is appropriate and specific. Here we outline the terminology most pertinent to this article. Cis-gender refers to people whose gender identity is the same as the sex they were assigned at birth. In this paper, the choice to use the term ‘gender-diverse’ encompasses any and all gender identities outside the cisgender ‘male’ and ‘female’. This includes transgender people, who often identify as ‘male’ or ‘female’, but whose gender differs from the sex they were assigned at birth, as well as intersex, gender non-binary and gender-queer people whose gender identity may not fall within the categorical binary. These definitions are not absolute nor

comprehensive, and we acknowledge that gender terminology is an evolving and dynamic field. For a more comprehensive explanation of different terms used when regarding sex and gender, we recommend the University of Technology, Sydney's LGBTIQ+ glossary: Physical Sex, Sexuality, Gender Identity and Gender Expression.[1]

Gender-diverse patients and the healthcare system

Understanding the unique needs of Australia's gender-diverse community is a major public health challenge. This is due to the lack of research specifically aimed at addressing the health needs of this community, the exclusion of non-binary gender identities in research and policy, and the inaccurate conflation of sex, gender and sexuality in the data collected. In Australia, there have not yet been any national population-based data collected regarding gender identity. Currently the Australian Bureau of Statistics is reviewing its Sex Standard, which currently codes only 'male' and 'female' in the census, but as yet no new policies have been outlined.[2] Studies that do look at health outcomes for gender-diverse people often do so as part of umbrella-terms, such as LGBTQI[1], encompassing various gender identities, sexual orientations and sexual behaviours,[3] which can fail to identify unique issues affecting these diverse subgroups. Finally, health priorities and needs can and do differ within sub-groups – for example, transgender men and transgender women have different experiences within the healthcare system and different specific needs as patients, which can be overlooked when considering the health of transgender people more broadly.

Recently, however, smaller-scale surveys and data have been emerging parsing out health and wellbeing outcomes specifically for gender-diverse people. This research suggests that health outcomes are poorer among trans-identifying people than the wider population, as well as other groups that are part of the LGBTQI community. Patient-reported health outcomes such as in *Private Lives 2*, a 2012 health survey of more than 3,000 gay, lesbian, bisexual and transgender Australians, demonstrated that transgender men and women reported lower levels of general health than both the

[1] Different studies referred to in this paper use different umbrella or categorical terms such as LGBT, LGBTQI and GLBT. With this in mind, inconsistencies in the use of these terms may exist in this review and are reflective of the terms used in the specific studies or papers referenced.

national average, and when compared to cis-gendered gay, lesbian and bisexual respondents.[4] Specific disparities faced by gender-diverse people include reduced engagement with cervical cancer screening programs and increased rates of smoking and associated diseases. [5,6]

Mental health is a particular area of disparity, with both transgender men and women averaging scores of 23.2 on the Kessler Psychological Distress Scale, indicating high psychological stress,[7] with more than half of gender-diverse people experiencing a diagnosis of depression in their adult lifetime.[6] Suicidality is of particular concern, with transgender people 12 times more likely to contemplate and 11 times more likely to commit suicide than the general population in Australia.[7] As well as high rates of depression and anxiety, transgender individuals also report higher than average rates of other psychiatric conditions, with 23.4% of transgender men reporting such conditions, compared to 3.2% of cis-gendered men.[4] With this in mind, it is still difficult to confidently quantify the particular health challenges faced by gender-diverse populations, as these conclusions come from small studies and/or studies looking more broadly at LGBTQI groups.

There are a myriad of factors contributing to the healthcare disparities experienced by gender-diverse populations, and these issues range from interpersonal challenges between patient and practitioner, to hospital and institutional practices, policies and structures and finally political and societal context. It is important to note, as found in research conducted by the Australian Research Centre in Sex, Health and Society between 2007 and 2014, that the poorer health outcomes experienced by gender-diverse people in Australia are due to these contextual factors like stigma and access, and are not due to anything inherent to this identity.[6] In the 2011 National Transgender Discrimination Survey of more than 6000 transgender people in the United States, large numbers of respondents reported experiencing violence, harassment, and discrimination when seeking medical care, with 23% being denied care altogether.[8] These negative interactions reportedly lead to individuals postponing or avoiding medical care. [8]

Healthcare providers are also lacking in both understanding the transgender experience and delivering quality care to gender-diverse people due to a lack of basic knowledge in

these areas. This begins with a failure to understand the continuums of and differences between sex, gender, and sexuality, and the tendency to conflate and confuse these terms. It also relates to the lack of education surrounding the specific healthcare needs of gender-diverse people, including gender-affirming therapies and their side effects, sexual health, and fertility. The National Transgender Discrimination Survey found that half of respondents reported having to teach their healthcare providers about transgender health.[8] While some specialties such as General Practice have higher reported rates of positive clinical experiences for gender-diverse people, stigma and misunderstanding is present even among those professions that are most likely to be involved in providing care to gender-diverse people, including psychiatrists, gynaecologists and paediatric endocrinologists.[9–11]

There are also socio-political structures that create barriers to healthcare access at an institutional level.[6] Many of the healthcare disparities faced by gender-diverse people in this setting relate to their lack of visibility. Simply, most healthcare organisations collect patient data about sex or gender - often used interchangeably - as a binary of ‘male’ or ‘female’. This method excludes those who do not identify within the binary, while simultaneously rendering transgender experience invisible, as it fails to capture the difference between an individual’s sex-at-birth and current gender identity. The purported aim of collecting this information is two-fold: to identify the sex-specific healthcare needs of a person, for example, the likelihood of pregnancy, and to provide gender-appropriate interactions, for example, the appropriate use of pronouns. However, the method of presenting patients as either ‘male’ or ‘female’ fails to serve either of these aims in relation to gender-diverse people.[12] In this binary system, transgender, intersex and other gender-diverse people are effectively invisible, a process termed ‘erasure’.[13]

The erasure that exists in health data collection is mirrored in many bureaucratic contexts, which themselves contribute to the substantial barrier to care that gender-diverse people face. For example, a large survey in the United States in 2015 found that only 11% of gender-diverse respondents had their accurate name and gender on all their official identity documents, with reasons for not changing their legal name including financial capacity and lack of procedural knowledge.[14] In Australia, most states and territories have significant barriers to correcting gender markers on official

documentation such as being unmarried or having had surgery to alter their reproductive organs.[6] If individuals are provided avenues to change or correct their gender marker within their medical record, these processes can be insensitive, often requiring intrusive forms of 'proof', and imposing significant administrative, financial, and psychological burdens on people seeking to do so.[6]

It is important to note that the inconsistent and inappropriate use of gender markers extends beyond clinical practice. This erasure exists across all levels of data-gathering and makes collecting and locating data about the health and wellbeing of gender-diverse people difficult, which in turn makes it hard to identify areas of need and action. Both demographic information and data regarding cause and effects of outcomes are necessary to create an evidence-based approach to the healthcare of gender-diverse people. Indeed, standardised tools have been created for use at various levels from population to individual clinic,[15] but large-scale implementation of these standards are still required to fill gaps that exist in our knowledge of both specific health challenges for gender-diverse people and appropriate strategies to address them.

If and when basic issues of visibility can be overcome, gender-diverse people face real pragmatic barriers to care in the form of governmental regulations and priorities. For example, the financial burdens placed on transgender people seeking gender-affirming therapies not currently funded by public or private health insurance. In recent years, there have been proposed changes to governmental policy in an attempt to address systemic barriers that gender-diverse people face in the healthcare system. Access to many Medicare and Pharmaceutical Benefits Scheme (PBS)-subsidised items are dependent on patients' Medicare gender classification (either 'male' or 'female'), making access to certain procedures and medications difficult for gender-diverse people. 6,000 such procedures and treatments were proposed to be modified to remove gender-dependent classifications, for example, making cervical cancer screening available to anyone with a cervix, as opposed to people whose marker is 'female'.[6] As of 2014, only 15 of the particular Medical Benefits Scheme billing codes had been changed.[6] Furthermore, some gender-affirming management options are still classified as cosmetic procedures and as such are not covered by Medicare. These policy-related issues contribute both to the significant barriers gender-diverse people face generally in

accessing care both for their well being, and those faced by transgender people seeking specific transition-related care.[6]

The Australian Medical Association (AMA) recognises transgender, intersex and gender-diverse people as a priority population in sexual and reproductive health.[16] Their 2014 policy document on sexual and reproductive health stresses the importance of reducing stigma in the healthcare setting, encouraging access to gender affirming procedures and medications, and improving data collection and research to identify gaps and improve the experience that gender-diverse people have with our healthcare system.[16]

Similarly, the Australian Medical Student Association (AMSA) released a policy statement in 2016, echoing the sentiment of the AMA document, as well as outlining specific recommendations for government bodies, medical schools and student societies to promote LGBTQI health and wellbeing.[17] As well as presenting recommendations for the provision of more competent healthcare to gender-diverse patients, AMSA's policy guidelines address changing the professional culture and the roles that medical schools and student societies play. The document calls on medical schools to promote visibility of LGBTQI health with integrated, accurate and destigmatised curricula, as well as inviting the participation of LGBTQI health care providers and community members to be involved in teaching and curriculum building. It also highlights the role of student societies in protecting and promoting the interests of LGBTQI students as well as raising the quality of teaching around gender and sexuality.[17]

Gender-diverse healthcare professionals

While only a small amount of research is available regarding gender-diverse patients, there is an even greater paucity of data regarding gender-diverse healthcare providers. However, with personal accounts of gender-diverse people who have chosen to write about their experience as medical students and doctors, as well as some small studies and reports of gender-diverse groups in the health workforce, we can begin to build a picture of gender-diversity among healthcare professionals.

Barriers for gender-diverse people in the healthcare workforce can emerge early, as evidenced by recent studies looking at how gender and sexuality is addressed and taught in medical schools. A 2015 survey conducted at Stanford Medical School investigated the experience of LGBT-related education by both LGBT and non-LGBT medical students. One quarter of LGBT students and 8% of non-LGBT students found the quality of their teaching surrounding LGBT issues to be 'very poor', and the discrepancy between these numbers highlights that the LGBT students did not feel their experience was represented appropriately.[18] Jai NicAllen, a British medical student wrote of their experience as a trans-person in medical school in an article for the Student British Medical Journal, noting challenges including factually inaccurate information about gender and health, and a generalised lack of knowledge among peers and teachers.[19] Furthermore, while the majority of medical schools provided at least 3 hours of teaching on sexuality broadly, it is difficult to know what and how gender is included in these curricula, and many reported little to no information about gender-diversity in their teaching.[20]

The potential result of the educational failures suggested by these studies is a medical workforce that lacks the confidence and capacity for caring appropriately for gender-diverse patients, but it also fosters an unwelcoming environment for gender-diverse medical students and professionals. With fear of discrimination from medical schools and residency programs being the two most common reasons among medical students for choosing not to disclose gender-diverse gender identity or sexuality, the failures of medical schools surrounding gender-diversity teaching carry on into the workplace with ongoing stigma and professional consequences for gender-diverse doctors.[18] In the absence of formalised information and support for gender-diverse students and young doctors, informal peer spaces like student forums and chat rooms provide some of the only reliable and confidential aid in navigating educational and career-related decisions.

The data available about gender-diverse doctors and other healthcare providers paint a similar picture of deficits and discrimination. A 2011 report put it powerfully: "most LGBT physicians continue to work in settings where they are invisible".[20] Robust policies surrounding gender-related issues in the workplace including harassment and reporting, pronoun use, dress codes, appropriate facilities, and general employee education surrounding gender identity are becoming more common and exist in various

guidelines.[21–23] However, there is little adoption or creation of such guidelines in the healthcare employment setting, and many gender-diverse physicians are not even aware of their workplace policies regarding gender and sexuality both for patients and employees, with 28% of respondents in the 2011 study noting they did not know whether their employer's non-discrimination policy included gender identity at all.[20] Rates of harassment and ostracisation of LGBT physicians based on gender identity and sexuality have shown improvement over the last 20 years, but still sit at 15% and 20% respectively in one reported study.[20] These discriminatory experiences can be at the hands of peers and bosses, but also patients, with a 2007 national study in the United States reporting that 30% of responders would change healthcare providers upon learning theirs identified as LGBT.[24] Finally, when considering reporting instances of discrimination, gender-diverse healthcare workers also have to consider how their identity and the perception of it by their superiors could affect their careers, for example regarding exclusion from promotions or other opportunities.[20]

Conclusions

The lack of large scale and robust data representing experiences of gender-diverse people in the Australian health system speaks to their lack of visibility, acceptance and representation within the healthcare system both as patients and professionals. Furthermore, the data and perspectives that are available highlight that the erasure and inappropriate treatment of gender-diverse people in healthcare is not uncommon, nor is it uncommon knowledge.

The challenges that affect both the health outcomes of gender-diverse people and their experience in the healthcare industry are due to barriers that exist at several levels. Individual factors in patient-carer interactions including prejudice and lack of awareness or confidence negatively influence gender-diverse people's access to and engagement with healthcare professionals. Institutional factors such as the binary description of gender used by medical systems leads to a lack of visibility of gender-diverse individuals, both within healthcare organisations and research. Policy and structural considerations including governmental focus, financial subsidies and public policy define the context in which gender-diverse people exist and interact with the healthcare system. Finally, for gender-diverse healthcare professionals, there are real workplace

ramifications for expressing their gender, not to mention the fear and anxiety perpetuated by a hostile work environment. We propose that the identification and understanding of these barriers will assist healthcare workers and organisations in Australia to begin to address these disparities.

Despite the perspectives of our large professional bodies, as well as the growing body of data, anecdotal experiences of gender-diverse people and the availability of guidelines, templates and recommendations both for gender-diverse patient care and employee relations, healthcare institutions in Australia are slow to change. In this case, the resources are available, and many of the necessary steps outlined in the relevant guidelines are simple, inexpensive and quick to implement on an institutional level. Reevaluating policy, practice and attitudes relating to gender-diverse patients and employees is necessary to enhance the standard of care given and to to cultivate safe working environments. Implementing institutional and industry-wide practical standards that emphasise visibility, education, and appropriate structural supports for gender-diverse people is possible and overdue.

What can be done

The most important step to creating step in facilitating positive structural and cultural change is for relevant institutions to create and implement policy protecting gender-diverse patients and professionals. Below we outline what we believe are the most important areas that such policies should address. We refer to guidelines and policy created by other organisations that we believe are appropriate and useful. An example of a template for creating a policy document regarding equal opportunity employment is available from the Victorian Equal Opportunity and Human Rights Commission [22].

Environment and culture

- Providing a safe and inclusive culture for gender-diverse persons, including encouraging cultural humility regarding gender issues.
- Create an inclusive physical environment, including providing bathrooms in which gender-diverse people can feel safe and comfortable, for example, by providing at least one gender-neutral bathroom. Allowing people to choose to use either women's or men's bathrooms is also an option when an appropriate environment

for this is created, for example, by posting signage encouraging people to be inclusive.

- **Education**
- Education regarding the meanings of biological sex, gender, and sexuality, and deconstruction of archaic views of gender-diverse identities.
- Education about the experience of being gender-diverse.
- Education regarding gender-affirming therapies, the specific healthcare needs of gender-diverse people, and the specific problems faced by gender-diverse people in their interactions with the healthcare system. Further information about these topics can be found in the a set of guidelines published by the Center of Excellence for Transgender Health, University of California San Francisco [25].

- **Sex and gender data**
- Data regarding sex and gender should be collected in an inclusive manner, to avoid alienating and excluding people who do not identify as simply ‘male’ or ‘female’. This applies to both practice and research. An example of a method for collecting sex and gender data is the two-step method proposed in the guidelines published by the Center of Excellence for Transgender Health, University of California San Francisco [25].
- Data regarding sex and gender should only be collected when this data is relevant and useful, as this can be an invasive and even harmful question. Options should be available for not recording gender when it is not relevant, for both patients and staff. Again, this applies to both practice and research.
- Institutions should store data relating to sex and gender in a useful and inclusive manner, so as to identify persons who are gender-diverse if that is what they desire, to best serve their healthcare needs.
- Institutions should have protocols for noting preferred names and pronouns, so as to avoid making assumptions about a person’s preferred names and pronouns.
- Healthcare systems should introduce streamlined processes for changing gender identity in medical records and for employment documentation [22].

- **Language**
- Healthcare workers should be aware of and use appropriate terminology relating to gender-diverse people, for example, the meanings of ‘trans-woman’ and ‘top surgery’. This includes not using language that is considered pejorative, for example, ‘transvestite’ [1]
- Healthcare workers should be aware of the appropriate use of gender pronouns.
- Gender-inclusive language should be used in policies, publications, and documentation e.g. phrases such as men and women could be replaced with “all genders”, and “he/she” could be replaced with “they”.
- Healthcare workers should be aware of inappropriate and intrusive questions. For example, asking about genital status or possible plans for surgical intervention without appropriate conversational context.

What should Level do?

- Work to develop cultural humility and appropriate skills in medical students and doctors that will allow them to better serve the healthcare needs of gender-diverse people.
- Raise awareness about the barriers faced by gender-diverse healthcare workers.
- Advocate for gender-diverse patients and healthcare workers.
- Ensure implementation and adoption of diversity and inclusion policies within its own operations.
- Support research and policy production regarding the healthcare needs of gender-diverse people and barriers faced by gender-diverse healthcare providers in the workplace.

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