Disclosures

- Prof. Gasse – None
- Dr. Gasse - None

Primary Care Considerations for a Gender Diverse Population

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Learning Objectives

As a result of attending this session, participants will be able to:

- Recognize the barriers to care for gender diverse patients as well as understand gender diverse patients' rights.

- Learn applications of existing skill sets as well as concrete steps every physician can take in order to better serve gender diverse populations.

- Understand the unique role primary care can and needs to have in caring for this patient population.

Guiding principles

- Gender is a social construct
- Gender and sexuality are fluid
- Gender identity and gender expression are different
- Gender identity + expression are different from sexual identity + expression
- Gender identity & gender expression are now protected grounds in the *Canadian Human Rights Act*
- In primary care, the duties you owe gender diverse patients comes with a unique standard of care
- Gender diversity is not be medicalized and pathologized - remove this from language, research and our approaches
- Transition does NOT legitimize identity & it is up to the person

Identity

- Two-spirit can be in addition to an identity within LGBTQ+
- Two-spirit can be an identity entirely separate from LGBTQ+
  - *Connects to community, spirituality and Nation-specific history in ways the Western ideas of gender & sexuality cannot account for*
- Transgender v Gender nonconforming
  - *Some transgender individuals might also be nonconforming*
- Genderqueer or non-binary
  - *Might have different preferred pronoun (ex. "they"). Outside of "masculine" and "feminine".*
  - *Queerness, as an identity, was taken back & tends to be about what it is NOT*
- Gender fluid
  - *More female one day…maybe male the next…neither some days…sometimes a mix of both…*
  - *Catch-all recognition that no one has to be locked into labels/norms if that isn't who they are*
- Agender
  - *Not having a gender. Genderfree*

At the end of the day, someone's identity is their own. Not for us to question or judge or determine (or appropriate).

- Go with what someone tells you
  - And it's perfectly okay for labels to shift with time, change per context, etc.

Beyond definitions & labels:

Language matters & preconceived notions can cause harm

- "Was a ___, now a ___"; "Born a ___"; "Wishes they were ___"; "The other girls"; "Was a gay girl"
- Trans-male vs male
- "Real name"
- Tiptoeing around Suicide
- What "guys" look like and what "girls" looks like

…and this is an urgent matter

- Lack of access to inclusive care, including medical transition is a suicide risk for gender diverse patients.
- Publication referenced below found nearly 75% on trans Ontarians 16 and older had ever contemplated suicide with 43% having attempted at some point:

Reference: Scanlon K, Travers R, Coleman T, Bauer G, Boyce M. Ontario's Trans Communities and Suicide: Transphobia is Bad for our Health. *Trans PULSE e-Bulletin, 12 November, 2010. 1(2). Downloadable in English or French at https://transpulseproject.ca.*

Per Canadian Institutes of Health Research 2017 publication on *"The mental health of Canadian transgender youth compared with the Canadian population"* (n=923)

- Transgender 14-18 year olds: **5x risk of suicidal thoughts**
- Transgender 19-25 year olds: **~8x the risk of serious suicidal thoughts** over 1 year period than the equivalent aged Canadian population; **>16x risk of suicide attempt**
- Non-binary 19-25 year olds: highest rates of self-harm, **>60% reported at least 1 instance of self harm** in a 1 year period
- Genderqueer & non-binary transgender adults have **among the highest rates of self-harm**
- Non-binary youth less likely to have social support than any other group

An urgent matter with frustratingly simple solutions (and well within the rights of the patient):

- Publication cited below posits a potential prevention of 160 suicidal ideations and 200 attempts per 1000 trans persons 16+ in Ontario, with measures to increase social inclusion and access to medical transition:

Bauer, G.R., Scheim, A.I., Pyne, J. *et al.* Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC Public Health* **15,** 525 (2015). https://doi.org/10.1186/s12889-015-1867-2

It's not enough to say your clinic/practice is open to gender diverse patients

- You need to be **competent** in gender diverse care and ready to offer in a way that meets the <u>standard</u> and <u>duty of care</u>
  - This is NOT a specialty – it is a standard of care in your role as primary care physicians.
- Commonality with all patient groups = humans going to the doctor.
  - But some humans have more barriers to even get to a doctor, let alone feel safe with one. To treat the individual, must first understand this.
    - Step 1 is broad, human and must be decolonial by nature.
    - Step 2 is specific, and you must be equipped to meet the standard of care.

    - **There are colonial underpinnings to the Canadian medical system that must be challenged & decolonized**

Well-known fact of lives of First Peoples: *"[…] the trauma of colonialism erupts in the minds and bodies of men, who then bombard the lives of women and girls, two-spirit peoples, and queers."*
-Billy-Ray Belcourt (Driftpile Cree Nation)

In the laundry list of what colonialism did:

- Assigned gender roles (and disenfranchised powerful groups)
- Promoted ideas of worth; hierarchies & social orders
- Created "masculinity" & "femininity"
- "Othered" and then shamed
  - In describing growing up, Billy-Ray Belcourt recalls:
    - *"I made myself exist less"…"I deflated everything I could"…"As such, I internalized the ugliness of colonialism"*

The erasure of Two-Spirit people was part of colonial design:

- George Catlin (American painter) depicted a Two-Spirit person brought into the community, being celebrated.
  - He was a witness to harmony, acceptance, and co-habitation
  - He said, "this is one of the most unaccountable and disgusting customs that I have ever met […] I should wish that it might be extinguished before it be more recorded"

"Our Indigiqueerness has always signaled fatalism in the eyes of the colonial powers, primarily the white gaze, from the directed killings of Two-Spirit people during Western expansion through to contemporary erasures and appropriations of the term Two-Spirit by settler queer cultures who idealize, mysticize, and romanticize our hi/stories in order to generate a queer genealogy for settler sexualities."

– Joshua Whitehead (Two-spirit poet and novelist, Oji-Cree member of the Peguis First Nation in Manitoba)

It’s no surprise that colonialism has also harmed non-Indigenous gender diverse people

Discrimination when not part of the **dominant culture**

White power + capitalism + ableism + sanism + cisnormativity + heteronormativity + paternalism + patriarchy

Cisnormativity:

relates to dominance of those falling into a gender binary of M or F

Heteronormativity (as defined by Desmond Cole):

Dominance of people accepting only heterosexuality as "normal", based on gender binary

Controversy over equity, inclusivity – it divides us! Not productive! Trying to create new hierarchies.

To those who find themselves fitting into dominant culture, there is little motivation to examine difference.

There is, at times, the notion that *"difference" won't hurt you if you just "overcome"*.

Or *learn your place.*

Or *accept what "works" (ie just conform).*

This turns the attention away from the barriers created by colonial design.

This push to “conform” is killing our kids

- American Academy of Pediatrics showed in 2018 that > 50% trans male teens have attempted suicide (at least once)…compared to 10% of cis-male teens
  - Connection to toxic masculinity – introduced in handout

Dominant culture leads to othering

- We other in oppressive ways. We don’t other to aim for inclusivity, but to re-inforce normative thinking.
  - The norm becomes the standard.
    - Out of this, “isms” are born.
- We educate from this normative lens, and this impacts what is and is not on our radar.
  - Ex. A transgender, gender nonconforming, black man requires different primary care considerations than a non-binary, disabled, white person
- Push for intersectional approaches!

Intersectionality:

- **Interconnected identity-related differences**
  - **We are shaped by our gender identity, gender expression, perceived gender, class, race, geographic location, sexual orientation, etc.**
  - Barriers & discrimination compounded for each aspect outside dominant culture. Must recognize how vulnerabilities intersect.
    - Cannot tackle at only one identity-related difference. We will fail
      - Ex. woman face discrimination. Within this idea, compounded if…
        - Pregnant white woman: pain examined. Potential complications typically known and treated.
        - Pregnant black woman: pain sometimes assumed to be exaggerated. Genetic pre-dispositions not typically known. (Maybe CAS involved)
        - Pregnant Indigenous woman: pain thought to be drug-seeking. Smudging denied upon child's birth. CAS involved. Coerced into sterilization.

He has had to play "straight on the rez in order to be NDN" and in the city he has played "white in order to be queer."

-Joshua Whitehead

Why might this patient be in your office?

- **Societal factors**
  - Find themselves overrepresented in statistics on depression and anxiety; suicide ideation; suicide attempt; self-harm; bullying; sexual assault victimization (trans bodies are fetishized and targets of violence); unsafe sex work; substance abuse; improper binding; accessing to faulty "hormone therapy" online
  - <u>It is not safe to walk this world openly gender diverse. Look out for these populations. There is deep pain stemming directly from dominant, colonial culture.</u>
- **Transition**
  - Seeking hormone therapy; seeking counselling, NOT to prove their identity from sound mind but to equip them with the tools for the aforementioned societal factors; surgeries; doctor's notes supporting social transition
  - Not sick! This is beautiful
- **Silent reasons**
  - Pregnant men; agender people with periods
- **The reasons anyone goes to a doctor**

*Spans youth to late adulthood – *"Trans Aging: We're Still Here!"*

**Autism and gender diversity, good thing to put on your radar

***__Gender diverse youth in need of protection → heightened awareness of bullying, conversion therapy attempts, misgendering & deadnaming + equal awareness of dangerous, harmful, traumatic experience for Child "Welfare" Survivors__

Steps to take, starting today:

- From booking to meeting the doctor
  - Male/Female, mandatory
  - Normalize pronouns
  - Practice they/them (for example); "significant other"; "people you live with"
- Read prepared handouts & turn to suggested resources
  - Reach out – happy to answer emails, schedule Zoom calls, send resources, learn of new ones, collaborate, share experiences, etc.

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Let's ask ourselves:

In law, medicine, psychology, social work, education…

- **Can you establish the trust relationship necessary?**
- **Can we really hire people who are anti-trans or uneducated on trans needs & understandings?**
  - When does "debate" become hate?
- **Are you taking the correct medical history if you assume their gender and their sexuality?**
- **Are you effectively treating a patient if you don't understand gender and sexuality play into health?**

- There are better ways and it is our personal & professional duties to follow these paths.

"[…} without a mirror held in front of me at all times, I felt without skepticism the platitude that anything was possible"

– Billy-Ray Belcourt, in describing his open & loving father, who rejected colonial ideas

Role of Primary Care

- Uniquely qualified and positioned to provide care to gender diverse populations
- Limitations in scope of this presentation – will not be going into details of treatments, hormone therapy etc.
- Goal is to underline a universal approach for primary care physicians
- Starts with understanding patients' rights and barriers to care, as well as the urgent need for care

Meaningful Access to Care

- Saves lives
- Starts with recognition of the need, the barriers to care and patients' rights
- Starts before the person even sets foot in your workplace
- Necessity to inform ourselves, become sensitive to the unique challenges and discriminations gender diverse patients face
- Involves a deliberate change in the language we use, becoming aware of our own biases and assumptions
- Recognizing that failure to do so will result in alienating one of the populations that need us most

Approach

1. Listen to the patient
2. Know where to go for information, knowledge and resources you may be lacking
3. Use this acquired knowledge to apply informed consent and allied decision-making models of care to the patient

Listening

- Respect the disclosure of pronouns, name and gender identity
- Hear what a patient is requesting, understand their context
- Understand how population-specific risks are relevant, but do not make assumptions
- Includes assessing for safety, suicide risk – in youth population includes assessing need for Youth Protection (*caveat – there are risks to DYP for gender diverse youth – calling DYP necessitates ongoing and close f/u)
- Includes using a trauma-informed approach (**1. Purkey E, Patel R, Phillips SP. Trauma-informed care Better care for everyone. Canadian Family Physician 2018;64(3):170-172**)

Where to go for more Info

- Handouts have been included with Montreal-based resources I compiled from Internet searches
- Handouts include where to go for more information and reading
- Very collegial and approachable network worldwide of physicians and healthcare workers providing gender diverse care
- For more detailed step-by-step approach starting “from zero”, recommend Rainbow Health Ontario’s website, under Trans Primary Care: https://www.rainbowhealthontario.ca/TransHealthGuide/intro-terms.html

Gathering more information

- Uncertainty how to proceed can happen
- Ensure a patient that you wish to help them, but you need time to inform yourself on the best approach
- Respectfully ask the patient for more time to become better informed
- Provide a timely and concrete follow-up to continue the discussion

Using your acquired knowledge

- Barriers to action that I have heard of:
  - Concern to "do harm" by prescribing hormones
  - Concern over lack of knowledge, that care is better administered by a specialist or specialized care team
  - Concern over litigation if patient "regrets" transition
  - Concern to "misdiagnose" and inappropriately rx hormones
  - Specifically for youth – concern that this is a "phase"

Concern over "doing" harm or lack of knowledge

- There is an overall lack of high-quality evidence that is population specific
- A lot is extrapolated from older data where the patient population studied is ciswomen and cismen
- There is increasing research in this area, but there is much that will only be known with time
- However, doing nothing or blocking access to care because of lack of data actively causes harm
- There are standards of care, published and freely accessible to guide provision of care. Primary care provision of medical transition is not aberrant or unprecedented practice by any stretch of the imagination

Concern over "regrets"

- From the data that is out there, actual "regret" is considered exceedingly rare
- De-transitioning does not necessarily mean "regret"
- Many may consider de-transitioning as part of their overall gender journey
- Providing care via informed consent model is a standard of practice in gender affirming care
- Our responsibility is to the patient's expressed needs in the present, not to alter care based on an undemonstrated risk of "regret"

Concern for "misdiagnosis"

- Gender identity is not a diagnosis
- The WHO uses Gender incongruence instead of Gender dysphoria or Gender nonconformity and removed from category of mental health disorders
- Relevant differential diagnoses to consider include schizophrenia, other psychotic disorders, dissociative disorder and body dysmorphic disorder – these are **rarely** found to be underlying requests for medical and/or surgical transition. If there is reasonable doubt or uncertainty, referral should be done carefully to a psychiatrist comfortable with gender diverse care

Just a "phase"?

- In 2016 term "Rapid onset gender dysphoria" was coined and is categorically false and harmful
- Data from trans-antagonistic websites informed this "diagnosis" and is widely regarded as an attempt to circumvent existing research on the importance of gender affirmation

A critical commentary on 'rapid-onset gender dysphoria'

Florence Ashley

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In Summary

- Process involves becoming attuned to the needs of gender diverse patients seeking care
- Knowing how to inform ourselves how to best provide this care
- Applying this care through an informed consent model
- Gender diverse care touches on all the CanMEDS roles and it behooves us to build our skillset as primary care physicians to serve this population

Conclusion

- Primary care is often a thankless job with many burdens
- Providing care to gender diverse populations, while not without its challenges, can be one of the more beautiful and rewarding experiences a person can have as a primary care physician
- Educating ourselves, advocating for our patients, communicating with other professionals and synthesizing it all into a holistic and collaborative model of patient care is the very essence of primary care, and it is central to providing meaningful care to a gender diverse population

Sample of suggested readings, Podcasts, videos:

- “Jeunes trans et non binaires: de l’accompagnement à l’affirmation” by Annie Pullen Sansfaçon and Denise Medico
- “The Trans Generation: How Trans Kids (and Their Parents) Are Creating a Gender Revolution” by Ann Travers
- “No House to Call My Home: Love, Family, and Other Transgressions” by Ryan Berg
- “A History of My Brief Body” – memoir by Billy-Ray Belcourt
- “Jonny Appleseed” – novel by Joshua Whitehead (and just won 1st place in Canada Reads competition!)
- “Love After the End: An Anthology of Two-Spirit & Indigiqueer Speculative Fiction” – Edited by Joshua Whitehead
- “Sovereign Erotics: A Collection of Two-Spirit Literature” (edited by Qwo-Li Driskill, Daniel Heath Justice, Deborah Miranda, and Lisa Tatonetti)
- “Indian Blood: HIV and Colonial Trauma in San Francisco's Two-Spirit Community” by Andrew Jolivette
- “Autistic Traits in Treatment-Seeking Transgender Adults” Link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6223809/
- “Trans Aging: We’re Still Here!” Link: https://www.lgbtagingcenter.org/resources/resource.cfm?r=535“Transgender History: The Roots of Today’s Revolution” by Susan Stryker (excellent definitions at beginning of book)
- Personal accounts, example, “Before I had the Words: On Being a Transgender Young Adult” by Skylar Kergil
- https://restforresistance.com/zine/the-ascending-circle-a-two-spirit-poem
- https://www.youtube.com/watch?v=A4lBibGzUnE&ab_channel=them
- https://www.youtube.com/watch?v=juzpocOX5ik&ab_channel=OurStorieseTextbook
- https://www.youtube.com/watch?v=4Hj-a5AE-VM&ab_channel=ThomsonReutersFoundation
- https://lgbtqhealth.ca/projects/two-spiritedpodcasts.php?ap=14#JeremyDutcher