The Erasure of Sex and Gender Minorities in the Healthcare System

ÉTUDE DE CAS / CASE STUDY

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Reçu/Received: 1 May 2013 *Publié/Published:* 15 Sept 2013
Éditeurs/Editors: Marleen Eijkholt & Renaud Boulanger

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Résumé
Les notions socioculturelles du genre et du sexe influent sur la structuration des systèmes de soins de santé. Cette étude de cas illustre la façon dont la notion occidentale du genre binaire, et la cisnormativité en particulier, peuvent créer des obstacles à l'accès aux services de soins de santé pour les populations transgenres et conduire à l'*effacement*.

Mots clés
Transgenres, transsexuelles, identité de genre, disparités en santé, santé de population, éthique, vulnérable, discrimination

Summary
Socio-cultural notions of gender and sex influence the structuring of healthcare systems. This case study exemplifies how the Western gender binary, and cisnormativity in particular, can create barriers to accessing healthcare services for transgender populations and lead to *erasure*.

Keywords
Transgender, transsexual, gender identity, health disparities, population health, ethics, vulnerable, discrimination

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Remerciements
Aucun

Acknowledgements
None

Conflit d'intérêts
Aucun declaré

Conflicts of Interest
None to declare

Introduction: Sex, gender and non-conforming populations

Profound population-level health inequities exist amongst sexual and gender minorities, an issue that has garnered concern in recent public health scholarship [1]. Sexual minorities (lesbian, gay and bisexual persons (LGB)) as well as sex and gender minorities (trans (T)[1] persons) face negative health outcomes several times greater than the average population, ranging from higher rates of depression and suicide attempts, to violence originating from hate crimes [4-8]. Significant inequities exist in terms of the ability of LGBT populations to access health services that are sex- or gender-specific and cater to their specific medical needs, and there is a further lack of public health oversight of the specific health needs of the LGBT community [5]. The reasons for these inequities are manifold, with misguided perceptions of sex and gender that promote marginalization within the healthcare system being of particular interest.

[1] *Trans*, short for transgender, is "an umbrella term for persons whose gender identity, gender expression, or behavior does not conform to that typically associated with the sex to which they were assigned at birth" [2]. This includes any gender non-conforming persons who identify as transsexual, genderqueer (those who identify outside of the male/female gender binary) or intersex (those who are born with a reproductive or sexual anatomy that does not fit the typical definitions of female or male) [3].

In order to discuss how perceptions of sex and gender lead to this marginalization, the difference between sex and gender must be clarified. While *sex* is defined by biological factors such as chromosomes, hormones, and genital appearance, *gender* incorporates social factors that are "constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women" [9]. *Gender identity* is psychological, "a person's *internal sense* of being masculine or feminine, whether or not the biological, chromosomal, or hormonal structure matches that sense of self" [10].

According to a traditional view of gender, gender corresponds to one's birth sex; the only two possible sexes are that of male (man) and female (woman). This is called the *gender binary*. Current definitions in sexology are more representative of human diversity in advancing that gender is not biologically determined by sex but rather socially constructed. From this perspective, gender can be viewed as a matter of personal development and self-identity that is unconstrained by the gender binary. Gender identity is most often conceptualized as a spectrum, with "woman" at one end, "man" on the other end, and "genderqueer" in the middle. This acknowledges the role of psychosocial influences and helps to establish the nuances found in the construct of gender identity. For instance, just as sexual orientation is a combination of several dimensions – namely sexual behaviour, sexual attraction, and sexual self-identity – gender identity is a combination of gender *expression* (how one expresses their masculinity and femininity), gender *presentation* (presentation of oneself to others in day-to-day life), and gender *self-identity* (internal feelings and personal identification).

One's sex and one's gender are separate constructs that are often mistakenly seen as equivalent in Western societies [11]. The assumption that all people are *cissexual*[2] – that they are born with either male or female genital organs and develop a gender identity that corresponds to their sex assigned at birth – is commonplace. This assumption is called *cisnormativity* and is also found amongst healthcare practitioners [12]. Though it is empirically incorrect that everyone is cissexual, cisnormativity is a pervasive belief that exists because of Western society's binary gender norms. Indeed, if gender binary did not exist, the existence of trans identities and trans bodies would be readily acknowledged – or considered a part of human diversity, on equal grounds to cissexuality – which would render cisnormativity non-existent.

Despite the growing recognition of the spectrum model of sex and gender, the dominant model in health contexts remains the gender binary, which implies cisnormativity. The very use of the words "man" (or male) and "woman" (or female) undermines the possibility of trans individuals; the term *erasure* refers to this nullification of transgenderism through a binary discourse [13]. A system, such as the healthcare system, that does not recognize the possibility that people other than "men" or "women" exist engages in the *institutional erasure* of sex and gender minorities [13-15]. Institutional erasure manifests itself through policies, forms and documents that are not adapted to trans identities and trans bodies [14]. As a result, sex and gender minorities commonly face systemic discrimination when attempting to access health services, or their health needs go unreported within population health assessments [15]. Erasure of trans individuals also promotes their social marginalization, which has been cited as a leading cause of the health inequities observed in this population [14, 15].

Because a great deal of trans persons do not wish to alter their appearance or do not present to gender clinics, it is suspected that the prevalence of transgenderism is much higher than current estimates [16]. These estimates range from 1:30,400 to 1:200,000 for female-to-male individuals and 1:11,900 to 1:45,000 for male-to-female individuals [17]. This underestimation, along with various forms of erasure, reinforces the perception of trans persons as being few and thus easily overlooked in society. Overall, the erasure of trans populations negatively impacts public health research, prevention, and intervention priorities for these community members; consequently, sex and gender minorities consistently receive low priority in public health [18].

[2] Cissexuals (or cisgender) persons are "people who are not transsexual [or transgender] and who have only ever experienced their mental and physical sexes as being aligned" [12].

The following case study will demonstrate how gender binary and cisnormativity can inhibit access to healthcare services by transgender populations[3].

Case study: Trans erasure in the healthcare system

Patient records at a local hospital define the sex of patients as either 'M' for male or 'F' for female. The sex of a patient is automatically entered into electronic hospital records from the information on a patient's birth certificate, which is accessed through a digital birth registry. This information is often used to help identify patients.

A trans person by the name Jennifer, whose gender presentation is visibly 'female', sits in the waiting room at the hospital. After reviewing Jennifer's file, the attending nurse calls out: "Mister Smith, you may now enter the examination room… Mister Smith, are you here?". Jennifer is hit with waves of emotions. First insulted, then embarrassed, her feelings quickly turn to fear as other people in the waiting area scan the room for 'Mister Smith'. Having previously been the victim of a hate crime, Jennifer does not want to take the chance of being perceived as a 'man'. After a period of silence, she discretely leaves the room.

A week later, another trans patient is in the same situation. His chosen name is Julian, but his identification documents contain his name assigned at birth, Lily. He is called forth with a feminine pronoun, and he correspondingly presents himself as 'Miss Leuwen'. The attending nurse looks at the advancing individual with surprise and disbelief. Julian is then accused of trying to 'jump the queue' and is asked to wait his turn. Julian tries to explain his trans identity, yet the nurse asserts that his gender does not correspond to their records on file and that institutional policies state that "all patients must be identified through information found in a patient's file". Julian leaves feeling stigmatized as 'non-existent' and 'dishonest'. This experience adds to Julian's pre-existing feelings of mistrust towards and resentment of the healthcare system.

Questions

1. Put yourself in Jennifer and Julian's shoes:
   - What do you think of their decisions to leave the clinic? What of the nurse's reaction when confronted with Julian's gender non-conformity?
   - What ethical issues do these situations raise, for example, in terms of justice?
   - What kind of training – and in which settings – could be provided to healthcare professionals to avoid such situations? Are there reasons that would justify a lack of training?

2. What factors in healthcare make sex and gender minorities constitute vulnerable populations? What responsibilities do public health decision-makers have, if any, towards vulnerable sex and gender minority populations?

3. Strictly from a public health perspective, would there be an advantage to being able to identify patients as sex and gender minorities through their medical files?

4. What would be the ethical implications of labelling individuals as "trans" in their medical files, for example, in terms of confidentiality? What would be the advantages for trans patients? The disadvantages?

5. How do sex and gender influence the structuring of the healthcare system?

[3] Please see the references and suggested readings for more examples of barriers to healthcare faced by trans individuals.

6. Why can it be important for healthcare professionals to know a patient's sex assigned at birth (female or male)? In such a context, what do you think of the possibility of removing sex designations in patient files?

7. How could the different dimensions of gender (gender expression, gender presentation, and gender self-identity) be incorporated within the healthcare system to recognize the diversity of individuals and identities found in the trans population?

8. Are the issues raised in this case study also relevant to the average patient population, meaning the sex/gender majority (cissexual persons)? For example, are any of the ethical issues raised herein pertinent to ethical issues concerning gender discrimination and bias against women in healthcare?

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