Transgender and Gender Non-Conforming Peoples Experience of Being Admitted to Hospital

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Abstract: - **This article explores issues that a transgender and/ or gender non-confirming individual may face when admitted to hospital, such as being admitted into the wrong ward. The article uses Seedhouse's ethical grid to critically analysis ethical decision making when admitting a transgender and/ or gender non-confirming individual into a traditional hospital ward. The article then explores language and micro aggressions and their impact on an individual's identity and selfhood, including, inappropriate naming of wards, such as, women's health units. The article finally highlights the need for hospitals and healthcare services need to develop transgender and gender non-confirming policies to appropriately care for this demographic.**

Keywords: - **Transgender, Gender Non-Confirming, Non-Binary, Healthcare, Hospital Care**

I.INTRODUCTION

This Article will focus on a hypothetical case study of a pre op transgender manand/or a gender non-conforming individual admitted onto a 'women's health unit' for gynaecological care. The article will explore ethical considerations regarding the case study, the impact of power and expertise, theories of identity and how they apply to the case study and lastly communication and leadership considerations. This article will focus on the experience of transgender individuals admitted to a hospital. A transgender individual is a person who does not identify as the sex they were born as (CIS Gender), this includes male to female, female to male and people who do not conform to the gender binary often known as non-binary or gender non-conforming. According to the Equality Act 2010 an individual is protected under the characteristic of gender reassignment they do not identify as their CIS gender, whether they have had gender reassignment surgery or not.

Transgender individuals often have negative experiences of healthcare, facing discrimination and healthcare staffs lack of understanding of their individual needs (Winter et al 2016, Safer 2018 and Stroumsa et al 2019). According to Carroll-Beight and Larsson (2018) 73% of Swedish transgender individuals do not access medical care. There is a need for healthcare settings such as hospitals to be more transgender inclusive. There is the need for change, this is in the care provided for transgender individuals to make it more inclusive, also, change needs to happen on a more structural level with policy reform and environmental changes needed (Carroll-Beight and Larsson 2018). The discussion of the hypothetical case study aims to identify the needs of an individual and how hospitals need to change to be more inclusive for all.

II. CRITICAL DISCUSSION OF THE CASE STUDY

The hypothetical case study discussion will focus on how gendered wards may not be inclusive for everyone, especially, if a person's gender does not match the gender of the ward they are admitted to. Transgender individuals commonly fear healthcare, this is often due to healthcare professionals lack of knowledge and understanding (Winter et al 2016, Safer 2018 and Stroumsa et al 2019). It is also common for Healthcare professionals to dismiss transgender individuals and their opinions of what they need, due to perceived medical expertise (Stroumsa et al 2019); this could therefore mean that a transgender person's wishes may be overridden, especially, if a medical profession feels they should be on a specific ward based on their biological needs. Wards with specialisms are important, they allow specialised care (Oliver et al 2010), one of the problems in this case discussion is the name of the ward not the specialism, 'women's health units', 'gynaecological wards' would be more inclusive for people who need gynaecological care but do not identify as a women.

This article will use Seedhouse's Ethical Grid to explore the ethical considerations within the hypothetical case study. Seedhouse's Ethical Grid consists of four layers: Core Conditions of health care, duties and motives, consequences and outcomes and the last layer is the external considerations (Seedhouse 2008)

If we apply Seedhouse's core conditions to the case study, it is evident that we need to consider respect for the individual involved, according to Seedhouse it is essential to 'respect persons equally' and to 'respect and create autonomy (Seedhouse 2008). Therefore, a person who is transgender should be given the choice of where they are admitted to, where possible. If a hospital has a 'women's health unit' this might not be the choice a transgender man will chose, therefore, flexible arrangements on other wards may be required with a gynaecological consultant visiting the patient on the more appropriate ward.

The next layer explores the healthcare professional's duty and motives (Seedhouse 2008), Seedhouse states that healthcare professionals should be truthful, trustworthy and minimise

harm by doing the most good (Seedhouse 2008). When we think about minimising harm and going 'good' we must think about the individual holistically, while it can be argued that the individual would be better off on a specific ward medically, this can have other impacts on an individual, for example, exacerbating a n individuals body dysmorphia if they suffer with that. Historically in acute care there has been an over reliance on physical health (Van Dijk et al 2016), whereas if we really want to minimise harm and do the most good, we need to look at an individual more holistically.

The next layer is concerned with outcomes, this includes the best outcome for the individual, others and society. As previously stated there may be two views about what is the best for the individual and often, we need to think more holistically to meet all the individual's needs. Another consideration that we must think about is what is best for others, having an individual that does not conform to the gender of the ward might be unsettling for other inpatients on that ward. In this case, the individual might agree with the decision to be on a different ward due to themselves not feeling comfortable on the ward. However, some groups within society champion that sex-based rights overrule the rights of a person based on the gender they identify, therefore, where they are placed should be based on their biological sex, these people are often referred to as Gender Critical or Trans Exclusive Radical Feminists (TERF) if predominantly fighting for the right of CIS gendered females(Williams 2016). The view of this group of people is to protect CIS gendered people from danger and fear from people of the opposite sex as they reject an individual's self-identified gender(Williams 2016). This demonstrates a rift within society and identifies a challenge of what is best for an individual, verses, what it best for everyone within society. According to the Equality Act 2010 transgender individuals are protected under the protected characteristic of Gender Reassignment, therefore we must not discriminate based on this. Many have argued that the Gender critical/ TERF viewpoint is discriminatory as it does not recognise an individual's identify and their rights as human beings (Weber 2016). If we applied a Utilitarian view of the greatest good for the greatest number, we would lean towards supporting the transgender individual as the TERF/ Gender Critical view is often widely opposed, especially in academic and healthcare related circles. This rejection is evident through a recent letter from 30 academics/ university employees signing a letter stating that the right to not recognise transgender individuals' identity is their right under academic freedom, over 3,000 academics/ university employees opposed this view(Pennock and Ashton 2019), demonstrating that it is not the dominant opinion. The support of the greatest number would also refer to the other inpatients on a ward, ensuring that everyone is comfortable in the ward they are admitted onto.

The last layer is concerned with external considerations, such as, available resources, risks, codes of practice, evidence, legislation and wishes of others (Seedhouse 2008). Here we must think about the practicality of an individual being admitted onto a ward that is not specialist in the needs of the individual. Hospitals are often short of staff and resources (Alderwick and Dixon 2019), therefore, creative solutions might be needed to overcome these challenges, such as, the use of IT for skype consultations and greater team working between the specialist medical team and the medial team on the ward that the individual has been admitted to. Legislation such as the Equality Act 2010 and Human Rights Act 1998 are both relevant, this article has already explored the importance of not discriminating against someone based on being transgender, the Human Rights 1998 also states that it is a human right to be free from discrimination. The human Rights Act 1998 in addition states that an individual has the right to a private life, due to certain people within society having negative attitude towards transgender individuals, a person might want to keep that part of their identity private. It is therefore important that healthcare professionals and organisations respect this, this is also stated within the Equality Act 2010 under the protected characteristic of 'gender reassignment'. A transgender man admitted onto a women's health unit/ gynaecological unit might indicate to other that the individual is transgender; therefore, the individual being admitted onto a non-gender specific ward would respect an individual's privacy.

III. POWER AND EXPERTISE IN PRACTICE

When unwell and admitted to hospital we are often at our most vulnerable, oppressed groups face a double jeopardy of vulnerability (De Chesnay and Anderson 2019), therefore being aware of power in healthcare for transgender individuals for example, is essential to be aware of.

Regarding sex and gender, Foucault's theory of govern mentality is particularly relevant, this is where we self-regulate instead of having top-down power from a sovereign head of state (Foucault 1975 and Foucault 1998). As stated, power, according to Foucault is not top heavy but comes from many different sources and is not necessarily negative; it can cause positive developments and new knowledge (Foucault 1975 and Foucault 1998). Internalised transphobia or internalised stigma is common, it is often caused through an individual experiencing negative experiences from society through victimisation, micro aggressions and discrimination, it is also common for a transgender individual to develop self-stigma through negative experiences of healthcare services (Mizock and Mueser 2014, Austin and Goodman 2017). According to Lawler (2008) in the western liberal world we often have a choice to be governed by society, however, lawyer also explores how according to Foucault subtler forms of power can be the most powerful. This is evident in the case study as being placed on a gendered ward can have a negative impact on an individual who does not identify with that gender, it may reinforce social norms of gender which does not fit with an individual's authentic identity. Micro aggressions such as miss-gendering or as in the case study admitting an individual onto a gendered ward are examples of

subtle demonstrates of power, this is often by accident(Nadal et al 2010).

When a person is vulnerable and in the care of others, this also removes the 'choice' of being governed by the people in power, in this case, health cares professionals. According to Doran et al (2018)health care professionals often have limited understanding of the needs of people from the LGBTQ community, particularly, transgender individuals (Winter et al 2016, Safer 2018 and Stroumsa et al 2019). Miss gendering, inappropriate medical treatment and taking vulnerable individuals off hormone treatments unnecessarily for polypharmacy reasons are some examples of health care professional's lack of understanding and negative experiences of transgender individuals (Heng et al 2018). This lack of knowledge creates a stigma, especially as it common for there to be a power dynamic between a transgender individual and a health care professional, often due to the professional seeing themselves as the expert in that patient's care.

The categorisation of sex can also be seen a form of power, especially from the medical profession. Labels can be viewed as the over medicalisation and therefore, problematization of the human body (Macaulay 2019). Historically in medicine what is not understood is labelled, this encouraging further scientific study (Foucault 1998). This could explain why sex-based rights is used within many professional's settings, including healthcare, as it is a historical way of categorising and better understanding people. This, in turn enforces societal norms about how each sex or gender must be or how a person should act, this can make environments, especially medical, not inclusive for individuals who do not associate with their biological sex, including transgender individuals and gender non-conforming individuals.

Another concept that Foucault discussed was the theory of surveillance, where Foucault uses the analogy of a panoptic on to explain why we self-regulate our behaviours, ensuring that we behave in a way society seems as acceptable (Foucault 1975). This is another way to look at internalised stigma critically and role society play in making a person self-regulate. In a hospital where a patient is often under 24 hours a day care an individual might feel increased pressure of this surveillance, therefore a transgender, particually gender non-conforming, individual might feel the need to conform to social norms of gender. In healthcare settings it is important to create an environment where a transgender individual does not feed judged, and therefore feels safe to be their authentic self.

IV. THEORIES AND PRINCIPLES OF IDENTITY AND SELFHOOD

Gender is an important part of our identity; however, the nature of gender is often debated. This is particually relevant for a transgender individual as societal norms around gender may cause internalised stigma, especially if an individual does not conform to societally accepted norms. Butler (1999) states that society champions the heterosexual (CIS Gendered) norms through a concept called heteronormativity. This can particually be an issue for a person who is nonbinary or does not conform to gender norms as a person may not feel included within the norms championed, for example, a non-binary individual might not conform to the binary in which heteronormativity is complicit within.

Butler (1999) states gender is like a performance, it is us meeting social norms through repeated actions, it is therefore like an act. Butler (1999) calls this theory performativity. If we apply this to a hospital context, we can start to understand the impact of gendered wards on an individual's identity. For example, the social norms of a women's health unit or gynaecological unit would be for a patient to act in a way that society associate as female, such as, long hair, make up, dresses or skirts. A pre op transgender man or gender non-conforming individuals for example, may not express themselves or 'act' in such a way, therefore, they might not feel welcome on the unit as they do not conform to the accepted norms of the ward. This can cause them to feel singled out which as previously discussed may disclose that they are transgender and cause anxiety for the individual due to presumed negative beliefs from others.

Another viewpoint that commonly dismisses self-identified gender is from gender critical theorists. Gender critical theorists also dismiss gender, but they recognise the sex that a person was born as and that this does not change (Williams 2016). This belief dismisses a transgender individual's self-identified gender and that their rights and needs are based on their sex at birth. If we apply this to the hospital context, gender critical theorists would state that a transgender man is still female and a woman, therefore, a women's health unit would be the most appropriate ward for the individual to be admitted to. Feminist critical theorists also known as TERFs defend sex-based rights of females, they state that transgender females negate these rights and the inclusion of these individuals in female only spaces make them no longer safe (Williams 2016). This view can influence the decision of where an individual might be placed on a ward if the bays are gendered. Gender critical theorists would state that a transgender individual should be admitted to the gendered bay based on their birth gender. This might cause negative reactions as the individual will be expressing themselves as a gender other than what the assigned gender of the bay.

Butler (2011) explores the social creation of gender by dismissing the 'materialisation of sex'. The materialisation of sex is the theory that sex is created by the lens in which we view the body, therefore, what we view 'sex' as is a cultural construction. Butler (2011) refers and builds on the work of Foucault where he states that we over medicalise the body and create labels to understand human phenomena better. This view if applied to a transgender individual can give an individual freedom from their birth sex, as this can be believed as a construction as well as gender. Another theorist that denies that birth sex is only what defines an individual is Simone De Beauvoir, De Beauvoir (1949) uses the following

quote to detail that gender identity is more than biological sex and social construction alone, *'One is not born a woman but becomes a woman'* (De Beauvoir 1949). De Beauvoir states that socialisation and societal pressures is what shapes how a person identifies and presents their gender. This view conflicts with the gender critical view as a person's birth sex does not solely define them, therefore, they can 'become' their identified gender through socialisation and fitting with societal norms, such as, not being admitted to a women's health unit if they do not identify as a women.

Performativity and the materialisation of sex, also as well as stating how gender is constructed and sex viewed, dismisses the gender binary. If gender is not a fixed truth, instead a social construction, therefore gender is not exclusively a binary (male or female). This is evident in other cultures where there is often a recognised third gender, for example the fa'afafinein the south pacific and Two Spirt people in native American culture (Jacobs et al 1997, Vasey and Bartlett 2007) This demonstrates that the gender binary is a western creation and not necessarily fact, therefore nonbinary individuals and individuals that do not conform to gender norms identity is valid and therefore should be considered in healthcare.

V. COMMUNICATION AND LEADERSHIP IN PRACTICE

As identified, transgender individuals often face several barriers to healthcare; this includes an individual's fear of discrimination. According to Safer 2018 an individual's fear often comes from healthcare professionals lack of understanding of transgender needs. Greater training in the needs of LGBT particularly transgender needs is needed in healthcare (Doran et al 2018). According to Daley and McDonnell (2011) Equality and diversity training often focus on cultural competency and there needs to be greater focus on gender and sexuality training. As well as training, greater visibility of transgender inclusion is needed in healthcare settings, the use of transgender leaflets, imagery and pins on lanyards for example would demonstrate that the setting is aware of the existence of transgender individuals and that the setting is committed to improving visibility in society.

It is essential for healthcare professionals to be aware of the power they hold over vulnerable individuals within society. Buber a well know philosopher explored the idea that we need to move form an authoritarian approach where we see the individual as needing treating to working with an individual (Kramer and Gawlick 2003), this philosophy has been adopted as being the basis of modern-day person-centred care. Rogers (2012) details three core conditions to 'client centred therapy', we must have empathy, congruence and unconditional positive regard. These three core conditions and working in partnership with an individual would help break down power dynamics between healthcare professionals and a transgender individual.

Micro aggressions against LGBT individuals are common in healthcare (Nadal et al 2010). A micro aggression is a subtle, often unintentional form of discrimination Nadal et al 2010). Micro aggressions often come from a lack of awareness of how subtleties in language for example can cause offence. An example, would be, refereeing to an individual's pronouns as 'preferred' as assumes that the gender they identify as is an arbitrary choice, instead, we should ask what a person's pronouns are without any subjectivity in the language as this does not question an individual's identity (Khan 2015). Another micro aggression that healthcare settings often commit is that they apply heteronormative assumptions about transgender narratives, for example, that all transgender individuals are born as the wrong gender (Khan 2018). This assumes the binary and that gender exists, for some transgender individuals, particually gender non-conforming individuals, the binary of male and female is rejected, and societal norms of gender do not conform to an individual's identity. Healthcare professionals need to become more aware of subtleties within language, ensuring that healthcare settings are safe and inclusive places for all.

Gendered wards/ bays can also be perceived as a micro aggression, particually, for individuals that do not conform to gender as bays are based on the gender binary would not be an inclusive environment. This identifies the need for there to be some wards/ bays that are not gendered, ie, mixed gender wards. Hospitals often have side rooms that are not gendered, and this might be an option, however, this can cause segregation and isolation. This, however, should be an option offered to a transgender individual, especially if they do not feel comfortable being on a sing sex ward. This problem demonstrates the need for a more structural change leading to policy reviews ensuring that hospitals become more inclusive for all.

The Department of Health have same-sex accommodation guidance, this is where hospitals are required to offer same sex accommodation in hospitals. There is separate guidance on the rights of transgender individuals based on accommodation. The guidance states that decisions of where an individual should be admitted should be based on the gender presentation not on biological sex, as well as, advice regarding the need for dignity and privacy to be respected (Department of Health 2010). The guidance does state that, in the occasion that the individual requires specific care based on a gendered wards specialism this should take priority (Department of Health 2010) This therefore could cause tension, as previously discussed, as it might not the wishes of a transgender/ gender non-conforming individual. The guidance, while provides advice regarding transgender individuals that conform to the binary, it does not clearly address any needs of individuals who do not conform to the binary, while this guidance document has had some updates there has currently been little to no changes to the guidance around non binary and gender non-conforming individuals, therefore the document needs updating to provide advice on healthcare for all.

VI. CONCLUSION

This article has explored a hypothetical case study of a pre op transgender man and/or a gender non-conforming individual admitted onto a 'women's health unit' for gynaecological care. There are many ethical considerations that need to be addressed in this case study, this includes taking the resources of the NHS into account, considering other peoples views of gender and taking the legislation into account. The next section of the article explored how power in hospitals can influence the experience a transgender individual might have, particularly through internalised stigma and the power dynamic healthcare professionals hold over some the most vulnerable within society. Identity and selfhood have also been discussed, in this section theories around gender and sex have been discussed. Butlers theories around gender being a social construct and sex being a cultural lens help us to understand the nature of gender, which, helps to defend a transgender individual's identity against gender critical theorist who reject self-identification and base an individual's rights on their birth sex. The last section focuses on how practice needs to develop particually regarding how we communicate and how on a structural level changes need to be made, for example, making policy and guidance more inclusive for non-binary individuals.

Healthcare professionals need to become more self-aware of the power they hold over the most vulnerable ins society. Transgender individuals that are unwell face a double jeopardy of vulnerability, therefore, healthcare staff needs to feel empowered to be able to defend the rights of this group of people. Improved training and guidance are needed that meet the needs of this specific group, for example, ensuring that, for example, official guidance includes gender non-conforming individual not just people who conform to the gender binary. Greater Awareness of the needs of transgender individuals is increasing, the hope would be that healthcare will listen to this group of individuals, leaving behind outdated views of gender, creating inclusive healthcare for all.

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