SHE CAN DO IT

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ASSOCIATION OF WOMEN SURGEONS
FOUNDED 1981

ISSUE [NO.22]
GENDER-AFFIRMING HEALTHCARE

Released February, 2024. RCSI AWS Student Chapter presents 'She Can Do It' - a magazine dedicated to marginalised physicians who have made an impact in the world of medicine and surgery.

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WELCOME

Hello SCDI readers!

We are so happy you're here.

The AWS team have created this bimonthly newsletter in hopes of bringing about a comforting, informative, and inspiring place for you to dive into different topics relating to the field of medicine. SCDI features a wide range of article styles, including information-led, opinion, and expert interviews. We also encourage submissions from you, our dear readers. Take advantage of this platform to share your perspectives and hone your writing and communication skills, which are crucial to being a great physician.

What's in store this month?

As an organisation, AWS actively promotes full participation from all members of our community "regardless of race, ethnicity, gender, or sexual orientation". The AWS RCSI Chapter, specifically, recognises the significant underrepresentation of the trans* community in healthcare and the lack of understanding of their unique challenges and needs. We believe that addressing these issues requires concerted efforts to increase awareness, which would enable us to better support and advocate for gender diverse individuals. In the SCDI Issue 22, "trans*" is used throughout as an umbrella term referring to a broad range of identities within the gender identity spectrum that do not conform to the cisnormative, binary model of gender. The asterisk is a symbolic way of liberating the community from expectations and restrictions placed on their lives by the rigid societal gender norms, while highlighting how one's gender can morph and change as we grow in our humanity.

Yours truly,

Linh, Laura, Sarima & Harnoor




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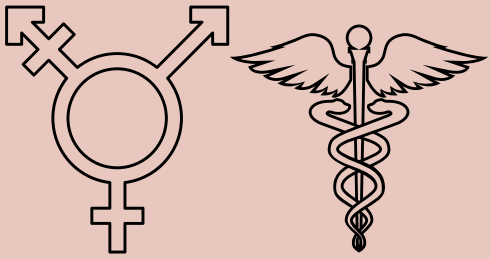


Defining Terms

Sex, Gender, & Gender Identity

Sex: Often differentiated as male and female, however there may be differences in the biological characteristics that dictate sex and the means by which they manifest.
Gender: Often centred around the social constructs that influence the expression of identities of those who identify as male, female, or gender diverse. It can impact an individual's perspective of themselves, others , and impact societal expectations and roles.
Gender Identity: Not restricted to the dichotomies in the binary of male of female. Gender identity is not stagnant and may evolve overtime.

Defining Terms & Making the Invisible Visible

Gender expansive: an umbrella term that encompasses people whose gender expression is expanded from the norms of society.

Non-binary, an additional gender identity, is considered to be an overarching term used to describe those whose gender identity does not align with the binary of male or female irrespective of the gender they were assigned at birth. Non-binary individuals may also choose to identify as gender queer. Moreover, **gender queer** is also a gender identity that describes someone who does not lay within the binary of gender and may include *those who do not identify with either male of female or identify with both.* **Gender non-conforming** describes someone whose expression of *gender deviates from the traditional societal gender norms in relation to the sex they were assigned at birth.*

Trans*: Individuals whose gender identity does not align with their sex assigned at birth.

Gender fluid: A person whose gender identity may be ever-changing or who do not identify with one specific gender.

Gender Affirming Medical Care

As described by the NHS, "Gender Dysphoria is a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity". Gender-affirming care is a means of healthcare, including medical and non-medical care, that may be used by individuals, such as those who identify as transgender, gender queer, non-binary, or gender expansive. However, it is important to note that not all trans* people experience gender dysphoria and it is often a complex and non-linear experience. Gender-affirming care is typically sought out to further support an individual's expression of their gender identity biologically, mentally, and interpersonally. Examples of gender-affirming care include counselling to support an individual as they come out to family, friends, and peers, speech therapy, hair removal, breast binding, genital tucking, padding in various areas of the body (e.g., breasts and hips), and hormone therapies (e.g., puberty blockers). Social transitioning encompasses the aspects of transitioning that may not be strictly medical, which can include coming out to oneself and to others, changing one's name, identifying with different pronouns, using a different restroom than prior to one's transition, and making physical changes to one's appearance. Ultimately, these changes help reduce the discordance one might feel between their physical bodies and their gender identity.

A Brief History of Gender-affirming Care

1 The history of gender affirming healthcare can be traced back to the **early 20th century**. During the 1920s, a German physician, **Magnus Hirschfeld** and his fellow colleagues conducted studies and carried out treatment for individuals experiencing gender dysphoria. Hirschfeld spent much of his life **advocating** for individuals from marginalised backgrounds, shedding light on the **various aspects of sexuality and gender identity** for which he was often considered beyond his time. Magnus Hirschfeld and his peers worked to gather data about people who identified as trans* from various interviews, clinical studies, and surveys. To this day, this group of scientists is considered one of the **first to identify the need for gender affirming care** for trans* individuals while emphasising the **distinctions** between gender identity and sexual orientation. In **1910**, Hirschfeld defined the term "transvestite" that has now been replaced by the term "transgender".

Magnus Hirschfeld

2 Lili Elbe was the **first person to undergo gender reassignment surgery** in **1930**. She underwent a series of 5 procedures to better align her gender expression with her gender identity.

3 In the year **1947**, Dr. **Alfred Charles** established the Institute for Sex Research at the University of Indiana. He was a professor in biology, zoology, sexology, and entomology. In 1948, at the Institute for Sex Research, he was appointed as the founding director. The Institute for Sex Research went on to conduct **research for trans* people** while also examining various gender-affirming treatments available for the community.

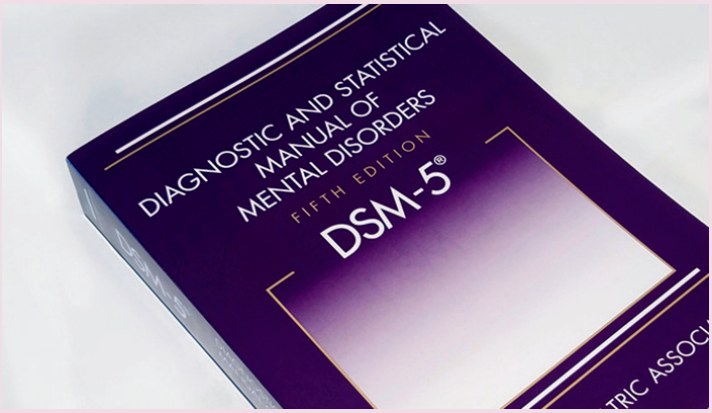
4 In **1952**, Christine Jorgensen's story about her transition made headlines in the United States as she became **one of the first people to be widely recognised by the media for her transition**. She encountered support, as well as negative coverage, from the media surrounding her story.

5 During the 1950s, Harry Benjamin assisted in the establishment of the Society for the Scientific Study of Sexuality. He went on to publish *The Transexual Phenomenon* in **1966** in which he describes individuals who identified as **transvestites were not the same as individuals who identified as homosexual**, as transvestites include heterosexual men who experience sexual pleasure from wearing clothing that may be traditionally worn by women without the desire to transition to female. Benjamin also noted the **possibility of overlap** amongst both identities.

6 In **1979** the Harry Benjamin International Gender Dysphoria Association was established. The has since been renamed to the **World Professional Association for Transgender Health** which established a **standard for the care** of individuals who identify as trans* across the world.

7 In **1980** the Diagnostic and Statistical Manual of Mental Health Disorders **added Gender Identity Disorder** which was done as a means to **increase awareness and access** to gender-affirming support for people who identify as trans*.

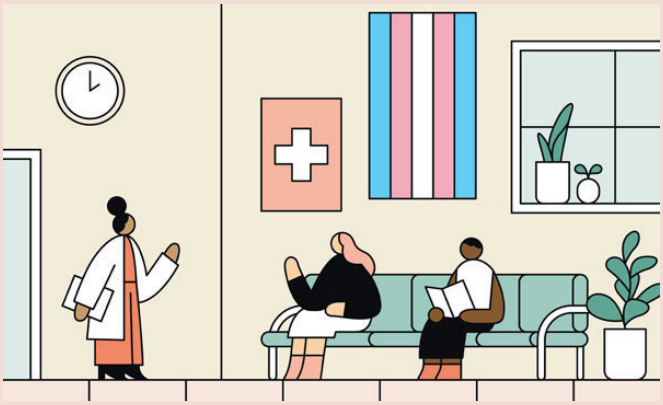
8 In **2013** the term Gender Identity Disorder was **substituted for the term Gender Dysphoria** in the latest edition of the Diagnostic and Statistical Manual of Mental Health Disorders.



9 In **2014** it was ruled by the government of the United States that it was **mandatory for medicare to include gender affirmation surgery** if it is considered medically necessary.

Medical Needs in Gender-affirming Care

There are two main medical options for gender-affirming care:"puberty blockers" which use certain types of hormones to pause pubertal development, and "hormone therapy" involving testosterone hormones for those who were assigned female at birth and oestrogen hormones for those who were assigned male at birth.



Hormone Therapy

From 16 years old, young people who have been on hormone blockers for greater than 12 months may be given cross-sex hormones, also known as gender-affirming hormones. These are a type of medicine trans* individuals can take to **cause their body to begin physically developing into the gender they identify as**. These are the synthetic versions of testosterone or oestrogen.

What Does Testosterone Do to the Body?

- Increased libido
- Vaginal dryness and thinning of vaginal walls
- Oilier skin and acne
- Increase in amount & thickness of body/facial hair
- Clitoris growth (on average 1-3 cm)
- Body fat moves from hips/thighs to tummy
- Menstrual period bleeding stops
- More red blood cells generated
- Voice deepens
- Increases in size and strength of muscles
- Head hair loss

What Does Oestrogen Do to the Body?

- Lower libido
- Fewer erections when not involved in sexual activity
- Reduced level of haemoglobin
- Softer skin and less oiliness of skin
- Less muscle bulk and less strength
- Body fat moves from tummy to hips/thighs
- Breast growth
- Smaller testicles
- Fewer sperm are produced - affects fertility
- Less hair on body and face

Puberty Blockers

A safe type medication which can temporarily pause puberty and are **fully reversible**. For trans* youth who are aware of their gender at a young age, going through puberty can **cause intense distress and dysphoria** as they experience their physical body transitioning into a gender that is not theirs. In some instances, puberty blockers may be prescribed early in puberty in order to **temporarily stop the body** from going through the unwanted physical and developmental changes of puberty. The right time to start treatment varies on a case-by-case basis, but ultimately give individuals time to continue exploring their gender identity before potentially moving on to more permanent transition-related care when they are older.

For trans* feminine

Options include:

- Gonadotropin-releasing hormone (GnRH) Therapy (injection)
- Finasteride (tablet)
- Spironolactone (tablet)
- Cyproterone (tablet)
- Bicalutamide (tablet)

For Trans* masculine

Options include:

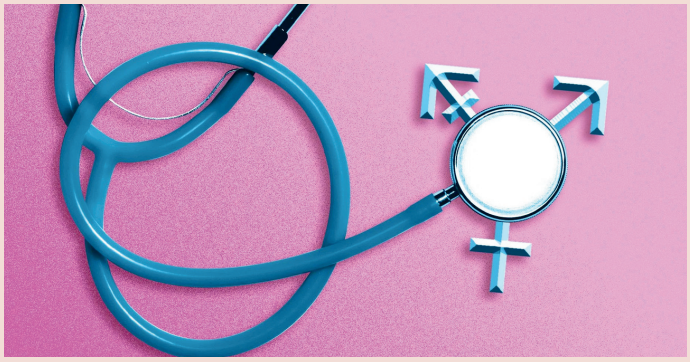
- GnRH Therapy (injection)
- Progesterone (tablet)
- Progesterone (implants/coils)

Possible side effects

Loss of libido
Low energy levels
Mood changes
Injection site reactions (redness, swelling)
Headaches
Dizziness or nausea
Joint or muscle pain

How often do you take them?

GnRH therapies are injections that are generally taken every 12 weeks, while tablets are taken daily and implants/coils can be months/years.



SURGICAL NEEDS IN GENDER-AFFIRMING CARE

Gender affirming surgery (GAS) refers to the various surgical procedures that a person may undergo to aid in transitioning to their identifying gender. This can vary from procedures, such as facial surgery to chest and genital surgery. Surgeries typically involve **enhancing or lessening physical characteristics** associated with the assigned male/female sex at birth (AMAB/AFAB).

Gender affirmation is **associated with many positive outcomes**, including better quality of life, decreased rates of mental health conditions, such as depression, anxiety, psychological distress, decreased gender dysphoria, and mitigation of stigma associated with gender presentation. Nevertheless, **not all trans* individuals experience symptoms of dysphoria** and many opt only for social transition, such as changing name, pronoun, or way of gender expression. Not all trans* individuals want or have the ability to transition medically or socially. Many **barriers to surgical care** currently exist and differ from country to country. Access is associated with **structural** barriers (insurance and waiting times), **provider** barriers (insufficient physician knowledge) or **ethical dilemmas** (preconceived judgement).

One such barrier is the **framing of gender affirming healthcare/surgery** as a treatment of a mental health disorder. The DSM-5 describes trans* individuals as being gender dysphoric. The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) advises trans* patients to obtain a letter of reference from a healthcare professional outlining their gender dysphoria. Therefore, in order for trans* people to access the surgeries they want, they **must fulfil the criteria** of being persistently gender dysphoric. This propagates the **assumption that psychological distress is an essential aspect of being trans***.

*Prior to 2011, gender affirming surgeries were **relatively rare** and undertaken by a small fraction of people. In **2011**, a US study showed that of the transgender population that was commercially health insured, only 21 people, accounting for 0.5%, had gender affirming surgery that same year.*

*By **2019**, this figure had risen to **8% (794 people)**.*

Gender affirming surgery is not performed in Irish hospitals, however the HSE can fund the expense for people to go abroad under the **Treatment Abroad Scheme (TAS)**. In order to qualify for TAS, the treatment must not be available in Ireland or not available within the time normally necessary to get it in Ireland. A patient **cannot self-refer** for this scheme, the referral must come from a consultant in a public hospital in the state. Reports show **merely 200 cases** of publicly funded gender affirming surgery have been approved under TAS between 2012 and 2020.

What are the types of gender affirming surgery?

There are three broad categories: facial reconstructive surgery, chest or "top" surgery, and genital or " bottom" surgery. Within these 3 categories, there are a broad range of procedures that can be undergone, however we are going to outline some of the most common types.

Facial Reconstructive Surgery - to make the face more feminine or more masculine
Chest or "Top" Surgery - removal or enhancement of breast tissue to become more masculine or feminine
Genital or "Bottom" Surgery - reconstruction of the genitals

Examples of gender-affirming surgeries for those assigned female at birth:

- **Chest reconstruction, breast reduction**, **hysterectomy** (removal of the uterus), **oophorectomy** (removal of the ovaries).
- **Metoidioplasty** is the use of tissue from a hormone-enlarged clitoris to surgically create a penis. It is somewhat similar to a **phalloplasty**, which uses skin tissue from elsewhere in the body to create an average sized penis, approximately 5-6 inches.
- **Scrotoplasty** procedures, typically occur alongside phalloplasties, involve reconstructing part of the labia majora into a scrotum.

Examples of gender-affirming surgeries for those assigned male at birth:

- **Orchiectomy** is the surgical removal of the testes. Alongside its use in gender-affirming healthcare, it can be performed under varied circumstances, such as treating tumors or testicular torsion.
- **Penectomy** is the surgical removal of the penis and can be partial or total.
- **Vaginoplasty** and **vulvaplasty** surgeries are done to surgically construct female external genitalia.

Post-operative care after gender affirmation care is relative to the type of surgery performed; however, it may commonly include assistance in surgical recovery, consultations with a mental health professional and physiotherapy for the pelvic floor, which may come at an additional expense.

TRANS* PERINATAL CARE

Significant reform to the provision of trans perinatal care is needed to ensure access to safe and appropriate gender-affirming care for childbearing trans* individuals.*

Conversations around maternal health issues often disregard the fact that **not all people who give birth are women**. There is a major lack of knowledge despite the growing number of trans* people who have become pregnant. Stories of their experiences call attention to the **strong association of childbearing with femaleness and the stereotypes that come with that**. It begins even before pregnancy. For many trans* people, the best and at times only sources of information about conception, accessing perinatal care, and managing lactation or chestfeeding would be **informal networks** of people with similar experiences, as **research in that area is still very limited**. Only in recent years, questions have moved from *whether* trans* people should get pregnant to focusing on **how to best meet their needs** during pregnancy and childbirth.

Apart from the **lack of individualised care** that involves taking into consideration how trans* patients understand their own bodies, their cultural expectations of pregnancy, and/or transition into parenthood, the main deficits in quality perinatal care stem from both **institutional and individual erasure**. This means that where the systems or individual healthcare providers cannot make sense of a non-woman pregnant patient, they are **treated as female regardless of their actual identity**. This ultimately causes harm, especially in the process of managing their fertility, sustaining healthy pregnancies, and accessing care during labour and delivery.

Even **after childbirth**, trans* patients not only experience the typical challenges of postpartum recovery but also the burden of healing from the emotional and psychological harm resulted from having to navigate a **highly gendered** perinatal care process. These harms can be inflicted not only by transphobic providers, but also by well-meaning providers who **lack the knowledge** and whose thinking is so influenced by gender norms that they misunderstand their patients' experiences and healthcare needs. Nevertheless, it is not sufficient to train providers on providing respectful care if the underlying systems remain blind. In hopes of promoting **individualised, holistic, and patient-centred care** for trans* people, it has been proposed that the Midwives Model of Care can be a well-suited framework to **accommodate the wide variation in trans* patient needs** and hence should be incorporated into the healthcare system more broadly.

Socioeconomic Challenges in Accessing Gender-affirming Care

Trans* individuals are amongst the most vulnerable members of society and often experience high levels of stigmatisation and marginalisation. Research shows suicidality, regular harassment and violence, and systemic discrimination are becoming increasingly common.

Economic challenges to accessing healthcare have been identified as the expense of care and onerous insurance policies. **Poor experiences** with healthcare professionals and a **lack of provider training** are significant obstacles, and many trans* people feel compelled to act as educators for their medical professionals.

Ireland was the EU's lowest-ranked country for trans healthcare in November 2022, with almost 1200 persons on the waiting list for gender-affirming care.

There are approximately 5000 patients on **the Tavistock**'s waitlist, a gender identity clinic for children in London; of those, 72 were previously referred from Ireland as of the time of validation. The clinic was **launched more than three decades ago** to help children and other young people struggling with their gender identity. However, it has instead proved to represent the **systematic failure** of an entire healthcare system stemming from **disorganisation or under-information**. For specialised psychiatric care, the HSE continues to refer children and teenagers to the NHS; however, as of November 2022, the Tavistock Clinic **no longer accepts** direct referrals. Now, a board triages all referrals to the NHS and assigns them to new facilities.

The **Gender Recognition Act** was approved by the Irish government in 2015. Gender recognition laws facilitate the process for trans* individuals **to obtain complete legal acknowledgment** of their desired gender and permit them to receive a new birth certificate reflecting this modification. Anyone over 18 years old can apply to change their gender. The process is slightly different for those aged 16 or 17 and may take longer. Under 16 years old, it is not possible to change gender that is recognised by the State.

The HSE created a **Model of Care (MoC)** for all trans* services between 2014-2016, which prompted funding for the programme. However, the HSE report in 2022 concluded that **"it is clear Ireland needs to update our MoC."** It was found that stating that there is a MoC for all trans* services is **misleading**, as it implies that all HSE trans* services in Ireland are following a single MoC, which is not the case.

There are **rarely any surgical options available in Ireland**; practically all gender-affirming procedures are sent to foreign hospitals and paid for by various government reimbursement programmes. **Concerns and worries** expressed by the trans* community are often with regard to finances, logistics, language barriers, and potential health issues after surgery when having to fly abroad for surgery.

Trans* youth are **disproportionately affected by homelessness**. Family disputes are often the main cause of young people losing their homes, and for trans* children, their gender or sexual orientation can play a major role in such conflicts. Trans* individuals may face several serious obstacles that compromise their safety, health, and general well-being if they become homeless. Some people are **pushed into survival sex** due to lack of financial support, putting their physical and mental health at danger as well as their personal safety. Furthermore, many are at an **increased risk of assault and exposure to sexually transmitted infections**. On top of **preexisting cisgender presupposition** that already permeates many healthcare agencies, the lack of a permanent home also adds to increased difficulty in receiving healthcare services, including general care, sexual and mental health.

GENDER-AFFIRMING HEALTHCARE:

ARE YOU AWARE OF YOUR BIASES?

Stigma can be defined as a set of **negative or harmful beliefs** that a society, group of people, or an individual may have about specific circumstances, character traits, or health symptoms. There are several **different types of stigma**, including structural, personal, and interpersonal. Health practitioner stigma is of particular importance in the discussion of gender affirming healthcare. As a healthcare professional, one of the most fundamental roles is to provide the best care for a patient, which involves **active listening, understanding, and non-judgment.** Stereotypes and stigmas are harmful in all healthcare situations, especially towards those deemed part of a **minority group in society**.

In gender affirming healthcare, examples of stigma may look like:

1. Having the perspective that a person **who does not conform to societal gender norms is deemed as sexually deviant or disordered** in some capacity. In 1968, the Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association supported this notion in their works, which further propagated **harmful stigma** in healthcare providers. Today, having a non-conforming gender identity is no longer viewed as a disorder, however is termed *gender dysphoria*. The **labelling of trans* people** as being gender dysphoric supports the idea that psychological distress is an essential aspect of being transgender. This can manifest as healthcare providers believing trans* people are sick and hence treat their trans* patients as being mentally unwell.

2. **Lack of health insurance** is seen at a higher rate in trans* individuals compared to the general population. This may in part be due to lower rates of employment and pay grades, potentially stemming from **employment discrimination**. In the subset of people who do have private health insurance, challenges still occur due to both **inter-personal and structural stigmas**. Full coverage may not be offered for gender affirming medical needs due to the stigma that procedures are "cosmetic," or "medically unnecessary". **Doctors may refuse to refer their patients** for essential gender affirming healthcare or surgeries because they personally believe that the procedures are **not medically necessary.** Without insurance, this leads to trans* individuals **not being able to afford** the required healthcare. Additionally, individual physicians **may refuse or are simply incapable** of treating trans* patients due to significant lack of knowledge of their health needs.

3. **Mistreatment in the healthcare setting.** Research has shown how interpersonal stigmas in the healthcare setting lead to discrimination and poor care. Of over 6000 trans* adults, **28% had experienced harassment** in medical settings, **19% were refused care**, and **2% experienced violence** in their doctor's office. Provider mistreatment can be a result of incorrect language, e.g. wrong pronouns due to a **lack of education or implicit bias**. Participants in a 2023 Dutch study, which explored barriers to gender-affirming healthcare, were asked to describe some of the encounters they have had with healthcare providers. Unsurprisingly, lack of knowledge and understanding from their healthcare professional(s) regarding their gender identity and desired gender-affirming care choices were the most common experiences recalled.

Impacts of Discrimination in Gender-affirming Care

Ra'eesah Ali, RCSI medical student

Imagine looking in the mirror. What do you see? Perhaps the way your hair lies gently on your shoulders, or minor imperfections that you judge yourself too harshly for. Most of us would not feel a sinking realization that our appearance might not match how we feel on the inside, wondering if one day we will look in the mirror and feel just right. Imagine navigating this already judgemental world with a constant sense of unease that there is a mismatch between your biological sex and your gender identity. This is a reality that many within the trans* community struggle with every day. The healthcare system, which comprises of people who swore to do no harm and to help without discrimination, has played a significant role in mentally and physically harming trans* individuals. Beating them down to the shell of their former selves, stripping what little hope left that, "hey, maybe doctors could help me."

Globally, mainstream healthcare practices have not been kind to those seeking gender-affirming healthcare. Many are met with rude comments, called delusional or mad, turned away, and laughed at by the same people who solemnly swore to do no harm. As medical students, we sit in lectures listening to how we must treat patients with respect and without discrimination, empathise with them, and find the best ways to help. If we all heard the same message in medical school, why is it that the healthcare industry, in practice, is so hostile towards trans* individuals seeking gender-affirming care?

It must be acknowledged that in many countries, the legality of gender-affirming care is still up for debate, or even flat-out banned. Those who go against these laws will be faced with cruel punishments, sometimes even the death penalty, or discriminated against by society and family. This leaves trans* individuals, especially those already struggling with gender dysphoria, with not only distress and anxiety but also feelings of fear and shame for something that is entirely out of their control. In countries that do provide gender-affirming care, there is still an overwhelming amount of hostility in the medical settings, with healthcare professionals mistreating those who come to them for help. When they finally find someone willing to guide them through their gender-affirming care, the bare minimum of what it means to be a healthcare provider, they are then met with bills for surgeries and hormone therapy of tens and thousands of euros that they have to foot themselves as gender-affirming care is not seen as essential, but as a luxury.

This is not pocket change for many trans* individuals. To make matters worse, it is exceedingly rare to find an insurance agency willing cooperate since gender-affirming care is seen as non-essential, despite the evident correlation between mental health issues resulting from lack of care. All of this just so a person can wake up, look themselves in the mirror, and feel comfortable in their own skin - a luxury that many take for granted. The World Health Organisation (WHO) states that "there is no proper health without mental health". Yet, the healthcare system makes it an astonishingly unjustifiable challenge for individuals who wish to align how they feel on the inside with what they see on the outside through means of medical care. It is absurd how even when help cannot be given at a particular institution, healthcare professionals are unequipped to provide information on where a patient could seek help. Failed by the healthcare systems, trans* individuals fall into one of the higher demographics at risk for serious mental disorders and suicide. This highlights an urgent need for gender-affirming care as a topic to be aggressively discussed and to swiftly reach solutions that make gender-affirming care accessible, affordable, and equitable.

It is evident that there are severe consequences to discrimination in gender-affirming healthcare, such as increased rates of mental health issues, substance abuse, and suicide. Healthcare providers must recognise the undeniable importance of gender-affirming care for the betterment of society. This is not a topic that should go on a back burner; everyone deserves to live a pleasant life, and healthcare settings should feel like a safe space for all, including those seeking gender-affirming care. Enquires regarding gender-affirming care should be taken seriously and medical professionals should be educated and trained to either provide help themselves, or refer patients appropriately. As with any other patient, harassment or unfair treatment of patients should be taken seriously.

Gender-affirming health care is essential health care, not a luxury. As current and future healthcare providers, we need to strive to make this industry a judgment-free zone for all; it is our job to treat without discrimination. A person should be allowed to live without mental torment. A person should be allowed to live their truth.

Fostering Trans* Inclusivity in Healthcare

The following article summarises crucial recommendations put forth by a research team working within the NHS of England, based on real-life challenges young people in the country face in accessing gender affirming therapies. A more thorough read of the full handbook is highly advised.

Through a series of Participatory Action Research workshops, the research team developed the following recommendations inviting those in healthcare to **reflect on their own practice and address the barriers** that hinder trans* people's access to medical services.

1. Be proactive in your allyship

Meaningful allyship goes beyond interpersonal solidarity. It requires thinking about 'being an ally' as an **action** rather than an identity, without being asked to or being prompted to by the presence of trans* people in the room. Many trans* people experience dismissal and invalidation in the early stages of seeking treatment. Hence, even small gestures such as **stating your own pronoun(s)** and asking others about their own can make a big difference in creating an environment where trans* people feel affirmed. Other suggestions include **actively developing trust** with your trans* patients by: reschedule if patient appears too anxious, create a comfortable space for questions or worries, **communicate clearly and directly** about every upcoming step of a physical exam.

2. Know your country's own guidelines and laws

Example: the NHS guidance on policies, such as name and gendermarker changes to NHS records, which can be done by healthcare providers to help their trans* patients avoid unnecessary distress. This is very important as it should not be up to trans* people, like any other person, to create a safe environment for themselves. As healthcare professionals, we should be more knowledgeable about their care to not only assist them in making better decisions, but also avoid undermining their trust and perceived safety. Where guidelines/laws do not allow to accommodate a person's wishes/requests, be sensitive and communicate clearly why they are ineligible – do not simply state that they are ineligible.

3. Ask only what is necessary about a person's identity (gender, race, sexuality, etc.)

Example: it is not relevant to ask about gender or sexuality when trying to determine whether they might be pregnant. The relevant question is whether they have engaged in a sexual activity that may result in pregnancy. An example of where it could be relevant to involve a person's gender is when determining what blood tests to order for particular androgens.

4. Be proactive in discussing terminology

This is particularly important with terminology used to describe/denote a person's anatomy. Suggestion: **use medical diagrams** and **gender-neutral descriptions**, when possible, during appointments to avoid language that might cause unnecessary dysphoria, distress, or anxiety. Nevertheless, even the most well-intentioned allies also make mistakes and that's okay. When that happens, **avoid centring yourself** in the conversation, **politely apologise and move on**. Making a big fuss only serves to appease our guilt and potentially putting the patient in the situation of feeling responsible for your emotions.

5. Initiate institutional changes and "earn the right to the rainbow flag"

Meaningful and sustainable changes require moving beyond interpersonal acts and **scrutinising the role bureaucratic tools,** such as treatment criteria, tick-box categories, protocols, or referral forms might play in perpetuating, reinforcing, and reproducing a system that structurally harms trans* people. To keep in mind that these are designed by human beings and **may often reflect social norms and biases** within our society.

6. Promote meaningful trans* involvement in research, service design, implementation, and delivery

Suggestion: a simple approach is to have a dedicated space for feedback from trans* patients. The intention to make your practice/hospital trans*-inclusive should be matched with a call for actions to provide appropriate training for staff at all levels.

RESOURCE LIST

IT IS OUR RESPONSIBILITY TO EDUCATE OURSELVES, SO HERE ARE SOME GOOD PLACES TO START!

ALLYSHIP

A NECESSARY WATCH

A RESOURCE FOR EVERYONE!

RECOMMENDATIONS FOR HEALTHCARE WORKERS

THE SAFE ZONE PROJECT

PFLAG

A TEACHING TOOLKIT

HISTORY

A HISTORY OF PROTECTING GENER-AFFIRMING CARE

HISTORY OF TRANS RIGHTS

A VIEWING FOR THE EVOLUTION OF TRANS RIGHTS

A HISTORY OF TRANSGENDER HEALTH CARE

HEALTHCARE NEEDS

THE NATIONAL GENDER SERVICE (NGS)

A REALLY GREAT VIDEO

TREATMENT IN THE UK

THE RAINBOW PROJECT - OPTIONS

THE NATIONAL LGBTQ+ YOUTH ORGANISATION

BOOKS/PODCASTS

THE WOMENS PODCAST

THE GENDER GP PODCAST

WHAT THE TRANS!?

TRANSITIONAL, BY MUNROE BERGDORF

THE TRANSGENDER ISSUE: AN ARGUMENT FOR JUSTICE, BY SHON FAYE

I AM A...

HEALTHCARE WORKER

• Draw on the recommendations in your day-to-day engagement with patients, colleagues, and people in your life.
• Gain a deeper understanding of the potential (mental) health consequences of existing healthcare design, practice, and referral processes.
• Distribute the recommendations far and wide, and use them as a starting point for learning and dialogue with your colleagues.
• Develop your own reflective practice and share your learning on how to improve health services for trans* people.

MEDICAL STUDENT

• Use your knowledge to argue for the importance of trans* healthcare being a fundamental part of medical training.
• Reference trans* healthcare in your essays and assignments.
• Get inspired to seek specialist knowledge on how to work with various marginalised communities that mainstream medical training does not always cater for.

RESEARCHER

• Argue for more research and funding needed for trans* healthcare research, design, and implementation.
• Reflect on the gender norms and epistemic assumptions that might underpin the research framework and design of your work.
• Get inspired to conduct more co-produced research.

QUESTIONS

Gender-affirming Care

With every SCDI issue, we invite you to engage in four thought-provoking questions relating to the topic at hand. Through this activity, we hope to spark insightful dialogue surrounding important issues, foster critical thinking, and uncover new perspectives.

How might the integration of gender-affirming care services into mainstream medical practice challenge and reshape our broader understanding of gender, identity, and healthcare as a whole?

How can education on gender-affirming care be best implemented into medical curriculum? What would you like to see change in the way that medical students learn about it?

How has the recent representation of trans* rights in the media influenced the broader national perspective on the rights to accessible gender-affirming care?

After reading this issue and with your prior knowledge, what trajectory do you believe gender-affirming healthcare is heading towards?

Let us know your thoughts at womeninsurg@rcsi.com.
Best response wins a €10 voucher!

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