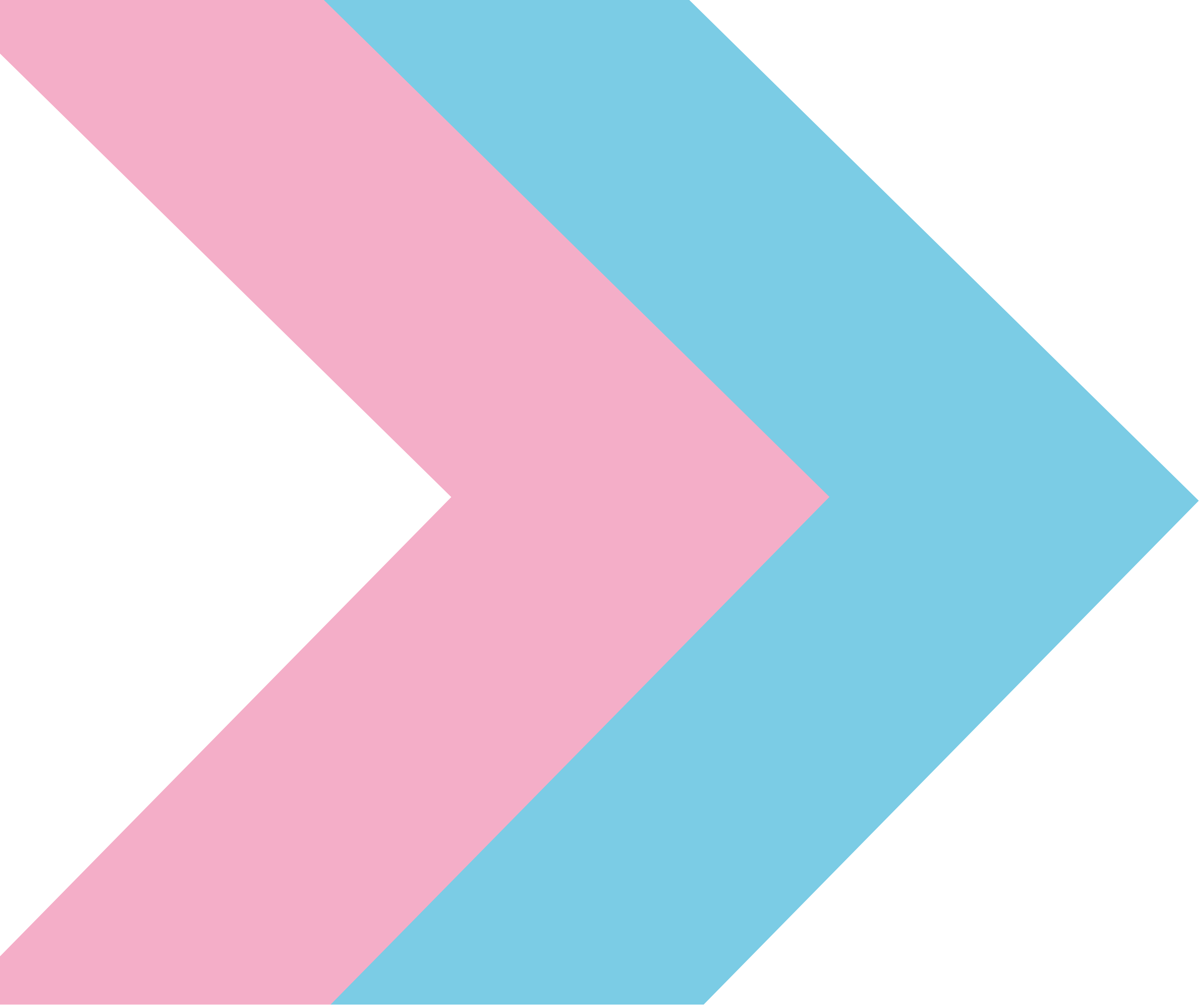

Recommendations for Trans*- Inclusive Healthcare

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gendered intelligence

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KING'S College LONDON

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Before you read on

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In the Spring of 2022, a group of trans* researchers came together to think about some of the challenges that young people face in accessing gender affirming therapies within the NHS services of England.

Through engaging in a series of Participatory Action Research workshops our research team have developed seven recommendations that invite those working in healthcare settings to examine their own practice and address the obstacles that limit young trans* people's access to medical services. We hope that these suggestions will begin a conversation and our list becomes an ever-expanding living document that can inspire change for safer environments for trans* people in healthcare settings.

While the below recommendations are primarily targeted towards healthcare workers (e.g. GPs, therapists, nurses, receptionists, researchers), we believe everyone striving to create trans*-inclusive environments would benefit from engaging with our suggestions.

Essential Glossary

Essential Glossary

trans*...

in this document is used as an umbrella term referring to a wide range of identities within the gender identity spectrum that do not conform to the cisnormative, binary model of gender. Adding the asterisk is a way to liberate ourselves from expectations and the restrictions placed on our lives by rigid societal gender norms. It symbolises how a person's gender can morph and change as we grow in our humanity.

Cisgender or cis…

refers to people who self-identify with the gender that was presumed for them at birth. Cis people can be either men or women, simply because these are the two genders that currently doctors in the UK label people at birth.

Gender affirmation…

is an umbrella term used to describe the range of actions and possibilities involved in living, surviving, and thriving as our authentic gendered selves. For a more detailed explanation please see: What is gender affirmation? — TransHub

Gender affirming therapies…

are an umbrella term for forms of gender affirmation that often requires the help of health professionals or healing practitioners. This includes (but not limited to) talking therapies, the administering of puberty-delaying drugs (gonadotropin-releasing hormone analogs), surgery, facial hair removal or interventions for the modification of speech and communication and more.

Gender dysphoria…

refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and the gender that was assigned to them at birth. Not all Trans* people experience gender dysphoria and it is often a complex and non-linear experience.

Introduction

Background

These recommendations were developed as part of the ‘Trans* Health Participatory Action Research’ Project led by River Ujhadbor, an NIHR Pre-doctoral Fellow at King’s College London. Funded by the Wellcome Trust, King’s College London’s Health Inequality Research Group and King’s Engaged Research Network in 2022, the project aimed to improve our understandings of the complex interplay between institutional processes, social environments and the mental lives of young trans* people.

For 12 weeks we shared a collective journey of Participatory Action Research (PAR) exploring our experiences of living life as a trans* person and seeking gender-affirming care on the NHS. By using arts-based and qualitative social-science methods, we mapped the obstacles young people face in attempting to access these services and we learnt about the subsequent mental-health impact of navigating these obstacles.

Why this? Why now?

This work took place at a time of increased media attention to trans* health care characterised by transphobia, debates rooted in misinformation and an escalating moral panic around gender affirming therapies including puberty delaying medication. In reality, there is no easy access to these therapies for young people on the NHS. According to the independent interim report of the Cass review[1], in October 2021 there were 4,600 children and young people on the waiting list to see a specialist with a waiting time of over two years. While it is important to acknowledge how institutional neglect and a structural underfunding of trans* healthcare have greatly contributed to a dysfunctional healthcare design for young trans* people, we believe that the answer is not to further restrict young people’s access, but to improve the quality of services and to develop gender-affirming, holistic and person-centred care for all young people.

Primary care providers are among the first institutional contact points for trans* people seeking support with their transition. Medical professionals play an essential role in young people’s journeys of medical, social and legal transition. While accessing healthcare can be a source of anxiety for many trans* people, this can be avoided by adapting a trans-inclusive and gender-affirming healthcare ethos, design and practice. These are some of the reasons why our recommendations are specifically focusing on healthcare environments and those who work across healthcare institutions.

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[1] The Cass Review (2022). Independent review of gender identity services for children and young people: Interim report. https://cass.independent-review.uk/publications/

Who are we?

While each member of the research team self-identified as trans*, making sense of our identities is always a complex and unique journey. And, of course, as researchers and human beings we don't lead one-dimensional lives. Some of us were born in different countries, some of us have never left the British Isles, some of us are white, Black, People of Colour and some of us refuse to be labelled with racialised identities. Some of us hold university degrees and some of us are finishing college. Some of us intend to enter the world of academia and some of us are committed to knowledge production as a means of community care. Some of us came from wealthy backgrounds and some of us are "fucking poor". Even though we come from many different walks of life, it is important to acknowledge that our experiences do not represent the whole trans* community. However, our findings are indicative of some of the patterns and social determinants of health that impact many trans* young people living in England.

The research workshops were facilitated by Nat Gohlan and River Újhadbor. The co-researchers on the project were Eshka Chuck, Franceska Groce, Tobey Hambley, Daisy Silverman and Lucian Wu. Academic supervision was provided by Charlotte Woodhead and Doerte Bemme, while youth work supervision was offered by Isa Sallinen.

What did we want to find out?

- What are young trans* people's experiences of seeking gender-affirming therapies in the NHS and what are the realities of the referral and treatment process?

- What social, relational and environmental factors promote resilience and thriving among young trans* people?

- What are the mental health impacts and other forms of harm inflicted on young trans* people by clinical practice and referral processes?

- How we can make visible the structural shifts needed within medical and academic institutions for improved trans* wellbeing.

Why was this approach to research so important?

Participatory Action Research (PAR) principles were at the core of the project, whereby those who are directly impacted by the findings actively shape all stages of the research process. We worked closely with the trans*-led youth work organisation, Gendered Intelligence, to identify a relevant research topic and to recruit five young trans* co-researchers aged 18 – 23 who eventually co-created the recommendations below. Gendered Intelligence's expertise in safeguarding, community ethics and community care was fundamental to the success of this project.

Who are these recommendations for?

While the below recommendations are primarily targeted towards UK primary care providers in healthcare environments (e.g. GPs, therapists, nurses, receptionists, researchers), we believe everyone striving to create trans*-inclusive environments would benefit from engaging with our suggestions.

I am a…

Healthcare worker

- Draw on these 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 these 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. Our list is not exhaustive and what might be appropriate or helpful for young people in one context differs in another.

Medical student

- Complement your medical training.
- Reference this document in your essays and assignments (see citation above).
- Get inspired to seek specialist knowledge on how to work with various marginalised communities that mainstream medical training does not always cater for.
- Use these recommendations to argue for the importance of trans* healthcare being a fundamental part of medical training.

Researcher

- Create more trans*-inclusive research environments.

- 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.

- Argue for more research and funding needed for trans* healthcare research, design and implementation.

- Reference this document in your papers and publications (see citation above).

Working in education

Educators committed to creating gender-affirming spaces can have a life-long positive impact on trans* people’s wellbeing. They are frequently the first point of contact for young people seeking support with understanding their gender identity. While these recommendations are geared towards those working in healthcare, it offers a wealth of information on how you can:

- Create more trans*-inclusive environments in other settings, including schools and educational spaces.

- Signpost young people to services that can support them in accessing gender-affirming therapies.

- Develop insight into some of the challenges young trans* people face accessing the healthcare and support they might need from you in navigating them.

None of the above, but interested in how to create trans*-inclusive spaces

Improved access to person-centred, holistic healthcare that enables patients’ bodily autonomy, self-determination and informed consent benefits us all. If you do not belong to the above categories, you can still:

- Create more trans*-inclusive environments in other settings too

- Distribute these recommendations far and wide and use them as a starting point for learning and dialogue.

Some considerations for researchers working with marginalised communities

Research exploring marginalisation all too often focuses on specific aspects of our communities (i.e. lack of agency, lack of resources, experiences of violence) and our bodies (i.e. our pain, our suffering, our health risks). While it often does so in the hope of fostering social equity, it simultaneously runs the risk of reinforcing a one-dimensional picture of our communities as damaged, hopeless and powerless. In these studies, members of the community who are directly impacted by the research are rarely invited to shape the research process and when they are offered a space to contribute, they are given space to “only speak from that space in the margin that is a sign of deprivation, a wound, an unfulfilled longing.”[2]

In an attempt to avoid reinforcing these damage-centred frameworks we took inspiration from Eve Tuck[3], who encourages a desire-focused approach that is able to grapple with the contradictions and complexity of navigating our world. We flipped the microscope to look at the ways in which healthcare settings, health institutions and the social relationships within these spaces might be damaging to young trans* people. Beside mapping the social determinants of health which are structurally harming young trans* people, our study explored the desires, ingenuity, skills and resources that our communities hold to survive and nurture spaces of radical care. We thought about what brings us joy as trans* people and what social change we need to see in this world so our communities can thrive. We imagined a healthcare system where environments, relationships and processes of treatment enable our personal and collective growth and support us in our journey of becoming our authentic selves that can flourish and lead meaningful lives.

As part of our process in answering these questions, we created a radical boardgame, a documentary and many artworks. We have found laughter, generative conflicts and ultimately more questions. We also developed the below list of recommendations to guide healthcare workers in trans*-inclusive practice so they can take back some of the burden we had to carry and ensure better access for the next generation of young people.

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[2] Hooks, b. (1989). Choosing the margin as a space of radical openness. Framework: The Journal of Cinema and Media, (pp. 36), 15-23.

[3] Tuck, E. (2009). Suspending damage: A letter to communities. Harvard educational review, 79(3), 409-428.

Our Recommendations

Recommendation 1: Be proactive in your allyship

What is proactive allyship?

Being an ally means demonstrating that you respect, understand and support trans* people. Going beyond interpersonal solidarity, meaningful allyship seeks to create a world where trans* people feel affirmed, where they can flourish and be their authentic selves.

We invite you to think about ‘being an ally’ as an action rather than an identity. Being an ally to trans* people within healthcare settings requires continuous work that involves engaging with trans* people and their experiences to create trust and to provide appropriate treatment.

Being a proactive ally means that you are taking steps to demonstrate your allyship without being asked to or being prompted to by the presence of trans* people in a space; some allyship is easier to enact than others. Ways that trust may be earned include affirming behaviour, transparent dialogue and showing you are aware of the challenging realities facing trans* people, some examples of these are given below. Pushing for more profound and structural changes at your workplace to address institutionalised, internalised and/or systemic transphobia might require more resources and commitment than the adjustments listed below; however, they are essential for sustainable and larger-scale improvements in trans* healthcare services.

Why does this help trans* people?

For trans* people to feel safer in a space, it is vital that we feel that there are people there that we can trust and rely on to respect our autonomy. When we notice that a space is aware of trans* needs without needing to seek it out, or without calling attention to us as trans* people, it helps us to feel at ease and assured that we will be respected. For example, when we see staff in a workplace using name badges that display their pronouns, this suggest to some of us that staff are aware and care about people using pronouns correctly – something that is very important to trans* people.

Being a proactive ally is crucial as there should not be a burden on trans* people to make ourselves feel safe in a space. This is because requiring us to seek reassurance that our identities will be understood and respected does not help us to feel safe. When we need to determine whether a space is trans* inclusive, we may experience anxiety and discomfort.

What can you do?

A. State your own pronoun(s) and ask others about their own

When introducing yourself, state your name and pronouns to all your patients, and ask them what pronouns they would like you to refer to them with. It shows that you understand that you cannot assume a person's gender from their appearance, and that you want to respect a person's preferences for how they are addressed and being referred to. However, keep in mind that not every trans* person feels safe or comfortable disclosing their preferred pronoun at a medical appointment.

B. Actively develop trust with your patients

Trust from patients should be not expected, but actively developed. You might not be the first medical professional that your patient has encountered in their journey of seeking gender affirming care. Unfortunately, many young trans* people experience dismissal, invalidation and disbelief during the early stages of seeking treatment. These interactions can leave us anxious, frustrated and even angry. Listen to us, even if you pick up on these underlying emotions that are the remnants of previous medical interactions. Trust can be a slow bond to build, so patience is key.

Here are some tips to help you to develop trust:

- If a young person seems distressed, anxious or concerned at the start of their appointment, offer to reschedule it. If a young person decides to go ahead with it, discuss each step of the examination with them beforehand and make sure they give full consent for you to begin.

- Create a space for the young person to ask questions and to voice any worries they might have about the procedure. If needed, discuss helpful coping strategies with your patient that can distract them from the examination (i.e. listen to music, playing on their phone, having a chaperone in the room).

- During the examination, communicate clearly and directly about every upcoming step of the examination, explain the reason behind the steps and remind the patient that they can ask you to stop or take a break at any point.

C. State that your service is trans* inclusive

To reduce the time/effort burden on trans* people, it is important that a service states explicitly that it is trans* inclusive. For example, a GP stating that it is trans* inclusive and providing guidance on how to access the anatomically appropriate screenings. First, this reassures trans* people that our needs have been considered and that we will not need to explain ourselves when we ask for particular screenings. Second, it reduces the need for us to place ourselves in situations/conversations where we may experience dysphoria owing to the need to use particular terminology or misgender ourselves when talking to staff.

D. Initiate institutional change and “earn the right to the rainbow flag”

See Recommendation 6.

Recommendation 2: Know the guidelines and laws applicable to your work

What should you know?

Having a thorough awareness of the guidelines/laws that are relevant to a patient's care is vital to ensuring their wellbeing. This is not only from a practical standpoint of administering the appropriate treatment, but also in terms of managing expectations and meeting "secondary" needs like updating official records. As such, it is important to be familiar with the NHS's own guidance on trans* healthcare, as you would be with any other NHS guidance.

The NHS provides information on the treatment pathways available for trans* people and guidance on policies such as name and gendermarker changes to NHS records – these are based on the annual World Professional Association for Transgender Health (WPATH) recommendations.

GPs should also be aware of Home Office guidance that they have the power to write letters to the Passport Office to support a person's change of name and gender marker.

Why is knowing guidelines/laws important for trans* people?

As trans* people, researching the guidance relevant to us can be a distressing and anxiety-inducing experience. This is because, when doing so, we invariably encounter information that is transphobic, humiliating and dehumanising. Some of the information is also complex and uses jargon that we may not understand. Therefore, researching guidelines/laws ourselves places a heavy emotional and intellectual burden on us. This is made worse when we are forced to research these guidelines in urgent scenarios because the professional we are seeking help from is unfamiliar with the guidance.

For example, having the wrong name and gender on an NHS record may be a cause of significant distress for a trans* person. If a GP refuses to make changes because they are unfamiliar with the NHS's guidance, this prolongs the person's distress and compels them to subject themselves to further discomfort by researching the laws themselves.

This is related to the earlier recommendation on proactive allyship – it should not be up to trans* people to make themselves feel safe. When a professional who should be more informed than us about our care is not as knowledgeable as they should be, this undermines our trust and perceived safety because it suggests they do not care enough to know how to look after us.

Having thorough knowledge of guidelines is also important from an educational standpoint. In addition to the reasons outlined above, trans* people may be unfamiliar with guidelines/laws because there is simply a lack of accessible public information. By being better informed than a patient, a primary care worker may enable a trans* person to make more informed and better decisions.

What can you do?

A. Be familiar with the NHS guidance (including name-change guidance)

Having knowledge of the treatment pathways and other guidance from the NHS is important for ensuring the patient is as informed as possible and is also not required to delve into NHS jargon. Additionally, it means that a patient will not feel that they need to argue for/defend their rights regarding name/gender marker changes.

B. Admit when you are uncertain of the guidelines/laws - and seek knowledge around them

Sometimes, when confronted with trans*-related legislation with which they are unfamiliar, healthcare staff will make up rules that they think (or feel) should exist. This is unhelpful as it misleads patients into thinking that they have fewer rights/options than they have. For example, if you do not know what the NHS guidelines are regarding name changes, admitting that you do not know but will check is by far preferable to assuming that “you need to prove your name change with official ID” - which you do not.

C. Be sensitive and clear where guidelines/laws factor into a refusal to accommodate a person’s wishes/requests

In many cases, guidelines and laws were designed with the intention of promoting the wellbeing of patients. However, these intentions are not always made explicit and at times they do not align with the best interest of your patient.

For example, it is a requirement that a patient has spent at least one year on Gender Affirming Hormone Therapy (GAHT) before being eligible for surgical treatment on the NHS. In part, this rule seeks to maximise the quality of the outcome by allowing the result of hormone-induced changes to “settle” before the surgery. The legislation, however, does not communicate this intent and appears to simply be an arbitrary time requirement. Secondly, by adopting an abstract, reductionist and binary view of gender, it fails to cater to the real-life complexity of gender identity and expression. Some trans* people may never want to be on hormones so their surgical desires look different to those that want a more cisnormative result. This is particularly relevant to non-binary trans* people who are often excluded from the thinking around healthcare in terms of “desired outcomes”.

If a patient is ineligible for surgery because of such a law, it is important to communicate why they are ineligible – not simply that they are ineligible. If the law aligns with the patient’s best interest, you should clearly explain to your patient how this will benefit their treatment. This demonstrates an understanding of a patient’s frustrations and, relatedly, a recognition of the fact that many obstacles encountered by trans* people do not exist with their interests at heart. However, if the guidelines do not align with your patient’s best interest, acknowledge the bias and assumptions embedded in guidance and legislation (e.g. the law is often based on cisnormative ideas of what post-op trans* bodies should look like) and support your patient in finding a treatment pathway that is appropriate for them.

Recommendation 3: Ask only what is necessary about a person's identity

What is “necessary” in a conversation?

Characteristics of a person's identity (their gender, race, sexuality, etc.) should only be involved when it is necessary information to guide a person's care and/or treatment. For example, if you wish to determine whether a person might be pregnant, it is not relevant to ask about their gender or sexuality. The relevant question is whether the person has engaged in a sexual activity that has the potential to cause pregnancy. An example of where it may be relevant to involve a person's gender is when determining what blood tests to order for particular androgens.

If it is necessary to obtain information about how a person identifies, it is important to clearly explain why you are asking these questions.

Why does this help trans* people?

Unnecessarily involving a person's gender may make trans* people uncomfortable, anxious, distressed or dysphoric. This is because we may be forced to use terminology that we do not identify with or feel comfortable using to explain ourselves. It may also make us feel compelled to talk about feelings that we are not comfortable with disclosing or deter us from visiting our GP for further health concerns.

By limiting questions around a person's identity to only what is necessary, the likelihood of these distressing scenarios can be limited.

What can you do?

A. Only involve a person's identity when necessary, and clearly explain why you are doing so.

Questions about a person's identity should be treated in the same manner as questions about a person's medical history. You might ask about whether a person's family has a history of skin cancer when they present with a suspicious mole, but not when they present with a persistent cough. In such a scenario, you would also explain why you are asking about their family history. The same approach should be taken with questions regarding a person's identity. Clear explanations help to reassure us that these questions are necessary and not merely idle/invasive curiosity.

B. Ask direct, rather than “euphemistic” questions.

As far as possible, questions should use language that is unambiguous and clear. For example, if you wish to determine if someone is pregnant, it is unhelpful to ask: “have you had penetrative sex?”. For one, this involves terminology a person may be uncomfortable using. For another, it assumes a heteronormative model of sex where penetrative sex is limited to strictly “penile-vaginal” intercourse. It is much less ambiguous to ask: “have you engaged in any sexual activity that may result in pregnancy?”. If a patient does not understand the question or needs you to clarify what types of activity could cause pregnancy, you can explain further. This avoids unnecessarily involving a person's gender or sexuality, while still obtaining the necessary information.

Recommendation 4: Be proactive in discussing terminology when necessary

When is it necessary to discuss terminology?

As discussed above, while involving a person's gender is often unnecessary, there may be scenarios where it is necessary. In such scenarios, it is important to clarify the terms a patient is comfortable using to describe themselves. This includes, and is particularly important, with terminology used to describe/denote a person's anatomy.

Why is discussing terminology important?

The language that we use as trans* people to describe ourselves (such as our bodies or identities) may vary. For many, it is important to use words or labels that make sense with the way we identify, as it can be affirming - and not doing so can be uncomfortable.

It is common for trans* people to be referred to by words that do not align with them. They may spend a lot of emotional energy on initiating conversations about labels or terms whilst worrying that they won’t be respected or taken seriously.

To alleviate that pressure and facilitate good communication, initiate those conversations about the terms they may wish to use, including their pronouns (as mentioned in Recommendation 2) or any terms related to anatomy, their sexuality etc.

Before talking about a specific body part, it is good to know what language a patient would prefer to name or describe that given area. For instance, someone who feels uncomfortable with hearing the word “breast” in reference to their body part may feel better with a more neutral term like “chest tissue” being used instead. Additionally, when addressing someone’s sexual health you may need information about their sexual orientation.

Thus, talking about terms prepares you to treat the patient with respect for their identity during all consultations regarding any matter.

What can you do?

A. Use diagrams when discussing anatomy

By using medical diagrams during appointments you can avoid using language that might cause unnecessary dysphoria, distress or anxiety to your patients. These can also help you to be more accurate and clear in your communication with your patient.

B. Use gender-neutral descriptions when possible

All human genitalia develops from the same undifferentiated embryonic tissues and so some of these homologous structures share characteristics that do not need to be gendered when referred to. Additionally, if you are referring to an area of your patient's body parts, use the appropriate and specific term to describe it e.g. epididymis, testis etc. Again, take the patient’s lead in using their preferred vocabulary.

C. Spell/write out deadnames/genders

Some young people may decide not to use their legal name any longer and choose a name instead that better aligns with their gender identity. In these cases the legal name symbolically “dies” and becomes what we call a “deadname”. When you call a trans* person by the name that they no longer use despite being asked not to, it is an act of “deadnaming”. Using trans* people's deadnames is an explicit sign that you do not respect their autonomy and gender identity.

Due to gender essentialism being ingrained in the current medical system, sometimes it is required for young people to provide their “deadname” in order to proceed with their treatment. To lessen the distress and dysphoria some trans* people experience when asked to say their deadname or assigned gender out loud, your patient might find it helpful to spell out or write these down instead.

D. Avoid centring yourself in conversations with trans* patients

Treat your trans* patients with respect rather than with curiosity. Avoid treating trans* patients as medical learning opportunities. Centre your patient's needs and concerns during consultations instead of using the space to reflect on your own gender identity and/or expression.

Regardless of intentions, allies also make mistakes and that's okay. This is how we often learn. If you make a mistake like calling your patient by their deadname or you use the wrong pronouns when referring to them, just politely apologise and move on. Making a big fuss only serves to appease your guilt, and puts the patient in the situation of feeling responsible for your emotions. However, moving on minimises the harm caused to your patient.

Recommendation 5: Avoid debates on the validity of transness

What is “debate"?

Debates on transness such as: “Are trans* people real?”; “Should I have to use someone’s pronouns?”; or “Can a trans man ever be a real man?” all question the validity of trans* identities in a way that undermines our autonomy and our right to self-determination.

In mainstream media, amplifying transphobic views and hate speech are often framed as ‘debate’. It is not only harmful, but it is also unethical to debate human rights and people’s lived experience. A ‘debate’ on trans* self-determination is not neutral or objective. It maintains and reinforces a structure and culture of domination that is harming and killing trans* people.

In public ‘debates’ trans* individuals are often platformed with those who call themselves ‘gender critical’ - many of whom believes that someone’s sex is binary and immutable and as a result deny trans* people the right to be recognised and live as their authentic self. Their argument on trans* lives not only dehumanises the trans* person who is participating in the ‘debate’ but sends the message to the wider trans* community that we should not exist.

The stakes and results of these ‘conversations’ are incredibly unequal and, in their consequences, deeply damaging to trans* people.

Why is debate harmful for trans* people?

The aim of creating a stress-free environment can only be met if we are free from the burden of defending our gender identity or expression. Being repeatedly exposed to needless interrogation is a strain on anyone’s mental wellbeing - and can result in the mind being in a constant state of stress. Thus, it can be dangerous when conversations involve debates on transness. For instance, a patient could state their sex/gender identity to you as “non-conforming”. You might need to ask necessary questions for clarification if it concerns the trans* person's treatment or affects the services they receive (i.e. if you need information on their anatomy or reproductive system). However, an irresponsible comment would be to insist that they “can only be male or female”, as it pressures them to pick from two identities that aren’t authentic; and implies that non-conformity is not right. Vitally, it reinforces the false concept of a sex binary or gender binary.

Additionally, having debates on trans* people in our absence can be just as harmful, as it perpetuates disrespectful rhetoric that marginalises people who are not cis.

Our word on our gender is final; there is no need to doubt the validity of our identity.

What can you do?

A. Don't start 'debates'

B. Shut down or deescalate debates and direct people to sources where they can learn about gender diversity

C. Be conscious to question the potential harms of what you see and hear in the media or online.

You can use the browsing tool "Shinigami Eyes" that highlights websites and Facebook pages with different colours based on whether they're reported to be transphobic or trans*-friendly. (See resources section). Of course, it doesn't have to dictate what media you consume, as it's best to learn about transness from the source: trans* people.

Recommendation 6: Initiate institutional change and “earn the right to the rainbow flag”

Trans* health care should be an integral part of medical training as well as staff induction to healthcare settings. However, this is rarely the case. Therefore the intention to make your GP practice trans*-inclusive should be matched with a call for or actions to provide appropriate training for staff at all levels on trans*-inclusive practice and healthcare. The learning will not only make your practice more inclusive but will benefit your cis patients and your work environment, too.

To bring about meaningful and sustainable change, allies need to move beyond interpersonal acts and scrutinise the role bureaucratic tools like treatment criteria, protocols or referral forms might play in reinforcing, perpetuating and reproducing a system that structurally harms young people. Tick-box categories, healthcare protocols or treatment processes are never value-free. They are designed by human beings and they often reflect the social norms, biases and power relations that exist in our society. Implicit and explicit assumptions are embedded in them about pathology, credibility and ideas around deficit.

How is this harming young people?

Transitioning is a very human experience, but pathologising this experience turns us into a checklist of very specific characteristics and traits that one must meet in order to be deemed eligible to have the right to transition. This is problematic, because it assumes that there is only one correct way to transition and that there is a uniform box to fit into in order to access treatment. Gender identity and presentation might be shaped by the person’s cultural heritage and the social acceptability of transgressing certain aspects of gender norms can vary from community to community.

Growing up in a world where transphobia is rife can make it challenging for a young person to embrace their diverse gender identity or expression. It takes an enormous amount of courage, self-determination and, often, a supportive family to even just make our first appointment with our GP to explore the options in seeking gender affirming care. There are certain vulnerabilities inherent in being a patient seeking necessary therapies. Having to time and time again deny your authentic self to fit into the cis-binary boxes that will get you the needed genderaffirming therapies is distressing, anxiety-provoking and confusing.

For example, some young people's gender identity might not conform to the binary categories of male and female. If this young person attempted to describe the complex and fluid ways in which they see their gender to their health practitioner, they might risk their access to gender affirming therapies. This binary view on gender is not only inaccurate, but it is harmful as it cannot cater to the nuanced needs of many trans* people and it further stigmatises retransitioning.

At the moment there is an average wait time of two years for getting your first appointment to see a specialist after being referred by your GP to the NHS's Gender Identity Development Services (GIDS). Even after being seen by a specialist, many young people do not qualify for gender affirming care and for some young people the delay in treatment means that they end up needing surgical interventions that could have been avoided with appropriate and timely care. During the wait period there is barely any support or gender affirming therapy available to young people. These wait times are not inevitable, but a systemic shortcoming that reflects societal priorities.

What can you do?

A. Demand and work towards structural change

Fortunately, these systems can be critically examined, evaluated and redesigned so they enable the best possible health outcomes for young people. Fight for making these changes at all levels and encourage the inclusion of trans* led collectives and organisations who have expertise in this area.

B. Take direct action

When you see an opportunity to make your practice trans*-inclusive, act on it.
For example, it does not require much resource to create at least one All-Gender bathroom at your practice or to put sanitary bins in the men’s bathroom. You could highlight the importance to your practice’s management and campaign (if needed) to make toilets accessible to all genders. But don’t stop at changing a toilet sign! When you don't see an opportunity, seek it out. Inaction and remaining silent are still actions that reinforce some of the structural harms perpetuated by the current medical system.

C. Support the development of ‘informed consent model for trans healthcare’ appropriate to your patients’ age and understanding

An informed consent model to trans healthcare is rooted in the concept of ‘informed consent’ where clinicians are expected to effectively communicate about care options available, so they can assist patients to make informed decisions. This process includes the clear outlining of the risks and benefits of the recommended treatment pathway as well as the presenting of reasonable alternatives to that care option. This approach is the ethical and legal basis for most patient care decisions.

The informed consent model in the context of trans healthcare centres patient's autonomy and self-determination. It seeks to create a more effective and patient-centred referral process and treatment pathway based on the patient's and clinician's collaborative determination of the best available care option, but without the requirement of external evaluations, diagnosis or therapy by mental health professionals. [4] [5]

When thinking about the gender affirming care of under aged young trans people, worries around the capacity to make such decisions are often brought up. Fortunately, the NHS has a well-established test to assess whether a young person under 16 is mature enough to consent to treatment called Gillick competency.

While the informed consent model has been implemented across many trans healthcare clinics in the US and Canada with promising results[6], the research and evaluation of the service design is limited and remains structurally under-resourced. More funding is needed so the research, development and evaluation of this model is made possible.

D. Learn to recognise, name and acknowledge institutional transphobia

In the meantime, when talking to a young person, make sure that you acknowledge the transphobia embedded in the medical form/treatment plan/access criteria, explain what is the significance of this step in accessing the therapy they need and support them through engaging with it as best as you can.

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[4] Cavanaugh, T., Hopwood, R., & Lambert, C. Informed consent in the medical care of transgender and gender-nonconforming patients. AMA journal of ethics, 18(11), 1147-1155.

[5] Schulz, S. L. (2018). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. Journal of humanistic psychology, 58(1), 72-92.

[6] Deutsch, M. B. (2012). Use of the informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of selected clinics. International Journal of Transgenderism, 13(3), 140-146.

Recommendation 7: Meaningful trans* involvement in research, service design, implementation and service delivery

Historically, trans* people have been excluded from health research, design and delivery of services and treatments that directly impact them, and especially from leadership roles. Expertise rooted in the lived realities and experiences of growing up as trans* have time and time again been sidelined and devalued within academic hierarchies of knowledge. When trans* people are invited to contribute to research, they are often given voluntary, low-paid or tokenistic roles without substantial decision-making power. Participatory projects or Public Patient Involvement (PPI) often function as add-ons to the main research project that does not meaningfully involve the stakeholder community.

Why should we involve trans* people in health research, service design and delivery?

The systemic marginalisation of theories, methods and perspectives by the cis, white and male dominated academic realm has resulted in an epistemic bias and blind spots in medical knowledge on trans* health and wellbeing. Reflection on positionality and the inclusion of multiple perspectives from the missing vantage points of stakeholder community members is not only more ethical but makes for better research.

As the above sections have described, most trans* people have done so much research and advocacy that they become an expert on their own experiences and develop an in-depth critical understanding of the avoidable structural and interpersonal transphobia embedded in our care system.

Building on trans* people's wealth of knowledge, experience and wisdom could not only shed light on the blind spots that exist in trans* healthcare research, but contribute to a more nuanced, appropriate and efficient intervention design and delivery where young people don’t have to become bureaucratic experts on the bureaucracies that manage, harm and alienate them.

What can you do?

A. Have a dedicated space for feedback from trans* patients

Listen to us so you can gain a better understanding of your patients and how to treat them. Ensure easy access to different platforms catering to a spectrum of abilities and neurodivergence. Ensure that the questions and the feedback environment are explicitly trans* positive, otherwise you might find that it deters trans* people from investing time and energy in offering you suggestions. Employ trans* people to design and evaluate this feedback and to implement these changes.

Don't waste your and our time by asking for feedback without resources to implement those. It will create mistrust and jeopardise other more meaningful feedback processes.

B. Include trans* people at every level and at every stage

Hire trans* people in decision-making positions in all areas and seniority levels within healthcare, including health research, research ethics committees and funding bodies. Salaries for these roles should not differ from other roles with the same level of responsibility filled by cis people.

If there are not enough trans* people to fill these posts, offer training or scholarships to trans* people.

C. Avoid tokenism

It can be extremely exhausting and even harmful to be the only trans* person (especially if you also belong to other marginalised communities) in organisations where anti-oppression work is not built into the foundations of its structure, workplace culture and project designs. In these spaces we can feel like we are being held hostage to mechanisms that invite marginalised people to speak and critique the institutions that have been created, maintained and reproduced by these very mechanisms.

Anti-oppression work, co-production and engagement with the communities directly impacted by your work should never be just an "add-on" project to your research or service, but integral to every aspect of your work, collaborations and relationships.

Don't assume that just because someone self-identifies as belonging to a marginalised group that they are experts on anti-oppression work, on how to tackle the lack of oppression awareness of their colleagues or on how to reform structurally oppressive institutions (an impossible task).

D. Avoid homogenising trans* people

Our communities are not one-dimensional and those of us who are navigating intersecting oppressions and barriers in our lives are especially underrepresented in leadership and research roles. Racism, transmisogyny, classism and ableism are just four of those unjust social structures that systematically reduce marginalised trans* communities' life opportunities and access to resources even further. Be reflective about how various forms of intersecting identities might shape the experiences of trans* people and make sure this understanding informs the constitution of your research team.

E. Create support structures within your practice/organisation for those self-identifying with one (or more) marginalised identities

Being the only trans* person at your workplace can be emotionally and physically taxing even if your workplace has committed itself to develop a practice and environment rooted in an anti-oppression framework.

Develop a holistic, person-centred support plan to ensure the wellbeing of your colleagues or the members of your collective. This should always be designed in dialogue and be based on self-reported needs.

If your colleagues or members of your collective are already engaging in ongoing mutual support with each other to cope with the structural or interpersonal harm at their workplace rooted in oppression, acknowledge this work and allocate protected time for this often informal support to take place within their working hours.

In supervisions (or during equivalent non-hierarchical practices) be proactive and check-in about your colleague’s wellbeing related to their potential experiences of marginalisation.

F. Facilitate or enable co-produced research

Co-production in research is an approach that involves academic and non-academic researchers from the stakeholder community working together to design, conduct and analyse research as well as to disseminate their findings. It is characterised by a working structure that strives for the levelling of power hierarchies by valuing the multiplicity of knowledge practices, by sharing power, resources and responsibility within the research team and by the co-ownership of research findings.

Participatory Action Research (PAR) is a co-production methodology and is used as an umbrella term to describe a wide range of participatory approaches to action-oriented research. It is a collaborative process of research, education and action working towards liberatory social transformation[7].

A co-produced research process mitigates some of the dangers caused by ignorance over the lived realities of the stakeholder community. Having a research team with a wide range of lived experiences provides access to a broader range of perspectives and ideas, as well as supporting a more effective dissemination of results within the stakeholder community.

Co-produced research using PAR methodology values and actively seeks a plurality of perspectives. It represents a commitment to centring marginalised voices, understanding that people hold deep knowledge about 'their lives and experiences, and should help shape the questions, and frame the interpretations of research'[8].

Health inequity has been linked to oppression and marginalisation in society [9] [10]. As participation carries with it feelings of ownership, PAR methodology builds a strong base for acting on its findings and problem-oriented interventions within the community, an imperative for long-term and sustainable improvement of mental health within the stakeholder community [11]. Ideally, in co-produced research academic and community partners work collaboratively throughout each step of the research process.

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[7] Kindon, S., Pain, R., & Kesby, M. (Eds.). (2007). Participatory action research approaches and methods: Connecting people, participation and place (Vol. 22). Routledge.

[8] Torre, Maria E. and Michelle Fine. 2006. Participatory Action Research (PAR) by Youth. In, Lonnie Sherrod (ed.) Youth Activism: An International Encyclopaedia. Westport, CT: Greenwood Publishing Group, (pp. 363).

[9] Marmot, M. (2005). Social determinants of health inequalities. The Lancet, 365(9464), 1099-1104.

[10] Rose, N., Manning, N., Bentall, R., Bhui, K., Burgess, R., Carr, S., Cornish, F., Devakumar, D., Dowd, J. B., Ecks, S., Faulkner, A., Ruck Keene, A., Kirkbride, J., Knapp, M., Lovell, A. M., Martin, P., Moncrieff, J., Parr, H., Pickersgill, M., Richardson, G., … Sheard, S. (2020). The social underpinnings of mental distress in the time of COVID-19 - time for urgent action. Wellcome open research, 5, 166. https://doi.org/10.12688/wellcomeopenres.16123.1

[11] Israel, B.A., Schulz, A.J., Parker, E.A., & Becker, A.B. (1998). Review of Community- Based Research: Assessing Partnership Approaches to Improve Public Health. Annual Review of Public Health, 191(1), 173-202.

Fragments of a resource list

Helpful links

You can find a comprehensive list of resources for young people, families and professionals at the website of Gendered Intelligence:
https://genderedintelligence.co.uk/support/families-resources.html

If you would like to read more about some of the concepts and language used throughout this document: https://www.transhub.org.au/101

Affirmative care for non-binary people:
https://www.lgbtqiahealtheducation.org/wp-content/uploads/2017/02/Providing-Affirmative-Care-for-People-with-Non-Binary-Gender-Identities.pdf

The Cass Review (2022). Independent review of gender identity services for children and young people: Interim report. https://cass.independent-review.uk/publications/

Current wait times for gender affirming therapies across the UK:
https://genderkit.org.uk/resources/wait-times/

The official website and shop of Alok Vaid-Menon, an internationally renowned gender non-conforming writer and performance artist. https://www.alokvmenon.com/

Shinigami Eyes - a Google Chrome extenstion that highlights transphobic / anti-LGBT and trans-friendly subreddits / users / Facebook pages / groups with different colors:
https://chrome.google.com/webstore/detail/shinigami-eyes/ijcpiojgefnkmcadacmacogglhjdjphj?hl=en

Edinburgh ATH Trans Health Manifesto:
https://edinburghath.tumblr.com/post/163521055802/trans-health-manifesto

The Trans Justice Syllabus https://s4tj.com/transjusticesyllabus/

McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). Trans mental health study 2012. Scottish Transgender Alliance. Available at: https://www.scottishtrans.org/wp-content/uploads/2013/03/trans_mh_study.pdf

Levi Hord and Kirrin Medcalf (2022) Trans People's Experience of Healthcare in England. A community engagement report from the TRANSforming futures partnership. Available online: https://www.transformingfuturespartnership.co.uk/healthcare

Some books we found useful

Boag, P. (2011). Re-dressing America’s frontier past. University of California Press.

Choudrey, S. (2022). Supporting Trans People of Colour: How to Make Your Practice Inclusive. Jessica Kingsley Publishers.

Gill-Peterson, J. (2018). Histories of the transgender child. University of Minnesota Press.

Gilley, B. J., Masullo, G. (2022) Non-Binary Family Configurations: Intersections of Queerness and Homonormativity. Springer Nature.

Pearce, R. (2018) Understanding trans health: Discourse, power and possibility. Policy Press, 2018.

Rahilly, E. (2020). Trans-Affirmative Parenting: Raising Kids Across the Gender Spectrum. New York, NY: New York University Press.

Schuller, K. (2018). The biopolitics of feeling: Race, sex, and science in the nineteenth century. Duke University Press.

Shuster, S. M. (2021). Trans medicine: The emergence and practice of treating gender. NYU Press.

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