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Medical Schools Lack Cultural Competency for Transgender and Gender-Nonconforming Individuals

I am a cisgender, heterosexual woman, meaning I identify with the sex I was assigned at birth. I identify as female and my physical features reflect that. When I walk down the street, I have the privilege of not worrying about how my gender representation or gender identity will impact how I am perceived by others. This also means when I walk into a doctor's office to see my primary care physician for strep throat, I don't think twice about how my gender will affect my treatment. Consider a transgender patient who walks into their physician's office for pneumonia; rather than attending to the health issue at hand, the health care provider invasively redirects the conversation to the patient's sexual practices. According to The Report of the 2015 U.S. Transgender Survey conducted by The National Center for Transgender Equality, this is not uncommon. According to the survey 33% of participants disclosed, "at least one negative experience with a health care provided in the past year related to being transgender,"((National Center for Transgender Equality, 2015). These experiences ranged from being denied treatment, to verbal discrimination, to needing to educate their provider on transgender issues before receiving proper health care. From the same study, 23% of participants reported they, " did not see a doctor when they needed to because of fear of being mistreated as a transgender person in the past year." Furthermore 50% of respondents reported "having to educate their healthcare provider about their transgender identity." According to Dr. Juno Obedin-Maliver in an article for the *Journal of the American Medical Association*, as of 2011, only roughly one third of U.S. medical schools have addressed transgender health-care issues in some way. With these statistics

in mind, it is clear this issue is largely rooted in insufficient medical education with regards to transgender and gender non-conforming health issues.

In 2005, to address the issue of biases, discrimination, and stigma produced by providers in healthcare delivery, The Association of American Medical Colleges (AAMC) released the document, *Cultural Competence Education for Medical Students,* to help guide medical schools in adapting education in cultural competence into undergraduate medical curriculum. In this document, they provide definitions of cultural competence and cultural competence in healthcare. Also included in the document is the Tool for Assessing Cultural Competence Training (TACCT), which is an outline of recommendations for curriculum content learning goals and how to evaluate student comprehension of them at the end of the program. This instrument is broken into five parts called domains: Cultural Competence—Rationale, Context, and Definition, Key Aspects of Cultural Competence, Understanding the Impact of Stereotyping on Medical Decision-Making, Health Disparities and Factors Influencing Health, and Cross-Cultural Clinical Skills. In 2012, for reasons unexplained by the AAMC, the document was revised in, *Cultural Competence Education for Students in Medicine and Public Health,* with slight revision to some of the comprehension goals for students. Despite revisions, in reference to the definition of cultural competence, the AAMC focuses primarily on the terms "race", "ethnicity", and "culture," both in their definition of cultural competency as well as in their education assessments. And, unfortunately, while mentioning the term, "gender", occasionally, these documents are not comprehensive enough to be applied to the unique discrimination and stigma experienced by transgender and gender non-conforming patients when seeking health care. By analyzing language used in the AAMC's TACCT, it is clear the best way to eliminate stigmatizing practices by health providers and to improve health outcomes for transgender health

users in the United States is to adopt a culturally competent model of transgender issues in medical training.

A Clarification of Terminology

To fully understand this issue there are a couple terms that need clarification. The most relevant to clarify is gender, and gender as it relates to the umbrella term, transgender. Unfortunately, a confusing element to understanding issues of gender diversity, is the rapid emergence of LGBTQ (Lesbian Gay Bisexual Transgender Queer) language paralleled against the much more gradual pace of U.S. society to adapt. The most common way people conceptualize gender is through the *gender binary*. A binary is anything composed of two parts. The *gender binary* refers to the way gender is typically conceptualized: female/male. This binary is often and incorrectly conflated with other concepts in American society like sexual orientation and sex. It is important to distinguish gender identity from gender expression. Gender identity refers to your "internal sense" of gender, whether you internally identify with being female, male, a combination, or neither. Gender expression refers only to the way you physically express or present your gender whether that be through the sound of your voice or the way you dress, for example (TSER, 2017). These features are typically described as being feminine or masculine. Sexual orientation refers to who you are attracted to physically, romantically, or emotionally. It, in no way is determined by the gender you identify with. This means just because you identify as female, does not inherently mean you are attracted to males. And sex refers specifically to the genitalia you poses. And your sex does not have to align with the gender you identify with or express. Now, while there are many other terms to describe gender, two of the most general terms referring to identities of gender diversity are transgender and gender non-conforming (TGNC). The definition of transgender as I use it throughout this paper is, "an umbrella term for

people whose gender identity differs from the sex they were assigned at birth,"(TSER, 2017). And gender non-conforming is a term used to describe individuals who experience gender identity and gender expression outside of the gender binary.

The other concept central to understanding this issue is cultural competency. Cultural competency encapsulates, "awareness, attitude, knowledge, skills, behaviors, policies, procedures, and organizational systems," and is applied through the ability to understand and interact with populations of different backgrounds (Wilkinson, 2015). While, historically in the education of healthcare providers, cultural competency has usually encapsulated issues of only race and ethnicity, cultural competency can be applied to any social category.

Although the concept of "gender" is referenced specifically several times in these documents, when it is included in the definition of cultural competence and in the TACCT tool, it focuses on the narrow understanding of gender as binary, leading to a misunderstanding communicated to providers, of the diversity within gender identity as it relates to TGNC individuals. Gender is first found in the document, *Cultural Competency Education for Medical Students* released by the AAMC, in the definition of cultural competency. The authors cite the cultural competence standard using the language of the Liaison Committee on Medical Education (LCME):

> "The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient."

Next, in the section that outlines the TACCT content domains, gender is indicated a second time via the pronouns, "his/her" in this quote from the last bullet point describing *Domain II: Key Aspects of Cultural Competence,* "Information on the history of the patient and his/her

community of people,"(AAMC, 2005). And a final time in this document, in *Domain V: Cross-Cultural Clinical Skills,* " Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, and class," (AAMC, 2005). In a later section, *Developing and Implementing A Cultural Competence Curriculum,* in which the domains are explained in even further detail, the concept of "gender", is missing altogether from both domains, *II* and *V*. A couple major themes stand out in the evaluation of these excerpts. Most importantly, the term gender is used sparingly and inconsistently throughout the document, both in the definition of cultural competency, but also in the domain descriptions. Additionally, the fact the authors never explicitly describe gender as a diverse concept inclusive to TGNC individuals, and they use "he/she" in *Domain II,* gives the perception the authors are only referring to gender in terms of the normative binary explained earlier. Because medical education relies so heavily on a discourse of the gender binary to teach subjects like anatomy or gender specific diseases such as testicular cancer in males, if gender is left out of cultural competency and gender diversity is not distinguished from the gender binary, TGNC individuals can be left vulnerable to health disparities and discrimination inflicted by their provider. Consider the example reported in a study of health disparities for transgender individuals, in which researchers found transgender men who still possess their female genitalia from birth, face a barrier to basic gynecological care due to the assumption by health providers that patient genitalia is congruent with their gender identity (Lerner and Robles, 2015). According to a 2015 report on Transgender individuals and HIV by the World Health Organization (WHO), this is particularly problematic, because as a result of these kinds of assumptions, risk of uterine, cervical, and ovarian cancer among transgender men with female genital anatomy are significantly higher (WHO, 2015). An additional component important to understanding gender variance beyond the binary as it is

constructed most frequently in society, is the importance of proper pronoun usage, especially for transgender and gender non-conforming individuals. Pronouns are identifying words that refer to an individual in place of their name, and they are typically gendered. It may be obvious, the most common pronouns include he/him/his to refer to someone who identifies as male and she/her/hers to refer to someone who identifies as female. But, for those who identify outside of the binary, there are a wide variety of other pronouns they might use such as, they/them/theirs or xe/xem/xyrs. Generally, because medical documents include a box to identify sex, with the options male or female and, exclude gender identity, providers may make the assumption to use pronouns that correlate with the identified sex. For a TGNC person who prefers an alternative set of pronouns or who uses pronouns that do not appear to match their gender expression, a provider who assumes pronoun usage, rather than asking the patient's preference, risks disrespecting the patient. In a national survey on transgender discrimination, The Center for Transgender Equality reported these kinds of assumptions can influence the accessibility of healthcare for transgender men. About 20% of transgender men avoid healthcare due to being "misgendered" by healthcare providers and nearly 50% delay or refuse to seek preventative care for fear of being treated negatively (NCTE, 2012). If your gender identity aligns with the sex you were assigned at birth, and people perceive you in this same way, it can be difficult to conceptualize why assumptions regarding someone's genitalia or their pronoun usage based on the sex marked on their medical records could be problematic; but, as the statistics reveal, for TGNC people, when medical professionals make assumptions based on the gender binary, healthcare can become something that causes more harm than benefit.

Despite a revision to the document in 2012, students are supposed to be able to define cultural diversity including language, sexual identity, age, race, ethnicity, disability,

socioeconomics, and education, but not gender, further leading to a misunderstanding of what it means to be transgender. With the assistance of an expert panel, AAMC revised the TACCT and wrote a new curriculum guide that could be applied to both medical schools and now public health schools. This was an important revision because the learning objectives outlined for students in relation to cultural competency changed. Under the student learning objectives section of the document, *Cultural Competencies Common to Medical and Public Health Students,* no longer are learning objectives organized by domains, they now are broken into three categories with about 15 goals for each: knowledge (cognitive competencies), skills (practice competencies), and attitudes (Values/beliefs competencies). The first objective under cognitive competencies requires the ability to understand a working definition of different cultural competencies from which to build all other studies, skills and practices from. The language of the document is as follows, "At the completion of the program of study, students will be able to: Define cultural diversity including language, sexual identity, age, race, ethnicity, disability, socioeconomics, and education," (AAMC, 2012). Of all the learning objectives, this is the only one which includes specific social categories cultural competency should be applied to. Because they list "sexual identity", it is in this learning objective, a term describing gender identity, as well as sex for that matter, should be listed. In one way, the specific language, "sexual identity" to most likely describe *sexual orientation* is outdated, and some may argue is inaccurate. Someone can identify with gender, because *gender identity* refers to a perception of oneself. *Sexual orientation* is a more accurate term because sexuality in American culture is typically defined, not by the individual alone, but by the sex or gender identity of the person they are attracted to. Therefore, to use the language, "sexual identity," to describe attraction is especially confusing, when trying to distinguish a concept like *sexual orientation* from *gender identity*.

It is also important to note, the concept of gender identity or gender diversity is completely absent from this revised document. This is problematic because it is inconsistent with the older version of this document, making the definition of cultural competency even more unclear. Like the language being confusing, this is also problematic because, in the absence of gender identity, the listing of "sexual identity" related cultural diversity risks that medical students may confuse *sexual orientation* and *gender identity* as the same. This has been a common misconception in the medical context since the 1800's when homosexuality, initially understood as a pathology, was first conceptualized as gender inversion, or reversal of gender traits, (Stryker, 2009). As mentioned earlier, although homosexuality is not still defined as gender-inversion, this is still a common mistake within American culture, and within the culture of medicine. If a medical student cannot not define gender identity and diversity, they cannot understand terms like "transgender" or "gender non-conforming". There is stark evidence of this across several recent studies. In one study, researchers examined all research done on transgender healthcare in the last 10 years that focused on the perspectives of TGNC patients. An overarching theme across all the studies they analyzed was patients reported physicians held insufficient knowledge regarding trans-health interfering with the ability to provide HIV preventative care, hormone therapy, or gynecological care, (Lerner and Robles, 2017). They described in one study they analyzed including 101 transgender men, 32% of participants reported the most difficult barrier faced when seeking health care was finding a physician knowledgeable about transgender health. In an additional study with transgender individuals ages 16-24, not only did physicians lack knowledge regarding transgender health, they lacked experience as well. As a result, participants reported acquiring transition specific treatment like hormones was very difficult. Participants of one study even suggested barriers to healthcare

could be improved for transgender individuals if healthcare providers established an understanding of gender identity before serving healthcare users. In a study examining the experiences of transgender and gender-nonconforming patients in emergency departments, the authors concluded health provider knowledge is typically overlooked when evaluating patient satisfaction levels yet, in this study, reports of negative experiences were most common among participants who felt their provider lacked enough knowledge about their identity to provide proper care or avoid discrimination.

In a second article, a study which involved health care providers as well, physicians described feeling inadequately trained or educated to provide care for transgender patients (Jaffee, 2016). Jaffe said providers are more likely to, " unwittingly create an atmosphere of disapproval for transgender patients," when they feel uncertainty about treating a patient because they lack education about transgender and gender identity knowledge. In Jaffee's study, of the 30.8% of participants who reported delaying health care or avoiding it altogether,"respondents who had to teach health care providers about transgender people were 4 times more likely to delay needed health care due to discrimination"(Jaffee, 2016). It is evident throughout the existing literature, that lack of education about gender identity leads to negative experiences with health care for transgender individuals. Those who experience negative interactions with their providers are more likely to avoid and delay care which act as underlying risk factors for many health disparities.

Just as defining gender and gender diversity is left out of curriculum requirements, the assessment of cultural competency using the TACCT is also limited to assessing race, culture, and ethnicity, therefore not providing doctors the tools to assess their biases and stigmatizing practices in regard to treating transgender and gender non-conforming patients. This is harmful

because, TGNC individuals experience very specific health disparities due to the way their identity intersects with society in very different ways than race might influence their health. Willy Wilkinson, an LGBTQ activist and public health expert, provides a definition of cultural competency that extends to transgender culture and transgender health. It includes defining terms like gender identity, transgender, and concepts of gender diversity as well as the ability to appropriately use this terminology. It also means recognizing how to respectfully interact with transgender individuals using these terms(Wilkinson, 2015). For example, in a medical setting for physicians, this might include understanding how asking a patient certain types of questions, particularly regarding genitalia when it is not relevant to the patient's visit, can be sensitive or offensive for some patients. Wilkinson emphasizes transgender cultural competency also means understanding how patients experience discrimination in other various realms of society like politics or the judicial system (with bathroom laws, for example); within families or relationships; or economically. It includes understanding that discrimination experienced by TGNC individuals is typically intersected with one or more system of inequality such as class, sexuality, race, ability, language, or immigration status, (Wilkinson, 2015). Wilkinson says, much of the discrimination faced by TGNC people throughout society, including by the healthcare system, is rooted in this lack of cultural competency. That being said, applying comprehension of transgender cultural competency for healthcare providers, includes the ability to recognize personal prejudice shaped by learned stereotypes, recognizing when certain behaviors and conversations are hurtful, and apologizing when mistakes are made. Consider one study in which health care providers who, "expressed uncertainty about the nature of transgender identity" and transgender issues, tended to reproduce stigma and discrimination in their interactions with transgender and gender non-conforming individuals to preserve their authority,

or the perception of authority within the physician-patient relationship. With a growing body of literature exploring the impact of stigma on poor health statistics, Poteat claims this kind of knowledge gap regarding transgender issues directly impacts the utilization of healthcare by transgender patients (Poteat, 2013).

Although the AAMC eventually published a page to their website dedicated to LGBT education resources, because it exists outside of the cultural competence documents, the information risks being ignored as less important to medical curriculum integration. In a study released a short six years go, medical school deans of 150 U.S. and Canadian medical schools responded to a thirteen question survey conducted online regarding curriculum hours devoted to "LGBT-related medical curricula"(Obedin-Maliver et al., 2011). The researchers found on average, medical schools dedicate a total of 5 hours to "LGBT-related content" to medical curriculum over four years. They interpreted this as low. Additionally, of the 132 deans that completed the entire questionnaire, 9 schools claimed devoting no hours to LGBT topics during "preclinical years" and 44 schools reported devoting no hours during "clinical years". The study evaluated topic areas covered in curriculum, but the researchers were unable to report information specific to the transgender-related content used by these schools describing inconsistencies across programs. If only 5 hours are being devoted to the entire branch of LGBT content, it is safe to assume far less time is being devoted to gender-related education. Since then, the AAMC published its website page devoted to LGBT education resources in 2014. These resources include readings, videos, and content suggestions to be incorporated into LGBT related curriculum, but there is no self-assessment tool like the TACCT for medical students to evaluate their knowledge or biases. In April of this year, a new study found that as of now, the Accreditation Council for Graduate Medical Education does not require schools to devote any

hours of curriculum time to the topic. And, despite AAMC's published resources in 2014, there is no information reported on how successfully these suggestions have been incorporated into medical schools across the country (Johnson, 2017). To add, two schools of note have incorporated significantly new LGBT-related content to their curriculum. Both in 2016, Harvard did so with a new elective course in LGBT topics related to medicine that is optional for students and the University of Louisiana has incorporated a fully "comprehensive" program related to LGBT content integrated into their four year medical program for all students. Considering the information on LGBT related medical school curriculum or rather the lack thereof, only provides substantiating evidence that, although the AAMC has attempted to address the gap in transgender knowledge among healthcare providers, their efforts have not been nearly enough.

In conclusion, if the healthcare system does not take measures to address TGNC health and discrimination, health disparities with remain and transgender people will continue to die. Fair healthcare is something this country is more than capable of providing and there is much room for improvement, beginning with medical education training. A great place to start improving health outcomes for TGNC patients would be to revise the AAMC cultural competence documents to include transgender topics. TACCT does a thorough job of outlining how to incorporate cultural competency elements of race and ethnicity into medical training, and by using this as a template, this model can be adapted to include cultural competency for transgender individuals as well. The first step would be to include a comprehensive definition of how cultural competency applies to transgender health using Willy Wilkinson's definition of transgender cultural competency described earlier. For example, this could include a comprehensive understanding of gender identity and gender expression experienced by TGNC people and how to navigate proper pronoun usage. The next step would include the incorporation

of transgender topics into the five domains of the TACCT, just as elements of race, for example, are included. This topics would be included both in the learning goals section of the TACCT as well as the assessment section. For example, because so much of the healthcare system currently operates using the binary understanding of gender, such as in medical forms, medical students need to be given the tools for how to communicate with transgender or gender non-conforming patients when they encounter a medical chart that is marked incorrectly. Finally, by the end of the program, students should not only be expected to define what it means to be transgender or gender non-conforming but understand how to engage in respectful interactions with TGNC patients and provide whatever care is needed. With a little extra effort, there is hope, these health disparities can be turned around.

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