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How Cisgender Clinicians Can Help Prevent Harm During Encounters With Transgender Patients

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Abstract

Transgender people commonly experience discrimination from clinicians, which directly contributes to worse mental and physical health outcomes among this population. This article describes mechanisms by which stigma perpetuates health inequity among transgender patients and highlights its unique effects on transgender patients of color. The article concludes with recommendations to cisgender clinicians on how to help prevent stigmatizing interactions with transgender patients.

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Introduction

People who are transgender experience discrimination in every aspect of their lives, including health care settings. Perceived discrimination by clinicians contributes to health care avoidance, increased substance use, poor general health, and poor mental health among transgender individuals.^{1,2,3} Moreover, transgender people of color (TPOC) experience even higher rates of gender-based discrimination by clinicians and have worse health outcomes than their White counterparts.^{4,5,6} In this article, we describe mechanisms through which clinicians and health care systems perpetuate stigmatization of transgender patients. We also describe how compounded cissexist and racial discrimination shapes unique health inequities experienced by TPOC. Finally, we offer recommendations that cisgender clinicians can enact to prevent stigmatization of transgender patients.

Antitransgender Stigma

Stigmatization is a social process whereby human differences are identified, labeled, and linked to negative stereotypes, resulting in the social devaluation of labeled groups.^{7,8} People who are labeled experience a loss of status, which adversely affects their capacity for upward social mobility, their overall life chances, and their health.⁹ One widely accepted framework of stigma conceptualizes it as occurring at 3 different levels: structural, interpersonal, and individual.^{9,10}

Structural stigma refers to the systematic devaluation of people through institutional policies and cultural norms that limit access to important social resources. *Interpersonal stigma* refers to discriminatory actions carried out against a person due to the perpetrator's conscious or subconscious negative views about a labeled group. Finally, *individual stigma* refers to the negative beliefs individuals have about themselves due to the internalization of structural and interpersonal stigma.¹⁰ From a sociocultural perspective, stigma is believed to encourage conformity to social norms by punishing those who display attributes associated with labeled groups.⁷

Antitransgender stigma at every level is generated by institutional and cultural cissexism—an ideology that holds that cisgender people and their experiences are more natural and legitimate than those of transgender people.^{9,11} At a societal level, structural and interpersonal stigma render transgender people targets of discrimination, harassment, violence, and mistreatment in every aspect of their lives.⁹ The 2015 US Transgender Survey found that, as a whole, transgender people face alarmingly high lifetime rates of verbal harassment (46%), physical assault (9%), workplace discrimination (30%), mistreatment in primary and secondary education (77%), and mistreatment in undergraduate education (24%), as well as homelessness within the past year (12%) because of their gender identity.¹²

In health care settings, interpersonal stigma against transgender people is common. In fact, participants in the 2005-2006 Virginia Transgender Health Initiative Study reported experiencing health care discrimination more commonly than employment discrimination or housing discrimination.¹³ One-third of respondents of the 2015 US Transgender Survey who had seen a health care practitioner in the preceding year reported at least one negative health care-associated experience related to being transgender.¹² Overt acts of discrimination by clinicians include refusal of services because of gender identity, abusive language, physically aggressive treatment, and attempts to stop patients from transitioning gender.^{14,15} More insidious displays of interpersonal stigma include *misgendering* and *deadnaming* patients. Misgendering is the repeated use of gender pronouns inconsistent with a person's current gender identity (eg, using "he" or "him" when referring to a transgender woman), while deadnaming is the use of a patient's legal or former name rather than their chosen name.^{16,17,18} Clinicians also stigmatize transgender patients by asking them intrusive questions about their private lives out of personal curiosity, such as inquiring about their genitals, their sexual partners, or their sexual activity during encounters in which that information is not medically relevant.^{16,19}

Structural stigma against transgender persons within the health care system is also pervasive. One prominent example is pathologization of transgender experiences in reference works such as the *Diagnostic and Statistical Manual of Mental Disorders*.²⁰ For example, *gender dysphoria* is a miscodification that pathologizes normal gender variance and contributes to delegitimization of transgender individuals' experiences by characterizing transgender persons as mentally disordered.^{20,21} Moreover, that transgender people seeking to obtain medical interventions, such as hormone replacement therapy or gender-affirming surgery, are routinely made to undergo **psychological evaluation** before receiving treatment implies that transgender individuals are not competent enough to make these kinds of medical decisions on their own.²² Electronic health records that do not allow for accurate documentation of gender identity, gender pronouns, or chosen names also promote erasure of transgender

identities and can lead to stigmatizing experiences, such as misgendering or deadnaming.²³

Minority Stress Among Transgender People

The minority stress model developed by Ilan Meyer provides a framework for conceptualizing how stigma, prejudice, and discrimination create hostile social situations that result in higher prevalence of mental health disorders among sexual and gender minorities.²⁴ The 3 steps of this model proceed as follows: (1) hostile interpersonal interactions resulting from an individual's transgender identity create overt stress and/or physical harm; (2) the individual then learns to anticipate and watch for situations that may lead to repeated instances of stress or harm; and, eventually, (3) the individual internalizes the negative prejudices and stereotypes held by society, leading to increased psychopathology.²⁵ In other words, experiencing enacted stigma produces anticipated stigma, and both ultimately contribute to the worsening of individual stigma.

Transgender individuals who experience stigmatizing events in health care settings are more likely to delay or forgo future care out of fear of discrimination.^{1,2,13,25,26,27,28} Avoiding health care secondary to anticipated discrimination from clinicians is associated with mental health pathology, including depression, suicidal ideation, and suicide attempts.^{25,29,30} Additionally, some transgender people engage in the use of recreational substances such as alcohol, cigarettes, vaping, and marijuana to cope with emotional consequences of discrimination, including health care discrimination.^{3,25,31,32,33} New research is beginning to reveal the ways in which minority stress among transgender individuals contributes to physical disease through immune dysregulation, chronic inflammation, and elevated cortisol levels.^{34,35,36}

Minority Stress Among TPOC

TPOC experience compounded forms of minority stress due to the overlapping effects of cissexism and racism, and they are more likely to face barriers to health care access and to experience worse health outcomes than their cisgender peers of the same race.^{5,6,37} Among transgender individuals, those who hold the additional marginalized identity of being a person of color are at increased risk of experiencing overt health care discrimination because of their gender identity. Notably, they are more likely than White transgender people to be discriminated against by physicians in hospitals (26.1% vs 18.5%) and emergency rooms (16.8% vs 10.1%) and by paramedics in ambulances (8.6% vs 3.0%).⁴ TPOC are also more likely than White transgender individuals to experience discrimination when accessing social services such as mental health clinics (14.1% vs 9.1%), drug treatment centers (5.6% vs 1.9%), domestic violence shelters (9.6% vs 4.1%), and rape crisis centers (7.3% vs 3.9%).³⁸

In interpersonal interactions with clinicians, TPOC are more likely than their White counterparts to experience refusal of physical touch (18.4% vs 14.7%), to be denied medical care (28.7% vs 26.4%), to be subjected to harsh language (25.9% vs 19.7%), and to experience physically rough or abusive treatment (9.6% vs 7.3%).¹⁵ Consequently, TPOC experience a greater anticipated fear of health care discrimination.¹ Ultimately, TPOC are more likely than their White counterparts to have concerns that their gender identity will be a significant barrier to obtaining medical care (53.5% vs 51.8%).¹⁵

Recommendations

Clinicians have a responsibility to recognize the ways in which they directly contribute to the perpetuation of health disparities among transgender patients. Although action at a social and structural level will be necessary to bring about the greatest amount of change in care delivery and overall health for this patient population, **clinicians can act** at an individual level to prevent the stigmatization of transgender patients. To this end, we present several recommendations that cisgender clinicians can implement.

Signal an inclusive clinical environment. Help ease patients' fear of health care discrimination by openly communicating a commitment to gender-affirming care. Prominently display your clinic's nondiscriminatory policy indicating protection against discrimination based on gender identity. Use visual cues, such as rainbow-colored "safe space" signage on your office door, website, or work badge. Additionally, consider submitting your contact information to online directories of trans-affirming health professionals, such as Trans in the South or GLMA's online provider directory.^{39,40}

Employ gender sensitivity in communication. Recognize that language can intentionally and unintentionally lead to marginalization and stigmatization of transgender individuals.⁴¹ Train staff members to avoid using gender-specific language until they know the patient's name and pronouns.² Use affirming questions on intake paperwork, such as "What is your gender identity?" "What was your designated sex at birth?" "How do you self-identify by name and pronouns?"^{42,43,44} Respect patients by using names and pronouns with which they identify. If you use incorrect gender pronouns, offer a brief but sincere apology and correct the mistake.¹⁷ In addition to preferred name and pronouns, ask patients which words they prefer to use for their body or employ ungendered and neutral language, such as "external genitals" rather than "male genitals" or "penis."⁴⁵ Familiarize yourself with gender inclusive terminology by referencing a glossary of transgender terms.^{11,46,47,48} Avoid asking patients intrusive questions regarding genitals, sexual partners, or sexual activity. Finally, unless medically necessary, refrain from performing a genital exam, as such exams can cause significant anxiety and distress for many transgender people.

Consider multiple marginalized experiences. TPOC experience unique forms of discrimination and have worse health care access and health outcomes than their White transgender and cisgender counterparts.^{1,4,5,6,32} When caring for transgender patients with multiple marginalized identities, recognize that unless you share the same set of marginalized identities, you lack a full understanding of their circumstances and experiences.⁴⁹ Contemplate how your personal biases and lack of shared life experiences may shape your clinical decision making to the patient's detriment. Acknowledge the power differential inherent in the patient-physician relationship and relinquish some of that power by engaging the patient in shared decision making that takes their unique circumstances into account, allowing them to lead the way.⁴⁹

Engage with the transgender community. Although clinical knowledge regarding biomedical aspects of transgender care is important and necessary, it is equally important to seek out opportunities that increase your exposure to gender minority patients.¹⁴ One way to do so is by enrolling in a cultural competency training session at a local lesbian, gay, bisexual, transgender (LGBT) resource center or through an online platform such as the National LGBTQIA+ Health Education Center.⁵⁰ Collaborating with these groups in respectful and supportive ways fosters trust and helps to destigmatize transgender people.⁵¹ Although less interactive, media—such as documentaries, books,

news articles, or scholarly literature that feature transgender narratives—are also easily accessible resources for familiarizing yourself with the experiences of gender minorities.⁵²

Avoid pathologizing and gatekeeping. Recognize that, according to the World Professional Association for Transgender Health's *Standards of Care*, a diagnosis of gender dysphoria is not required for adult patients to access transition-related interventions.^{20,47} Become familiar with the difference between using gender dysphoria as a diagnostic label and to enable access to gender-affirming care, and only use it when genuinely necessary in order to avoid pathologizing transgender patients.²⁰ Implement an informed consent model for **hormone therapy initiation** instead of requiring adult patients to obtain a psychological evaluation before beginning treatment.^{22,53}

Although these steps alone will not lead to large-scale changes, they can mitigate some of the most common structural barriers that prevent many transgender patients from accessing gender-affirming care. In addition, consider how you can promote broader structural change by wielding the influence you have in positions of power—such as your seat on a medical board, your academic rank, or your connections to policymakers—to amplify the voices of transgender people. Clinicians in any capacity should feel empowered to promote equity for transgender individuals through advocacy in—and that extends beyond—their communities and their institutions.⁵¹

Conclusion

There is a wealth of evidence demonstrating that clinicians perpetuate the stigmatization of transgender patients, leading to poor health outcomes in this vulnerable population. TPOC are disproportionately affected by health care discrimination and inequity. Large-scale organizational changes that reject structural cissexism and racism, in conjunction with public health initiatives and policy changes, will be necessary to bring about the greatest degree of change for this population. Cisgender clinicians can act on a personal level and on a broader scale to prevent the stigmatization of transgender patients in health care settings.

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