The October 2018 Ethics for Lunch involved the ethics of caring for and working with transgender individuals. The panel discussion created a forum for clinicians to learn how to care for gender minorities (transgender, gender non-binary, gender fluid, and gender non-conforming people). Three cases were presented to highlight different aspects of delivering respectful transgender health care: (1) a teenager who comes out as transgender but whose parents are dismissive of their gender identity; (2) a parent whose name and gender do not match their current identity, which causes at the security desk; and (3) a non-binary patient whose endocrinologist offers hormonal options only for stereotypical binary gender transformation.

Key points from the session included:

1. The current health care system was not designed with transgender people in mind, and most clinicians have not received formal training in hot to deliver culturally and clinically competent care to the transgender population. Lack of education is one factor that contributes to health disparities for transgender people in the community.

2. The health care system has multiple barriers for transgender people to receive care—insurance coverage, gender identity (chosen name, preferred pronoun) in the electronic medical record, appropriate best practice advisories for preventive care, etc. Things are slowly starting to change to address these needs.

3. It is important to understand the perspective from which a person with whom you are interacting is coming from—identity is tied to race, sexual orientation, gender identity, age, class, place of residence, educational background, etc.—and how we perceive each other will be viewed through those particular lenses.

4. Gender minorities can face passive forms of discrimination that dissuade them from seeking medical care. One-third of respondents in a 2016 survey reported a negative experience with a health care provider in the preceding year. One-quarter of respondents indicated they did not go to the doctor when they needed to, because they were concerned about having a bad experience (either with the provider or when out in public getting to an appointment).

5. Small gestures can make a big difference in making people feel welcome, especially when they live in a world where they may not feel welcome or feel like they are not being seen and accepted.

6. In caring for adolescents with gender identity concerns or questions, health care providers must be mindful of confidentiality and issues related to disclosure to parents, akin to how sexual health issues (e.g., contraception) are handled (although gender identity and sexuality are different concepts). Regulations about involvement of parents in adolescent health care may vary from state to state. Providers have a responsibility to provide a safe space to their adolescent patients and advocate on their behalf, while also recognizing the role parents have in the upbringing of their children.

7. Evidence shows that youth who are gender minorities do better when there is family acceptance of their identity. Clinicians and parents agree that they want what is best for the child, and appropriate use of pronouns is one means to demonstrate this. Use of pronouns is one important way in which we convey respect to gender minorities, so asking patients what their preferred pronoun is based on their gender identities is a critical first step.

8. Attitudes about gender identity can be linked to cultural mores, religious beliefs, social acceptance, etc. The world is set up such that we interact with one another in a very gendered way (*cis* binary gendered way) and with an expectation that one’s gender should match anatomy. Gender non-conforming people challenge these assumptions.

9. Gender dysphoria is the distress a person feels when they are questioning their gender identity. Gender identity is not a mental illness. Historically, people who are different have been labeled as sick, and if they are sick, then they can be treated differently and their rights can be taken away.

10. All health care personnel should be trained in gender identity and gender expression. Respectful communication should establish how to greet people—for example, not using honorifics (Mr., Mrs., etc.) and not assuming what someone’s pronoun (he/him/his, she/her/hers, they/them/theirs, no pronouns, etc.) should be based on what they look like. Some people are gender fluid and may use different names and pronouns in different spaces and times. People should be asked what pronoun should be used to address them and what name they wish to be called, rather than automatically defaulting to the name that appears on a state ID card. It can be a daunting process for an individual to change legal documents from their birth-given name/sex to what they choose for themselves. Health system policy changes are needed to accommodate individual’s preferences (e.g., changing what is put on a wrist band as identifiers).

11. Respect is demonstrated through permission and acknowledgement. Permission entails asking the person how they wish to be referred to. Acknowledgement involves confirming how a person wishes to be addressed but for legal reasons why their birth name may need to be used in the delivery of care. A way to do this is to have the person state what name and date of birth appears on their identification without forcing them to “own” that name. Using a transgendered person’s former name is called “dead-naming” and can raise safety concerns (either by being a trigger for gender dysphoria or by targeting the person for victimization by others).

12. It is okay that people make mistakes in how they refer to a person of a gender minority; if they err, they should apologize once in a nice way and then move on. SOGI (sexual orientation, gender identity) questions should be universally used. A way to prevent mistakes is to do introductions in a routine way with every encounter: “Hi, my name is \_\_\_\_ and I am going to be your care provider today. My pronoun is [she/her, he/him, etc.]. How would you like me to address you? What pronoun do you use?”

13. Individualized care should be defined by the patient and tailored to that person. Gender affirming care should be directed by the patient’s goals and delivered in a safe, effective way. Transgender individuals may gain access to medications (e.g., hormones) outside of the medical establishment and may seek this route because of the barriers imposed by the traditional health care system. The health care system has to recognize that gender options are not just binary and that gender expression can take many forms. Gender goals are unique to each person. The patient is the expert of who they are, and clinicians should engage them in a shared decision-making model, informing them of the risks and benefits of the interventions being proposed to achieve the outcomes they desire. Communication goes more smoothly when the clinician has already educated themselves about the care needs of transgender patients.

14. It must also be recognized that gender minorities are in need of care for ordinary problems (common cold, broken bone) and not every encounter has to delve into their trans status or attribute the acute problem to the treatments they are receiving for their gender affirming care.

15. In today’s health care system, gendering happens. A transgender woman may be asked about her menstrual cycle or whether she could be pregnant. While questions along these lines may be routine, they can be upsetting to some patients.

16. The language used in clinical encounters is an important aspect of showing respect. Old terms like “sex change” or “sexual reassignment surgery” should be abandoned. The terminology used in the community may be different than in academic settings, so clinicians should be attentive to how patients phrase things. Clinicians should refer to body parts in a neutral fashion or use the terms that the patient is most comfortable with. The terminology evolves over time, so it is important to stay current but also to have cultural humility—when a statement lands wrong with an individual, recognize it and apologize without making a big deal of it.

17. Sexual identity and gender identity are different concepts. Sexual identity involves the sexual being of who a person is and includes attraction, behavior, and orientation. It is important for clinicians to recognize that sexual identity and gender identity do not always align.

18. Information exchange has to go both ways. Patients and families may have misinformation, so it is important for members of the interdisciplinary team to provide accurate information. It is likewise important for clinicians to listen to their patients and learn from them. Trans individuals should be part of the continuing education efforts for clinicians.

19. Every body is different. Treat each person as a unique human being.

20. If this is new territory for a person working in health care, it is okay to feel uncomfortable, but it is not okay to allow that discomfort to impact the quality of care they deliver.