Toward Developing Clinical Competence: Improving Health Care of Gender Diverse People

See also Landers and Kapadia, p. 205.

Research has consistently shown that gender diverse people (e.g., transgender, transsexual, gender nonbinary) are at elevated risk for multiple adverse health conditions and other clinical concerns. This includes substance abuse, HIV, nonsuicidal self-injury, and suicidal ideation and attempts.[1–5] These risks are exacerbated by the lack of properly trained providers to address clinical concerns (bit.ly/2fP1CfZ). In the 2009 report from the American Psychological Association, it was reported that only 27% of psychologists who responded reported a sufficient level of competence in working with gender diverse clients (bit.ly/2fP1CfZ). A study of undergraduate medical education indicated that students received an average of 7 (SD = 6.5) hours of education in working with lesbian, gay, bisexual, and transgender (LGBT) content.[6] It is appalling in the 21st century to find that health care providers are lacking the knowledge to provide basic care for gender diverse people.

This lack of education is seen by the gender diverse community as a crisis. It is a crisis when people are required to wait two or more months to initiate hormones because there is only one provider in the area who provides this treatment. If people are already experiencing distress about their gender and are emotionally and physically ready to start hormones, placing an untenable wait for care is tantamount to patient abandonment, which is considered by some professions to be unethical behavior (bit.ly/22FWYAf).

One of the challenges that gender diverse patients face is the assumption by many providers that they have a mental illness, in part because gender dysphoria is a diagnosable condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*).[7] Knowing that one's provider holds this bias may make it difficult to agree to seek care, regardless of the significance of the illness a person is facing. Moreover, there is significant disagreement in the gender diverse community about the usefulness of the diagnosis. Some experts maintain that the diagnosis is critical for people who access health care through a government-sponsored health program (e.g., Medicare and Medicaid). Additionally, people who are most marginalized (e.g., prisoners, people living in poverty) rely on the rendering of a diagnosis if they are to access care. On the other side are people who believe that being a gender diverse person is not a mental health disorder and that gender dysphoria, like homosexuality, should be removed from the *DSM-5*. This issue may be addressed when the new *International Classifications of Diseases* is released by the World Health Organization. It is important to note that many health organizations, including the World Professional Association for Transgender Health, the American Medical Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American Psychological Association, the American Psychiatric Association, and the National Association of Social Workers have released statements addressing either the need to depathologize gender dysphoria or to state in unequivocal terms that treatments that are part of a medical transition are medically necessary (bit.ly/2f5UxnF). This clause is one way that gender diverse people have been able to make the case for insurance coverage, which is far from ubiquitous for those who have access to health insurance.

These issues are more than a simple inconvenience for gender diverse people. In some cases, it is a matter of life and death. The case of Robert Eads (featured in the 2001 documentary *Southern Comfort*) is a prime example of the challenges some people have faced in accessing competent care. Eads, a transgender man, was diagnosed with ovarian cancer and subsequently denied service by as many as 12 physicians who were more concerned about their reputations as physicians than treating a cancer that may have been preventable. By the time Eads received care, his cancer was beyond treatment, leading to his death.

In addition, gender diverse patients are often put in the untenable position of providing education for their health care provider. This is inexcusable on the part of the health care provider. The gender diverse patient should not be the primary source of education in the health care setting. Although many providers are new to the field of transgender medicine, it is imperative that providers take the responsibility for seeking appropriate and accurate education around transgender health and health care issues.

The final area of competence is related to the need to treat the organ systems that are present in the gender diverse patient's body. This means that a person

ABOUT THE AUTHOR

lore m. dickey is with the Department of Educational Psychology, Northern Arizona University, Flagstaff, AZ.

Correspondence should be sent to lore m. dickey, PhD, Department of Educational Psychology, Northern Arizona University, PO Box 5774, Flagstaff, AZ 86011-5774 (e-mail: lore.dickey@nau.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This editorial was accepted November 13, 2016.

doi: 10.2105/AJPH.2016.303581

identified as a gender diverse male may need to have a pelvic exam, but will never need to have a prostate exam. Likewise, a patient identified as a gender diverse female may need a prostate exam, but she will never need to have a hysterectomy. This can be complicated by rigid electronic health records that code treatments based on the sex that is listed in the patient's chart. In addition to being competent to provide care, physicians, psychologists, nurses, and psychiatrists all may need to advocate on their patient's behalf to ensure they are able to access medically necessary care.

Why is this important? It is important because gender diverse people have the highest rates of suicidal ideation and attempts. It is important because gender diverse people have the right to access competent health care just as any other person does. Let this be a wakeup call for the health care profession. Gender diverse people are seeking care and are expecting, indeed demanding, the right to competent care. AJPH

lore m. dickey, PhD

REFERENCES

1. Clements-Nolle K, Marx R, Katz M. Attempted suicide among transgender persons. *J Homosex*. 2006;51(3):53–69.

2. Cochran BN, Cauce AM. Characteristics of lesbian, gay, bisexual, and transgender individuals entering substance abuse treatment. *J Subst Abuse Treat*. 2006; 30(2):135–146.

3. dickey lm, Reisner SL, Juntunen CL. Non-suicidal self-injury in a large online sample of transgender adults. *Prof Psychol Res Pr*. 2015;46:3–11.

4. Goldblum P, Testa RJ, Pflum S, et al. The relationship between gender-based victimization and suicide attempts in transgender people. *Prof Psychol Res Pr*. 2012;43:468–475.

5. Herbst JH, Jacobs ED, Finlayson TJ, et al. Estimating HIV prevalence and risk behaviors of transgender people in the United States: a systemic review. *AIDS Behav*. 2008;12(1):1–17.

6. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*. 2011;306(9):971–977.

7. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association; 2013.

Copyright of American Journal of Public Health is the property of American Public Health Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.