



Transgender Healthcare Does Not Stop at the Doorstep of the Clinic

TRANSGENDER HEALTHCARE DOES NOT STOP AT THE DOORSTEP OF THE CLINIC

Transgender healthcare is political because trans lives are political. Many countries are seeing lawsuits trying to curtail access to care for transgender people and, in the United States, some states have proposed bills that would criminalize offering transition-related medical care to trans minors. Although these efforts have so far been unsuccessful, they speak to the prevailing atmosphere of hostility toward trans people.

Clinicians working with trans patients should not only be aware of the broad-strokes politics of their practices but also of the impact of politicization on their patients. Prejudice, discrimination, and violence directly impact the physical and mental health of trans individuals.^{1,2} A history of pathologization and paternalism looms large over clinical practice.³⁻⁵ Ending engagement with trans communities at the threshold of the clinic, though welcomed by traditional professionalism, fails to reflect the deeply political aspects of trans healthcare. Trans health practitioners should engage with trans communities beyond the doors of the clinic and strive toward an ideal of community-engaged clinician-advocate. The benefits of this approach are fourfold: 1) it positions trans communities as knowers and subjects in their own healthcare; 2) it fosters a strong therapeutic relationship; 3) it grants access to otherwise inaccessible information; and 4) it responds to social and political determinants of health. After reviewing these benefits, we discuss what fruitful engagement with trans communities would look like.

COMMUNITY EMPOWERMENT

Trans health has long been dominated by pathologizing and paternalistic approaches to care, which unfortunately

remain to this day.^{4,5} Instead of viewing trans patients as self-determining people seeking access to transition-related care, clinicians viewed them as disordered. They tried to discourage them from being trans. They gatekept access to transition to exclude those they viewed as not really trans.

Until recently, trans people were overwhelmingly excluded from knowledge production in trans health. Thus, learning about trans health solely through traditional sources unwittingly perpetuates the disenfranchisement of trans communities. In ethics, this is known as hermeneutical injustice: a socially disadvantaged group is being left out of knowledge-production about themselves.⁶ By engaging trans communities on their own terms, clinicians can position trans communities as subjects and knowers within their own therapeutic life.

THERAPEUTIC RELATIONSHIPS

The clinician-patient relationship, which is a strong predictor of clinical outcomes, suffers in the wake of pathologization and gatekeeping. Many trans patients rightfully struggle to trust their healthcare providers because of them.⁵ As Dean Spade puts it, “No one trusts the doctors as the place to work things out.”³ Widespread lack of mutual trust between professionals and trans patients, a key component of strong therapeutic relationships, serves as an impediment to optimal healthcare. Patients who expect to be mistreated or to be denied care are less likely to seek out preventive and emergency healthcare.

Engaging with trans communities outside of the clinic fosters mutual trust. Trans people talk. Local organizations often maintain lists of trusted practitioners and can serve as a space for informal whisper networks. Social media invites large audiences to communicate with one another about clinicians and are often an important source of recommendations. The reputation of clinicians who socially and politically engage with trans communities, who are perceived to be “in the trenches,” and who are appreciated as good listeners, finely attuned to the realities of trans people, reverberates into their practice. Trans healthcare does not end at the clinic’s doorstep.

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MISSING KNOWLEDGE

The social positioning of cis (not trans) clinicians limits their access to knowledge about trans health.⁷ They do not experience the world in the same way as a trans person, and trans people experience the world in rich and diverse ways that cannot be reduced to a singular archetype.^{8,9} The historical exclusion of trans communities from knowledge production means that an abundance of information integral to trans healthcare is not yet reflected in medical education or scientific literature. Missing knowledge translates into ignorance and reliance on mistaken and cisnormative assumptions to fill gaps.

Some of the most blatant examples of such assumptions include the beliefs that all trans women must love dresses, hate their beard, and wish for a vaginoplasty (and vice versa for trans men) or that non-binary people are merely confused and should not be allowed to medically transition. Missing information also arises in more insidious and subtle ways. Novel approaches to medical transition often appear in trans communities long before making their way into scientific literature: low-dose hormones among trans people and surgical procedures resulting in both a penis and a vagina are examples of it. By engaging with trans communities outside of the clinic, professionals can evolve alongside trans communities and learn how to best meet their patients' needs. Involved clinicians are at the vanguard of trans health.

POLITICIZATION OF TRANS LIVES

Trans health cannot be abstracted from the sociopolitical environment. Best practices in trans health are politically controversial, with some jurisdictions attempting to prohibit and even criminalize interventions part of the standards of care. Debates over insurance coverage for trans people are mired in assumptions about the importance of transition-related care and the worthiness of trans lives. Interpersonal mistreatment, structural and institutional practices that privilege cisgender patients, and the impact of transphobic violence, discrimination, and harassment on cognitive and affective processes all lead to poorer physical and mental health among trans people.² You can't treat a patient who avoids healthcare settings because of past traumatic experiences or expectations of mistreatment. You can't help a patient medically transition if their insurance doesn't cover transition-related care and they are unable to pay out of pocket. You can't take care of a patient who is dead.

Insofar as social and political factors determine physical and mental health in trans communities, clinicians invested in trans well-being must step outside of the traditional boundaries of their professional role and advocate for and with trans communities. Clinicians are uniquely well placed to support and amplify trans voices, as their credentials and scientific education affords them significant social authority.

FRUITFUL ENGAGEMENT

Fruitful engagement with trans communities must be humble, attentive, and supportive. Without humility toward trans

realities, attentiveness to trans voices, and support for trans communities and political movements, extra-clinical engagement preserves paternalistic elements and fails to fulfil the promise of community empowerment, strong therapeutic alliances, access to communal knowledge, and effective political and social change. Humble clinicians approach trans communities with the assumption that they do not know best about trans health, realities, and needs and have much to learn from engagement. Humility entails decentering oneself, deferring to trans perspectives, and resisting the urge to inject cisnormative views, technical jargon, and medicalized perspectives into community spaces. Clinicians should strive to bring the comfort and joy of community into the clinic rather than bring the discomfort of the clinic into the community. Attentive clinicians do not react defensively or judgmentally, but eagerly listen to what trans communities say about trans-specific needs and realities. Attentiveness is of utmost importance when community members and organizations offer feedback and criticism. Supportive clinicians seek to meet trans communities on their own terms and use their clinical knowledge and power as professionals to promote voices and perspectives rising from trans communities.

When engaging with trans communities, clinicians should be aware of the diversity of trans experience. Trans people are not a monolith. Trans people live and desire across an inexhaustible range of gender identities, embodiments, and expressions. Clinicians should strive to decenter the assumption that trans people are able-bodied, affluent, skinny, and white, and actively prioritize the perspectives of those who live at the intersection of multiple axes of marginalization.⁸

In concrete terms, clinicians should connect with local trans organizations at events open to them, including some trans marches, conferences, and meet-and-greets. Clinicians should reach out to, cite, and collaborate with trans researchers. Those who use social media may also find it helpful to connect with local, regional, and national trans communities online, though providers should be mindful of ethical concerns associated with interacting with potential and actual patients on social media.

CONCLUSION

Trans healthcare should not and does not end at the doorstep of the clinic. Engaging with trans communities in humble, attentive, and supportive ways contributes to the depathologization of trans lives, improves patient-provider relationships, enhances clinical competence, and embodies a whole-person approach to clinical care. Taken together, these modes of engagement address not only immediate clinical needs, but also social and political determinants of health. Clinicians working with trans patients should strive toward an ideal of community-minded clinician-advocate.

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