SHARE SGIM Forum
MAY 2019 V42, NO.5

PERSPECTIVE: PART II

WHAT'S IN A NAME?: RESPECT AND IDENTITY IN TRANSGENDER CARE

Aliza Norwood, MD

Dr. Norwood (Aliza.Norwood@austin.utexas.edu) is assistant professor of population health at the Dell Medical School at the University of Texas at Austin and a general internist at CommUnityCare in Austin.

This month, the Society of General Internal Medicine will hold its 2019 Annual Meeting, with a particular focus on advocacy and equity. Although the transgender community has received more societal awareness in recent years they have still not achieved equity in health care, as demonstrated by well-documented health disparities between cis and transgender patients. The American Academy of Pediatrics found that 30% of male-to-female transgender adolescents and 51% of female-to-male transgender teens report having attempted suicide.[1] As adults, transgender patients are less likely than cisgender patients to have routine care and have higher rates of cardiovascular disease, psychiatric disorders, substance abuse, and suicide.[2,3] These disparities are worsened by transphobic systems and providers. A 2012 study revealed that 1 in 5 transgender people postponed or did not try to get health care because of fear of discrimination.[4] In contrast, transgender patients report positive healthcare experiences when their providers create an inclusive, safe space.[5] This article will highlight an example of how a simple patient-centered intervention strengthened the therapeutic alliance between a transgender patient and their provider and provide tips to increase trust in this underserved community.

The following story is about a young transgender man named Ethan and his account of a particularly meaningful moment he had with his provider. Ethan was born biologically female but suffered from intensely painful gender dysphoria and depression from a young age. With each step of his medical transition that dysphoria seemed to lighten, like a cloud lifting. He first started testosterone which gave him secondary sex characteristics that eased his transition including bulk, a beard, and male-pattern baldness. He had a mastectomy, relieving him of the daily task of tightly binding his breasts which had caused back spasms and breathing problems. These changes made him feel more normal, more like himself.

He decided to have a hysterectomy which required that he go to frequent gynecology visits. He told me about the experience of being a man sitting in a gynecology waiting room, surrounded by staring women. He brought his wife along for support and to deflect those stares. During these visits he had to talk about personal feminine body parts which triggered his gender dysphoria in a very intense way. These visits were extremely uncomfortable for him, so one day his wife had a strange but thoughtful idea. She renamed his feminine parts with masculine names. Instead of talking about his uterus, she referred to his *duderus*. His fallopian tubes were *fellow-pian* tubes, ovaries became *bro-varies*, and his cervix was a *Sir-vix*. It was ridiculous but it was a way to inject humor into a painful situation and it did make him feel better. Ethan and his wife joked about this during a gynecology appointment, and he told me that the doctor did something in that moment that completely changed the dynamic of their visits. She looked at him and asked, "Would you like me to refer to them with those names?"

When Ethan reached this part of his story, I could see in his eyes that this simple act changed the way he saw his doctor. It showed a level of respect and a willingness to adapt in order to make him as comfortable as possible. And it worked. He felt more cared for, and he trusted her in a deeper way.

On the surface, this story is about a provider who listened to her patient and offered a simple concession. But on a deeper level, she recognized these names were part of a new identity and they made Ethan feel safe and in control. This story also reminds me of watershed moments I've had with my own primary care patients. Those moments have invariably occurred when I've taken the time to ask some version of 'What is important to you?' As the medical community embraces patient-centered care, we should strive to apply that focus to our interactions with patients from historically underserved commu-

continued on page 2

PERSPECTIVE: PART II *(continued from page 1)*

nities, including transgender patients. Medical providers have a certain amount of authority both in the clinic and in society. We can use that power to not only affirm a patient's gender, but to affirm that they are worth our respect. The positive ripples from that kind of interaction can travel beyond the clinical space and provide another layer of strength and protection to transgender people.

In clinical practice, providing patient-centered care for transgender patients, referred to as gender-affirming care, means creating safe and inclusive spaces for patients. A few examples of how to create an inclusive space include providing gender-neutral bathrooms in the clinic, creating medical records that record gender-affirming names and pronouns, dedicated training for staff and providers, and universally asking patients what they preferred to be called. Cisgender patients may not understand the question, "what are your preferred pronouns," but asking the question "what do you prefer to be called" to all patients is a way to universally screen for gender identity and is a clear opportunity for transgender individuals to provide preferred name and pronouns. Regarding staff training, evidence shows that holding open forums with staff to discuss transgender biases can allow for targeted education.[6] There are high-quality free resources available to help with provider and staff education. The UCSF Center of Excellence for Transgender Health has an online Transgender Health Learning Center with helpful resources for healthcare providers, researchers, and the public. Fenway Health also has a thorough Web site with helpful information on gender-affirming care and support resources. GLAAD, an organization that advocates for LGBTQ inclusivity in media, has a great tipsheet for transgender allies that can be accessed at www.glaad.org/transgender/allies. At an academic level, medical students and residents should receive training so that more providers are willing and able to provide quality gender-affirming care, easing transgender patients' burden of teaching their providers. Finally, physician advocacy regarding discriminatory policies such as the military transgender ban and anti-transgender bathroom bills can help highlight how such policies create structural barriers to well-being for transgender people.

As medical providers, we took an oath to serve all patients to the best of our ability and to do no harm. Just as we practice universal precautions for infection control, so should we practice universal respect. One of the simplest things we can ask a patient is, "What do you want to be called?". When we ask patients what their pronouns are it isn't a silly exercise in semantics. A name is an identity. It carries with it a personal story, self-worth, and, in this case, a commitment to live an authentic life despite real risks of danger and bigotry.

Ethan's story is a reminder of how providers can empower their patients and create safe spaces by listening and asking, 'What is important to you?'.

References

1. Toomey RB, et al. Transgender adolescent suicide behavior. *Pediatrics*. September 11, 2018.
2. The National Center for Transgender Equality. The Report of the 2015 US Transgender Survey. http://www.transequality.org/sites/default/files/docs/USTS-Executive-Summary-FINAL.PDF. Published December 2016. Accessed April 1, 2019.
3. Gonzales G, Henning-Smith C. Barriers to care among transgender and gender non-conforming adults. *Milbank Q*. December 2017;95(4):726-48.
4. The National Center for Transgender Equality, National Gay and Lesbian Task Force. Injustice at every turn: A report of the National Transgender Discrimination Survey. Transequality.org/PDFs/Executive_Summary.pdf. Accessed April 1, 2019.
5. Baldwin A, Dodge B, Schick VR, et al. Transgender and genderqueer individuals' experiences with health care providers: What's working, what's not, and where do we go from here? *J Health Care Poor Underserved*. 2018;29(4):1300-18.
6. Boskey E, Taghinia A, and Ganor O. Public accommodation laws and gender panic in clinical settings. *AMA J Ethics*. November 2018; 20(11): E1067-74.

SGIM