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Discussion

# What all doctors should know about trans health – a conversation between a medic and a sociologist

DISCUSSION

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ABSTRACT

This article offers guidance on how to engage with transgender patients – people whose genders do not correspond with the assignment made at birth. The format is that of a dialogue between a GP and an academic sociologist, both with a special interest in trans health. The authors provide their allied perspectives on possibilities for improved inclusivity in clinical practice. The approach taken intends to simultaneously be familiar and accessible to those with medical experience, while also engaging with nuanced elements to provide a firm conceptual foundation. Following an orienting discussion of sex and gender (and how 'the biological' and 'the social' relate), the article engages with key concepts and practices when meeting a trans patient for the first time. More specific examples such as history-taking, physical examination, and sex-based reference range interpretation are discussed. The article closes with some evaluative take home messages, emphasising the importance of avoiding common assumptions, and the need for continual development of inclusive curricula.

**Who are we?**

As someone who studied medicine in London in the 1990s, drifted into emergency medicine, then after a decade moved to general practice, I did not come across training in transgender health or an awareness of trans lives until I (knowingly) met my first trans patient in 2018. To say that I was unprepared was an understatement. Horrified by my abysmal performance, I began my own journey to enlightenment, starting with some frank conversations with trans people about where I was going wrong. Although my journey took me further than I expected, as I now work and teach in this area as a general practitioner (GP) with a special interest, I am always reminded that actually, it pretty much always comes back to the basics of not making assumptions. When you assume nothing, and ask if not sure, you'll consult more openly and allow your patient to fill in the gaps. Simple skills, like checking for a preferred name and asking about pronouns, can be extremely impactful and will open the door to a richer clinical interaction. Take this further, and you'll broaden your understanding of all people as unique.

In 2019, as I was expanding my own learning, I had the good fortune of meeting Ben Vincent, a non-binary academic sociologist and author of Transgender Health: a practitioner's guide to binary and non-binary trans patient care. (1) I devoured their book on a flight to and from a conference in Dublin, the perfect read for someone like me with a limited attention span! Tangible, digestible, and in a language that I could understand. One key lesson revolved around the message "nothing about us without us" ("Nihil de nobis, sine nobis"); the idea that no teaching should be decided or delivered without the full and direct participation of members of the group affected by, or the subject of, that teaching. This being an educational article, I decided that we should therefore write it together; myself a cisgender medic with first-hand experience of clinical practice and the ways in which medical education encourages us to think critically, and Ben to review and challenge this, with the intention of making up for what was missing at medical school.

Rather than merge our two styles, I decided to lift Ben's comments and directly place them on the page, giving you not only the bones of the writing process employed for this article, but sight of an invaluable sociological perspective. I call it flesh.

**What should junior doctors and medical students know in regard to trans health?**

This was the brief for the piece. When I first read it, my brain immediately jumped to presenting the myriad of evidence regarding gender identity and how this is formed, echoing traditional medical teaching on 'aetiology and pathogenesis', followed by 'symptoms and signs', 'diagnosis', etc. This approach, however, tends to pathologize diversity among numerous living systems, including we humans. Looking beyond the boundaries of medicine, there currently rages an ideological war on sex and gender, rife with misinformation, that has seen trans people impacted by a surge of transphobic hate crime and challenges to legal protections.

Suffice to say, dissecting trans identities and disentangling the current discourse is not relevant to the fundamental teaching of the sensitive delivery of care, or to the application of affirmative consultation practices. As doctors, our duty is to treat the person in front of us in a non-discriminatory and non-judgemental way. The care of our patient must always be our primary concern. (2)

*Ben: A decent foundation is really hard to deliver because that depends on a lot of concepts that aren't part of medical or scientific education, mainly to do with the philosophy of what things are (ontology) and the processes by which we know things (epistemology). The temptation to try and address this arises when overly simplistic notions of sex and gender – and the relationship between them – result in de-legitimisation of trans people's genders, or the legitimacy and necessity of gender-affirming medical interventions. Perhaps people are able to just accept that it's beside the point and the issue is more about providing equal access to care that is respectful and competent.*

So, let's get started.

Medics should already appreciate the beautiful diversity of biology; the stunning variation in the way sex chromosomes are organised, express themselves, and are responded to. Differences of sex development are well understood and may well account for 1-2% of live births. (3) Chromosomes, sex hormones, internal reproductive anatomy and external genitalia are all biological traits housed under the label of 'sex'. Consider this a collective term but one that reflects substantial but often subtle variation. By contrast, the binary categorisation of sex, as 'male' and 'female', is based on observation of the external genitalia alone, and from this gender is assumed "it's a girl!", "it's a boy!".

*Ben: I agree that sex is the association of particular phenomena with categories – male and female – that are initially determined by what we expect to find, or see develop, in people born with a penis or vulva, respectively. Beware the idea that a person's physiology, anatomy, or genetics fundamentally are 'male' or 'female' things. Otherwise, this logically backs us into the corner of talking about trans women having 'male' biology, trans men 'female' biology, and frames non-binary people's body parts in these terms. Doing so is political, not a foregone conclusion of a morally neutral scientific enterprise. Generally, the whole concept can be sidestepped – it is always clearer and more accurate, for example, to specify XX chromosomes rather than 'female' chromosomes, testes rather than 'male gonads', etc. with the added benefit of not alienating your trans patient from their experience of healthcare.*

Gender identity is the personal sense of one's own gender, as being a man, woman, or something else. Like sex, this is unique to the individual. For most people, this overlays with the sex label assigned at birth. For trans people, this is not the case.

*Ben: In terms of the individual, their gender identity is their gender, of course, but gender is also recognisable as a system of social division and organisation. Older academic contributions framed gender as the attribution of masculinity and femininity – behaviours, tastes, and stereotypes. As already touched upon, the concept of sex and the biological makeup of bodies cannot be conceptualised independently of language, culture, and subject*

*interpretation (such that 'sex' is also social). I add this because it's important to recognise the oversimplification of framing the concepts of sex and gender as separate and independent, even if they can have slightly different associations. I tend to refer to them as 'mutually co-constitutive'.*

**How are trans identities experienced?**

In its updated ICD-11, the World Health Organisation offers the diagnostic term 'gender incongruence' to describe an individual whose gender differentiates from that assigned at birth. (4) This has for the most part replaced 'transsexualism' along with a welcome departure from its classification as a mental or behavioural disorder. For some, but not all trans people, gender incongruence causes clinically significant distress, termed 'gender dysphoria'. Gender dysphoria (5) can be experienced in relation to the body (often but not exclusively linked with primary or secondary sexual characteristics), or in relation to navigating within a social context; how one is perceived, 'gendered', or in fulfilling a particular gender role. It should come as no surprise that gender dysphoria can have a profound impact on psychosocial functioning, manifesting as anxiety, low mood, substance misuse, disordered eating (particularly to restrict pubertal development), and suicidality. (6) 'Minority stress' compounds matters. This is the additional burden of stress experienced by individuals belonging to a particular minority group, and for trans people this could be the stress of concealment (of a trans identity), of living in an unsupportive family environment, of bullying, of discrimination, or stigmatisation, et cetera.

The concept of 'gender euphoria' is also important and describes the sense of fulfilment or joy that comes from living in ones acquired gender, of being affirmed by others or experiencing positive bodily changes.

*Ben: How trans identities are experienced is also informed by social context; intimate elements of family behaviours and responses to gender exploration, on to peer (school, work) reactions, with key intersections of religion, culture, class, race/ethnicity, among many other social divisions. Some may consider their genders 'acquired', others may consider their gender was always what it was, and it simply took some time to realise because of the assumptions society places on people based on their bodies. Many other personal conceptualisations are possible, so it's important not to assume any particular relationship with the concept of gender, or with their gender history.*

**What is it that we need to distil for the purpose of our everyday practice?**

As a junior doctor or medical student, you will likely meet your trans patient in the context of their particular clinical complaint, and by this, I mean a complaint likely to be no different to that of a cis (non-trans) person. You aren't required to know all there is to know about gender identity, but there are some helpful things to understand; tips that will gain you the trust and respect of your patient, and avoid you being tripped up legally and clinically.

I want you to hone the skill of establishing how your patient wishes to be spoken to, and about, with regard to their gender, and to consider their individual biology when evaluating organs and their function.

*Ben: This is spot on. Wouldn't change a word. Underscores that I think in talking about sex and gender, we should move away from these as medically orienting terms because they just introduce noise. To paraphrase a research participant, MOTs don't have a checkbox for 'Toyota' versus 'Ford'! I love this metaphor because it captures that there's not only more possible categories, but also no single standard within the named categories.*

**Consulting in an affirmative way**

As a medic, you can have a profound impact on a person's healthcare experience simply with an enhanced awareness and sensitivity to your practice. Consulting in an affirmative way takes nothing from the clinical element while reinforcing good medical practice. This is what makes a good doctor, and it's simple.

Awareness should start from the first moment you meet your patient, so let's walk through a scenario.

We are trained to observe before anything else. Non-verbal clues – how well-kempt, what eye contact, what smell, do they look underweight? In the same way, our patient is reading us. What if the name on their file does not match what they are communicating by way of their gender expression? Do we seem perplexed?

For trans people, taking the decision to live in their authentic gender is known as social transition, and is often the first step to feeling more comfortable. This could involve a change of name, hairstyle or clothing, the use of a chest binder, body forms, or perhaps an adjustment to intonation.

"My file says Raymond, is this the name you use or is there another you would prefer?"

Asking someone their name and making an adjustment if appropriate is one of the best starts a doctor might make when greeting a trans person. Flowing on, establish the pronouns they use, as this will ensure that you communicate about them in the most appropriate way when writing up your notes.

*Ben: The name question is great for everyone, even if it's a William who always goes by Bill, or someone who goes by their middle name, etc. If it's become apparent someone is trans ask "can I confirm your pronouns" not "what are your 'preferred' pronouns", as for most trans people their pronouns are not a preference out of multiple options but simply the correct mode of address. Giving your own pronouns is good practice too – if you can't definitively ascertain them from looking, neither can anyone about you. Some people choose to wear a badge or pin with this information, which can be a great relief for trans people to see.*

*Non-binary people have a gender identity that is neither exclusively male nor female. It is always worth establishing what the individual prefers as there is no certain way to know without asking. Clinicians should be cognisant to the gender signifiers patients may be using in order to signal how they wish to be gendered or referred to. If a person has not begun any kind of social transition, then their requested name and pronouns may be entirely at odds with what you might assume from appearance. Not all non-binary people will be aiming to appear androgynous, so be prepared for literally any combination of gender expression and name/pronoun use. A final point is that you may be the first person a trans person has ever talked to about gender, or they may have transitioned 50 years ago. You may see trans people of just about any age, and this doesn't infer how long since they transitioned, if they have!*

By assuming nothing (about gender, but also about sex characteristics too) and checking on name and pronouns, you have a patient who is confident that you will speak to them and write about them in a sensitive way.

*Ben: Indeed! You now have a patient who is likely deeply relieved that you have shown cultural understanding and sensitivity. This can make a huge difference to their ability to feel able to access healthcare. They may have potentially put off going to see any health professional out of fear for a long time or may have had to change practice after a bad experience.*

With introductions out of the way and the doctor-patient relationship off to a good start, bring your focus to the clinical complaint and take a history in the usual way. History-taking helps to further explore a presenting complaint and formulate a working diagnosis. Woven into this are one or two considerations.

Some, but not all, trans people will access medical intervention (usually hormone therapy) as part of their transition process. This can help to better align physical characteristics and improve psychosocial and cultural functioning. Some people will undertake surgeries either privately or through the NHS with the same aim. This might include surgery to reduce or enhance breast tissue, genital surgery, hysterectomy, facial and vocal surgeries, et cetera.

Eliciting a 'transition history' might be important for your assessment, but make sure that you are able justify to your patient why this information is relevant to their particular clinical complaint.

*Ben: A common problem trans people experience is colloquially called 'trans broken arm syndrome' – when seeking help with a medical issue completely unrelated to trans status, but the clinician inappropriately focuses on trans status, assuming there must be a link. It can therefore be especially helpful to explain your reasoning, or why a course of action is necessary.*

Taking a comprehensive drug history will elicit whether or not your patient takes hormone therapy. In this context, be sure to enquire about "medicines prescribed or otherwise", as self-medication with hormone therapy is endemic in the UK and reflects the protracted waiting times for NHS gender identity clinic services. Being comfortable to ask about medicines purchased online will help to dispel fear or shame around this issue and might also uncover unsafe self-injection practices. Respect confidentiality, gently encouraging them to consent to you sharing this information with their GP so at the very least a harm-reduction arrangement can be considered.

When taking a sexual health history, it is important to know not only about the body of your patient but also about the body of their sexual partner(s). As for all patients, trans or not, what sex is being had, and with what body parts, is key here. And as you go along, check your assumptions. Have you assumed that your patient doesn't use his vagina for sex? Does he have a cervix or uterus, and what difference might this make in steering the screening and contraception advice you offer? Was his boyfriend also assigned female at birth, and how might that change the type of history you elicit? Finally, follow his lead with language; he may describe menstruation as "bleeds" rather than "periods", for example.

*Ben: Another thing to avoid assuming is a trans person's sexual orientation, or sexual practices. A trans woman might be a lesbian, but in a relationship with another trans woman; a gay trans man may have receptive vaginal but not anal sex with a cisgender gay partner – and this information doesn't tell you anything about what body parts each person has, or what activity they may do.*

Eliciting a social history, you might want to know a little about cultural or religious context, check they have secure housing and that there are no safeguarding considerations. Evidence suggests that one in four trans and non-binary people in the UK experience homelessness, (7) and negative social environments (e.g.: home, school, work) contribute to suicidality in young people. (8)

While being trans is certainly not a mental illness, patients often report strained mental health due to physical and social dysphoria, as well as minority stressors such as prejudice and discrimination. Ask someone about their mental wellbeing generally, and if you think it is relevant, about harmful coping strategies including food restriction, cutting, or illicit drug and alcohol dependency. Smoking is a standard question, and important in the context of hormone therapy.

Consider each component of the traditional history-taking structure and how it might be re-orientated to better accommodate trans people. Establish trust through openness and allow the patient to guide you if the territory is unfamiliar, for example self-medication, experience of belonging to an ethic group different to your own, et cetera.

Having taken a history, it is time to examine your patient. If you are of a different gender, be sure to offer a chaperone, and if you are not sure of their preference, ask. Be mindful that your patient may find being examined distressing, perhaps generally, or in relation to certain areas of their body. It might help in this scenario to 'check in' with them as you go along. Do not cut corners with your clinical evaluation, but perhaps think about your non-verbal body language in offering quiet acknowledgement. If someone wears a

chest binder, might you capture the information you need without asking them to remove it? If not, how might you approach this sensitively?

A trans masculine person using testosterone therapy may have thinning of the vaginal epithelium (vaginal atrophy) making examination including cervical smear testing painful. Selecting a smaller speculum and using additional lubrication can help.

In the context of a sexual health complaint, what "lower surgery" a person has had, if any, might be clinically relevant. Penile skin inversion is the most commonly used technique in the UK for vaginoplasty, a type of genital reassignment surgery that offers a skin-lined neo-vagina by inverting penile skin. A minority of people might have required a segment of sigmoid bowel to be used instead, particularly in cases where penile development was insufficient. Taking only a vaginal swab from a skin-lined vagina risks missing an STI, as relevant pathogenic organisms predominantly infect genital mucosa, so consider the urethral mucosa and include a urine sample for NAAT (nucleic acid amplification test).

In this particular patient also note that the prostate gland is retained but won't be palpable rectally if a neovagina is present as it will lie anterior to the vaginal wall. Transvaginal palpation is possible (9)

*Ben: Should a trans person be seeing you simply seeking a referral to a gender identity clinic, note that it is never appropriate to require them to be physically examined nor otherwise fulfil any expectation that might be had of what it means to be trans. Patients in England may choose to be referred to any of (and any number of!) the seven adult services across England, which all specify their referral requirements. As of the 2018 Service Specification, self-referral is also possible. GICs have their own referral forms – check what information is requested.*

Examining your patient builds on the trusting relationship you have established from the start. Demonstrate through your own behaviours that you are thinking sensitively about the possibility of bodily discomfort, and while it is important to be clinically thorough, "check-in" with your patient as you go.

By way of investigations, you might wish to evaluate the results of a swab, blood or urine sample. It is here that you will bring together all of the information you have gathered to decide on tests that will help you to reach a diagnosis. In this context, apply critical thinking to your patient's unique biology, particularly when it comes to the correct interpretation of sex-based reference ranges.

Androgen (testosterone) use in someone assigned female at birth will induce erythropoiesis and increase haemoglobin, haematocrit and red blood count to the 'male' reference range. If a 'female' marker is linked to the testing facility, this might be falsely reported as an abnormally high result. Smoking in the context of testosterone use can compound blood thickening and push an individual towards polycythaemia, an increased blood viscosity that risks thrombosis. Apply the 'male' reference range and respond clinically if appropriate.

Another common laboratory test is eGFR. People presumed male at birth have a higher eGFR than people presumed female at birth at the same level of serum creatinine because the formula assumes a higher muscle mass in men. (10) Testosterone therapy may induce significant gains in muscle mass, oestrogen therapy to the contrary, so consider applying the eGFR reference range that best reflects your patient's dominant sex steroid/body composition.

There are currently no studies looking at the impact of gender-affirming hormone therapy on cardiac mass, but it would serve you well to think carefully when interpreting a cardiac troponin, as upper reference limits vary with recorded sex.

Considering all biological and physiological systems as unique and applying this to clinical practice ensures best quality care. It echoes back to the phrase "I'm asking (about hormone therapy or surgeries) because I want to make sure that I order the right tests and interpret them in the right way".

Having taken a history, examined your patient, and completed the appropriate investigations, you might conclude that they require admission to hospital. It should go without saying that appropriate ward placement where at all feasible is critical to preserving dignity and comfort.

*Ben: Absolutely. Depending on personal circumstances, stage of transition etc., there may be times when some trans people may actually want to be on a ward of their birth assignment (whatever marker is on the NHS records). This may also pertain to the specific reason they're in hospital. I would say best practice when unsure is to speak to the patient and explicitly talk about what they would feel most comfortable with, including consideration of a private room if both desired and feasible.*

When writing up your notes, be mindful to only reveal your patient's trans status if you have their permission to do so. For someone with a Gender Recognition Certificate (under the Gender Recognition Act 2004), disclosing without permission or cause could amount to a criminal offence. While there are medical exemptions in contexts relevant to clinical care, best practice is to obtain consent to discuss where necessary and explain why if requested.

**Take home messages**

Whatever type of doctor you become, consulting affirmatively and sharing good practice with colleagues including allied staff is a powerful way of transmitting this learning beyond the article. Set the tone. From one, to a team, to a department.

Assume nothing; about a person's name, pronouns, gender, karyotype, genital arrangement, hormone status, organs, or the sex they have and with whom. Always be ready to justify your rationale for proposing the questions that you do, examine thoughtfully and sensitively, and seek consent around trans status when writing up your notes. Expand your understanding of biological systems and see all bodies as unique. Challenge the binary.

Trans health cannot exist without trans rights, and if trans lives are to be lived without fear of depreciation, consider the broader

context of allyship. Placing your pronouns in your email signature could be a positive first step towards awareness and inclusivity, as can calling out transphobia when you witness it.

As consumers of health education, you have a voice when it comes to curriculum content. Educating all healthcare staff to better understand trans identities and to interact with patients in a respectful and affirmative way is the responsibility of all health education institutions.

*Ben: Ultimately, trans people are people just like everyone else, and deserve the right to self-determination and respect. By reorienting our worldview on gender and unlearning gendered assumptions and stereotypes, all patients, trans or not, stand to benefit.*

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