Chapter 1

# Terminology in Transgender Medicine

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## 1.1 Introduction

Transgender and gender diverse (TGD) is an umbrella term for individuals whose gender identity/ies differ from sociocultural expectations of their sex assigned at birth. Labels and terms that people use to describe their identities can include but are not limited to transgender/trans man, transmasculine or trans masculine, transgender/trans woman, transfeminine or feminine of center, two spirit, bigender, third gender, agender, nonbinary, genderqueer, and genderfluid. Worldwide, TGD people face numerous barriers to quality service provision and clinical care across treatment settings (e.g. emergency services, ambulatory care, primary care visits, specialized services, etc.) [1]. These barriers to care, characteristic of micro- and macroaggressions, are often informed by implicit biases rooted in societal marginalization, discrimination, transphobia, and historical stigmatization of minoritized identities [2–5]. These sources of patient–physician rupture can occur at different points of access within the medical system and contribute to minority stress and trauma, adversely impacting patient mental health and well-being.

International health commissions and oversight governmental bodies have recognized and underscored the importance of standardizing best practices for healthcare service delivery to address structural and systemic inequities [6,7]. The World Health Organization's (WHO) Consolidated Guidelines on HIV prevention, diagnosis, treatment, and care for key populations [8] "outline best practices in the public provision of gender-affirming health care; training of healthcare workers on respecting the human rights of transgender persons including the rights to dignity, privacy, autonomy and physical and psychological integrity; and prevention of gender-based violence" [6]. TGD individuals need access to competent, trauma-informed care that incorporates cultural responsiveness and humility. It is considered a human right for TGD people to have access to the highest attainable quality of healthcare that is inclusive of sexual and reproductive issues [9–12]. TGD people accessing healthcare services should be treated with dignity and respect, rights often afforded to cisgender patients and taken for granted as treatment as usual.

Over the past three decades, language and terminology has been revised in diagnostic manuals (e.g. the *Diagnostic and Statistical Manual of Disorders International Classification of Diseases*) and guidelines for care (e.g. World Professional Association for Transgender Health Standards of Care). Language shifts were intended to focus on distress from dysphoria (DSM-5) or conceptualize symptoms to be treated as outside the classification of mental and behavioral disorders (ICD-11), to lessen the pathologizing of gender identities while also not compromising access to care [13]. Language in healthcare settings is important in order to better serve and understand the unique needs of various groups within TGD communities. For example, transgender women are often categorized with men who have sex with men, as opposed to recognizing the separate (yet potentially related) sexual and other healthcare needs of these communities [14]. The exclusion of TGD people in medical settings contributes to poor healthcare utilization [15]. While keeping in mind contextual factors, existing literature documents that within western healthcare systems, TGD people who are racially/ethnically marginalized disproportionately experience negative interactions in clinical encounters [16]. Failure of healthcare professionals and institutions to adapt to evolving terminology further contributes to the marginalization, invalidation, and exclusion of gender diversity in the medical field. Rather than dismissing or erasing unfamiliar identities, identifiers, or terminology, healthcare professionals need to collaborate with patients and reflectively listen to how the patient affirms their autonomy and agency by using patient-provided terms.

Systemic erasure of gender identities manifests differently across place, person, and time. Healthcare professionals and staff must consider the ways their positions of power manifest differently for each patient receiving care, depending on sociocultural and historical context, geo-political landscape, and both formal and informal power structures that reinforce disenfranchisement, marginalization, and erasure. Combating systemic erasure by means of culturally humble care requires valuing information about identity, identifiers, and terminology on the basis of *innate worth* (i.e. autonomy and agency as intrinsic to the human condition as opposed to conditional on healthcare professional or institutional validation) rather than feelings of familiarity or comfort with the term(s) being used. The healthcare professional's reflexive learning of terminology creates opportunities for TGD individuals to gain autonomy and agency in their healthcare. Further, institutional



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change must occur in order for this change to become systemic.

It is critical to acknowledge and understand that transgender medical care is situated within complex systems of power that center cisgender identity and experience by focusing on physiological and biological understandings of medical care, not necessarily the whole person. For instance, previous scholars [17–21] exposed how gender and sexes were gradually established as a natural order and embodiment of gender identities became regulated by pressures to conform to these established gender norms. Knowledge related to medicine was no longer specific to curing illnesses, but it became about what is considered normative and civilized for individuals and in society. Health and conformity to social expectations were conflated, and deviations from or questioning this practice were often not tolerated [19]. This narrow conceptualization of gender and sexual identities, rooted in White, cisgender, and heteronormative frameworks, was forcibly imposed onto indigenous and other global communities [22]. Under the guise of paternalism, this imperialist enterprise privileged *naturally* established and embodied understandings of gender and sex, which are maintained to this day [17,22].

Healthcare professionals must recognize that these western conceptions of gender and sexuality may not align with all communities around the world or with patients' terminology for their own experiences, behaviors, and identities. TGD patients may be exposed to ignorance and assumptions concerning cis-normativity leading to erasure regarding their gender identities (i.e. *"women's health"* spaces that center cisgender women's experiences, etc.), being more frequently asked intrusive questions that cisgender patients are not asked (e.g. regarding physical body parts, sexual behaviors, etc.), and experiencing microaggressions informed by limited training on TGD (or even, LGBTQ) competency [23–27]. When accessing medical care, TGD patients also experience inconsistent and unbalanced adherence to established treatment guidelines, protocols, and recommendations, to some degree resulting from minimal oversight and lack of regulatory consequences, which foster mistrust in medical systems and healthcare professionals broadly [4,23,28,29]. In some cases, differences in quality of aftercare may fuel additional mistrust in TGD patients (e.g. recent studies have begun exploring the differences in aftercare results and appearance post-surgery for trans men who have undergone mastectomies vs. cancer patients who identify as cisgender women, e.g. [30]).

## 1.2 Institutional Power Shapes Language: Terminology and Impact on TGD Patients

Terminology evolves at a rapid pace. While many resources provide definitions to terms known in transgender healthcare, there is no list that can be considered precise and standardized in gender care; cultural-specific and regional differences, translational concerns, and other nuanced considerations lead to difficulties with standardization. Further, institutional power that shapes language is influenced by social norms – not human diversity – in order to maintain efficiency [17]. Frameworks that center binary, mutually exclusive gender categories and definitions erase diverse gender identities and reduce them to cis-heteronormative, familiar terms and definitions for dominant group convenience (e.g. inherent assumptions and ascriptions of identity based on physical appearance, rejecting the use of they/them pronouns, and expecting people to use binary pronouns despite their identities, etc.).

To avoid reinforcing these types of harmful clinical encounters, we recommended referencing and including sources developed by and for the TGD community (with consideration of other relevant sociocultural factors). Most importantly, healthcare professionals need to talk with TGD patients about their own definitions for the words they use for themselves and honor their patients' self-definition of their gender. Healthcare professionals must also remain open and curious while not overburdening the patient by having them educate the healthcare professional or share their experience about their gender or transition when not relevant to their clinical care.

Collaborative patient–physician discussions about terminology and language used throughout clinical encounters are critical for a trauma-informed approach, building therapeutic connections, and having a more successful encounter. However, respectful and affirming use of terminology extends beyond introductions (asking names and pronouns). While some binary transgender people prefer the use of gendered language to validate their identities and foster inclusion, using gendered terminology can marginalize nonbinary people and those who have more fluid identities. Erasure of marginalized identities and language manifests within systematic power structures such as the medical field. For instance, medical and legal jargon used for coding and billing upholds exclusive systems of identity (e.g. male/female; FTM/MTF; OB-GYN; Women's Clinic) and can restrict access to necessary procedures for those who do not identify within the gender binary. As a result, medical healthcare professionals – relying on medical jargon for efficiency – reaffirm the exclusive system in their use of language with patients and colleagues. Medical jargon does not effectively encompass human diversity but instead aligns with the most visible or dominant groups. As healthcare professionals, it is important to challenge the reflex to deduce patient experiences to binary and mutually exclusive categories, including assumptions that particular categories are always synonymous (e.g. nonbinary, genderqueer, and gender fluid). Preventing erasure involves documenting the terms or descriptive language provided by patients to describe themselves as well as reflexively using the provided terms and language (while making shifts if the terms/language changes) across the lifespan.

Evolving terminology presents challenges for medical healthcare professionals. Adhering to reflexive learning practices can assist with (1) ongoing and active critical analysis of



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one's own thoughts, values, assumptions, biases, and personal and professional experiences, and (2) how these factors shape interactions with patients, health institutions, and relations to others in general. Language evolves, and healthcare professionals, staff, and care teams need to evolve with the language used by the TGD community [31]. For example, frequently asking for and updating patient-identified terms in their chart about their gender, such as their name, pronouns, or terms used for identity/ies or to describe various body parts supports patient self-determination. Using patient-provided terms also fosters trusting medical care through bodily autonomy and agency across the lifespan.

## 1.3 Basic Terminology to Keep in Mind (from a Western Perspective)

Below is a list of basic terminology for transgender healthcare. Please also see Table 1.1 which highlights ways in which terminology can be adapted to be inclusive of a variety of patient experiences.

- Gender binary: a system of viewing gender as having only two mutually exclusive categories, specifically female/woman or male/man. This system is oppressive to people who challenge gender expectations associated with their sex assigned at birth and those who identify outside of these two categories [32].
- Cisgender: an adjective that means that a person identifies with their sex assigned at birth [32].
- Cisnormativity: the assumption that all individuals are cisgender, the privileging of the needs of cisgender people, and the encouragement of conformity with such norms [33].
- Sex assigned at birth: the binary classification of a person as either male or female based on anatomy (genitalia, reproductive organs) at birth and/or chromosomes [32,33].
- Gender identity: a person's internal concept of the self as a woman, man, some combination of woman and man, neither woman or man, and/or another descriptor [32]. A person's gender identity does not have to align with sociocultural expectations of their sex assigned at birth.
- Gender dysphoria: distress felt due to the incongruence between a person's sex assigned at birth and the gender(s) with which they identify. Not all TGD people experience gender dysphoria [33]. Several factors including societal rejection, transphobia, adherence to the gender binary, and cis-heteronormativity often contribute to psychological distress.
- Nonbinary: an umbrella term, used as an adjective, that encompasses all genders other than exclusively woman or man. Notably, nonbinary is also a term that is used to describe an aesthetic or gender presentation of a cisgender or transgender person. Some nonbinary people identify as transgender and others do not [32].
- Transgender woman: a term that may be used by people who were assigned male at birth but self-identify their gender as woman/feminine. The person may not actively identify as transgender, preferring the term, woman. Ask patients what language they would like used, and avoid assumptions about pronouns [32].
- Transgender man: a term that may be used by people who were assigned female at birth but self-identify their gender as man/masculine [33]. The person may not actively identify as transgender, preferring the term, man. Ask patients what language they would like used, and avoid assumptions about pronouns [32].

## 1.4 Trans Oral History: Community Preservation and Challenging Historical Data Gathering

The use of oral histories may be a source of validation for TGD individuals, which can be helpful in clinical settings. Despite historical and ongoing medical discourse that often rejects diverse gender identities or perpetuates cisnormativity and transnormativity, oral histories within TGD communities allow for an open discussion of positionality and power differentials. This practice gives space for people to socially locate themselves in terms of their own gender diversity by using the labels and descriptions that are empowering and affirming to the individual. The use of oral histories challenges typical approaches to historical data gathering and validation, as well as the narrow conceptions of gender in that it ". . . sees historical and vexed categories of identity as subjects of inquiry, rather than as stable objects" [34]. When TGD autonomy and agency is emphasized, healthcare professionals also assist patients in feeling empowered and affirmed. Therefore, the terminology the patient provides is the terminology the healthcare professional uses.

TGD people are keen to overhear conversations or review the ways their concerns are considered by healthcare professionals. Sharing experiences with other community members is a way of creating oral histories [35], which have been largely excluded and disenfranchised by dominant culture. TGD people use oral history to relay experiences – positive or negative – to one another to create an informal, but crucial network of resources. Recounting negative experiences often results in a chilling effect [36]; that is, when members of a community informally but collectively avoid harmful healthcare professionals, clinics, or services. While the chilling effect reduces the already limited network of gender-affirming healthcare services and contributes to poor health outcomes, for TGD people, it can empower them to recreate their own networks of TGD-affirming healthcare professionals. Overall, this process can be healing and serve as a protective factor for TGD communities as they navigate mostly cisgender spaces.

## 1.5 Restorative Work in Medical Settings

As visibility and access increase for TGD communities, medical healthcare professionals across specialties are tasked with the challenge of intentionally deconstructing oppressive



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**Table 1.1.** Considerations, misconceptions, and recommended practices for inclusive and gender-affirming practices (from a Western perspective)

| Terminology used | Considerations for inclusivity | Common misconceptions | Recommended practice |
|---|---|---|---|
| Categorical terms concerning service provision for specific groups (i.e. Women's Health, Gynecology, etc.) | Use of binary terms with TGD patients can contribute to additional barriers to care and ruptures in treatment (i.e. othering and outing people as transgender without their consent, inadvertently discouraging TGD patients from seeking services resulting in them having to find other ways to receive treatment, etc.) | Use of gender-inclusive terminology and clinical practice can contribute to erasure of majority cisgender identities. | Incorporating the use of gender-neutral language and terminology to foster inclusion of TGD patients, such as sexual and reproductive health.<br>We recommend challenging assumptions and modifying marketing and design practices regarding who can and should access services (i.e. avoiding using traditionally gendered colors and aesthetics that center a specific community or demographic, staff and healthcare professional attitudes and expectations that reinforce Eurocentric gender conformity across patient care).<br>We suggest exploring how these practices marginalize TGD people, including those with multiple marginalized identities (such as TGD people of color) and those of non-Western backgrounds. |
| Gendered descriptive terms regarding anatomy (i.e. vulva, uterus, ovaries, breasts, etc.) | Using inclusive terminology in reference to anatomy in patient care: recognizing and prioritizing patient preferences for affirming terminology | Beliefs that certain body parts and anatomy exclusively belong to certain genders (e.g. "women's" body parts, assumptions about prostates and gender) | We recommend considering the following inclusive terms, as a few examples of alternatives to traditionally gendered language:<br>- Vulva: external pelvic area/region, outer parts, external genitals<br>- Uterus and ovaries: internal reproductive organs<br>- Breasts: chest<br>Trans Care BC [42] provides additional guidance on inclusive terminology. |
| Descriptions of traditionally gendered physiological processes (i.e. period, menstruation, etc.) | Using alternative inclusive terminology that captures patient experiences and asking patients if they have preferences for specific terminology that is affirming. | Beliefs that certain physiological processes are experienced exclusively by certain genders (i.e. cisgender women and menstruation) | We recommend considering inclusive terms as alternatives to traditionally gendered language (e.g. instead of period and menstruation, using monthly bleeding or cycle). We also suggest discussing medical issues/conditions without ascribing gender (i.e. rather than connecting pregnancy with women, healthcare professionals can explain "pregnancy may occur without contraception") [42]. You can reference Trans Care BC [42] for additional recommendations. |

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| **Identity terminology** | | | |
|---|---|---|---|
| **Terminology used** | **Considerations for inclusivity** | **Common misconceptions** | **Recommended practice** |
| Language used to describe or label people who do not identify with the gender binary (i.e. 'third' gender, agender, nonbinary, genderqueer, genderfluid, etc.) | Language varies across place, space, and time requiring ongoing acceptance of identity formation to foster culturally humble care. Some people identify beyond common or socially constructed definitions requiring ongoing reflexive acceptance from healthcare professionals and staff. | Translations or interpretations of terms, identities, or labels are static. | We recommend having multiple mechanisms for acquiring gender-identity-related patient information and being receptive to changes in identity and terminology as preferred by the patient.<br>- Using gender-inclusive patient intake forms.<br>- Having culturally responsive training that focuses on gender-inclusive and gender-affirming practices (that includes all points of contact for the patient).<br>- Initiating reflexive conversations with patients about gender identity labels and pronouns. |
| Gender identity labels (i.e. transmasculine or trans masculine, transfeminine or feminine of center, two spirit, bigender, 'third' gender, agender, nonbinary, genderqueer, genderfluid, etc.) | Gender identity labels are socially constructed, contextually situated, and constantly changing to meet the needs of the TGD community. Some people use multiple labels, simultaneously or throughout their lifespan, to illustrate aspects of their identity that are not fully captured by one term. Accommodating and supporting nuance in identity aligns with gender-affirming, culturally responsive practice. | Terms mistakenly used interchangeably but can have different meanings. | See comments above |

*Note*: The intended use for this table is to highlight ways in which terminology can be adapted to be inclusive of a variety of patient experiences.

training models and actively expanding their clinical knowledge to incorporate the medical and healthcare needs of TGD patients [25]. Medical healthcare professionals, however, are often ill-equipped to do so due to competing systemic demands, limited access to inclusive training resources, and lack of transgender representation [25]. Despite the extant literature on barriers to care and clinical encounters that contribute to treatment nonadherence, the medical system has not been able to adapt to the needs of the people it is meant to serve [15,16,24]. Medical healthcare professionals' perceptions and enactments of gatekeeping, influenced by common trajectories for gender transitioning and superficial understandings of gender identity and expression, continue to serve as a mechanism for identity invalidation for TGD patients [16]. These dynamics are further exacerbated by contextual factors such as geographical power and positionality (i.e. differences related to urban vs. rural communities, diverse regions, indigenous communities, etc.), which result in patients having less autonomy and choices to select their healthcare professionals [1,2,37].

Prior to making large-scale changes, medical sites need to conduct their own specialized needs assessment and engage in a consultation process with community stakeholders (e.g. assembling a community advisory board) to address areas needing improvements [15,29,38]. Multilevel changes need to target (a) sources of clinical rupture with patients, (b) healthcare professional training to improve implementation of system-wide interventions to foster culturally responsive care, and (c) institutional policies that disproportionately impact patients with minoritized identities [15]. These changes can begin with an extensive review of medical terminology and language that assumes binary gender categories (e.g. using colloquial, gendered titles or honorifics, binary gender labels, etc.) [24]. Subsequent changes should focus on eliminating heuristic, if-then understandings rooted in gender ideology and corresponding stereotyped behavior (e.g. expectations about the types of sexual activity certain people have based on gender expression, perceived congruence of gender and physical body, etc.). Smaller-scale changes should consist of integrating consent-based inquiries and assessment from a TGD-inclusive and patient-centered framework that does not assume static identity [4,24]. Illustrations of this can include asking patients which pronouns they use, having conversations about the name the patient would like used in different settings (in conversation, in documentation, if others are present, etc.), and having discussions that prioritize patient needs and experiences [4,24].

Other modifications to patient care should also include: (1) implementing adaptations to electronic medical record software (e.g. infrastructure changes that include diverse gender identity options, pronouns, chosen names, and other aspects of identity to minimize misgendering and identity-related clinical errors, etc.), and (2) updating medical forms and documentation to be inclusive of TGD patients (e.g. providing multiple response options or open-text responses for questions about gender and sexual orientation)[39–41]. These changes can be enhanced by integrating multiple points for check-ins and periodic inquiries about demographic information to invite communication regarding identity changes, strengthen rapport, and maintain accurate medical records (e.g. changes to gender identity, sexual orientation, name, pronoun use, etc.).

Overall, shifting the operational paradigm in clinical settings promotes transparency and communication in decision-making, improving treatment adherence, outcomes, and patient satisfaction [2,4,16,25,29]. To more effectively address barriers to care for TGD patients, oversight commissions and agencies have begun evaluating quality of service delivery and providing incentives to institutions demonstrating measurable improvements in service and patient satisfaction [1]. The above-mentioned adjustments to service delivery can demonstrate a clear commitment to rectifying the pre-existing hierarchical dynamics between the medical system, healthcare professionals, and patients by fostering respectful and collaborative working relationships.

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