

Inequalities in Access to Healthcare for Transgender Patients

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Abstract

The last decade has seen a rise in the widespread recognition of trans* individuals and a developing understanding of what it means to be trans*. Although education about this is increasing across schools, communities and the National Health Service in the United Kingdom, inequalities in access to health care remains a contemporary issue. Prejudice, stigma and discrimination are the deterring fears when seeking health provision and interventions. This paper will explore the campaigns, charities and Government publications on changing attitudes towards trans individuals; analysis of health care provision, and highlight the reasons for transphobia in the UK.

Keywords

Transgender, NHS, Inequality, Stigma, Nurse, Primary Care, UK,

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Introduction

Trans* is an umbrella term used to describe individuals that may be transgender, transsexual or non- binary, (GIREs, 2016). This article will focus primarily on transgender individuals. However, it is important to consider that trans* health care should not be generalised, and separate guidelines should be considered for disparate groups within the trans* community (DH, 2008). The Office for National Statistics outlined that the 1990s saw the rights of trans* people recognised for the first time. Although campaigning has encouraged commendable historical achievements, inequalities remain prevalent in the National Health Service (House of Commons, 2015).

Historical Advances

Social views on sexuality, changes in terminology and societal awareness, make it difficult to gather sound historical evidence of trans* communities. 'Action for Trans Health' campaigners emphasise that the chronicles of modern Britain contain accounts of "people who did not fully identify with or present as the gender they were assigned at birth" (Action for Trans Health, 2016). During the 19th Century, individuals indicating transsexual 'deviations' were treated in asylums and suspected to be a result of defective genes (Garber, 2012). In the 1940's Dr Micheal Dillan, one of the first British males to undergo phalloplasty, described how "the body should fit... to the mind" (Dillon, 1946). When discovered that Dillan had undergone gender affirmation surgery, Dillon fled to Bengal living as a monk until his early death in 1962, aged 47 (Boisvert and Johnson, 2012). The 1950's saw Roberta Cowell become the first known British woman to undergo affirmation surgery; both Dillon and Cowell's novel procedures were performed by the same surgeon

(Boisvert and Johnson, 2012). Increased media coverage of late has become a catalyst for further movement in the ever long journey to equality. Knowledge and awareness of the trans* community is increasing in the public eye, with the intention of reducing discrimination and encouraging social inclusion (PHE, 2016).

It is however, crucial to note at this point that although there have been significant improvements in rights for lesbian, gay and bisexual communities, as well as trans* communities; the significance of trans* people can often be overshadowed by LGB communities (Formby, 2012). With the fluidity of Lesbian, Gay, Bisexual and Transexual (LGBT) remits in years past, Trans* communities have repeatedly been marginalized. Hunt and Manji, (2015, p 3) suggest, "Homophobia, transphobia and sexism are intrinsically linked, and not acknowledging this has perpetuated society's apathy and misunderstanding of trans* people". Nonetheless, Government legislation now ensures trans* rights are aligning to those of the general population. Development of the Sexual Discrimination Act (1975), Gender Recognition Act (2004), Equality Act (2010) and Marriage (Same Sex Couples) Act (2013) provide legal policy for the trans* communities; although Whittle, Turner and Al-Alami, (2007) suggest that this could progress further. In 1980, Harry Benjamin founded the International Gender Dysphoria Association, later to be known as the World Professional Association for Transgender Health, an organisation devoted to transgender health provision (WPATH, 2016).

The 90's saw preliminary legal recognition for trans* rights in the UK. The first parliamentary forum on transsexualism took place in 1996, evidence was collated surround the 'biologically based, multifactorial etiology for transsexualism' (GIRE, 2009). The Gender Identity Research and Education Society was established in 1997,

providing fundamental literature surrounding trans* individuals to educate the nation and establish foundations for further research. The North West Lancashire Health Authority came under scrutiny in 1998 after refusing three women gender reassignment treatment; the High Court ruled this as unlawful and stated that no Health Authority was to “impose any policy amounting to a blanket ban on funding medical treatment for the purposes of gender reassignment” (Whittle, Turner and Al-Alami, 2008). Amendments to the UK Sex Discrimination Act were made in 1999 to ensure protection surrounding gender reassignment in accordance with the Sex Discrimination (Gender Reassignment) Regulations. Thus ensuring further safety remits for trans* individuals within different communities with regards to accessing goods, services and employment (SDA, 1999).

The early 2000’s saw the UK Government recognise that “transsexualism is not a mental illness” (DCA, 2009) and trans* individuals in the UK became legally able to change their gender to align with the gender in which they identified (Gender Recognition Act, 2004). The Gender Recognition Act was enforced in 2004, enabling trans* communities’ full legal recognition of their affirmed gender. This was a monumental event in trans* history with the responsibility of the prolific event a result of Press for Change Organisation ensuring success (GIREs, 2015). The first trans* health summit took place in 2006 in London; ensuring that health provision is tailored to requirements and found that the trans* community are constantly viewed to be mentally ill within health services and individual’s needs are overlooked (Whittle, Turner and Al-Alami, 2008). Subsequent to this, the first National Health Service (NHS) initiative with the Department of Health was held in 2006, chaired by Christine Burns, trans* political campaigner and internationally recognised health advisor (Burns, 2005). Burns (2005) along with Press for Change Organisation

drove the movement of raising the profile of trans* health in the UK. As a direct result of this, the Department of Health commissioned Burns to write “Trans: a practical guide for the NHS” a publication on best practice and guidance for NHS staff (DH, 2008).

Since then, resources for NHS staff have developed and become widely recognised as imperative for high standards of care provision. The RCN published guidance for nurses caring for trans* patients in 2016, following the Women and Equalities Committee’s transgender equality inquiry pledged to the Government in 2015 (RCN, 2016). Public Health England responded to the inquiry outlining the necessity to improve training for NHS staff, improving research and data, monitoring public attitudes towards trans* communities, and working to eliminate trans discrimination, inequality and prejudice in the UK (GIRES, 2016). In short, campaigners across Britain have taken exemplary action to ensure that trans* rights become recognised further by mainstream political agenda and enable inequalities to be further eliminated.

Access to Health Care

The National Health Service (NHS) provide seven Gender Identity Clinics (GIC’s) for adults in England and just one service for those under the age of 17 (NHS England, 2015). However, an estimated 65,000 individuals currently residing in the UK, are likely to be, to some extent, gender incongruent (Mitchell and Howarth, 2009). At this point, it is essential to highlight the lack of robust data collected on trans communities within the UK; indicating of an often alluded “hidden community” (Health Policy Project, 2015).

Understandably resulting in a difficulty to suggest whether the number of services provided are sufficient to accommodate the needs of the trans population (ONS, 2009).

Similarly, NHS England found that they were unable to recommend service provision in

accordance with the need for services due to a lack of feedback received (ONS, 2009).

The BBC reported that currently, there are 4,500 referrals to GIC's in the UK per

annum; with an average waiting time of 18 months (BBC, 2016). Research from the

Equality and Human Rights Commission (EHRC) debates this could be a ramification of

the low priority of trans* services, in comparison to other areas of healthcare (Combs,

2010). Nonetheless, the Chair of the NHS National Clinical Reference Group (CRG) for

Gender Identity Services, Dr John Dean, regards not treating people, as doing more

harm (DH, 2015). Some of the consequences of ineffective health provision will be

explored in this article.

Nursing Transgender Patients

The lack of clinical guidance outlines the limited knowledge that nursing staff, as well as

other health professionals, have surrounding transgender health care. There are

currently no NICE guidelines for nursing transgender patients within the NHS. The NMC

does not identify transgender in its standards for pre-registration nursing education,

indicating a deficit in nurse education (NMC, 2010). Following Stonewall's trans*

inclusive movement in 2014, Hunt and Manji (2015) found that 20% of individuals

interviewed had witnessed disparaging and negative remarks towards trans people. By

disregarding professional standards; health professionals encourage a stigma (NHS

England, 2015).

Nursing values and behaviours must promote the importance of patient satisfaction,

daily (NMC, 2015). Alongside this there is a need to create an environment appropriate

to promote recovery, patient experience and increased long term health and recognise

individuals needs (NMC,2015). Aforementioned recommendations urge nurses to

ensure that they act with discretion, care and sensitivity; by enabling trans* patients to feel relaxed and preventing prejudicial views being conveyed to the patient regardless of the reason for attending. There is a need for professionals to ensure due regard in accordance with section 149 of the Equality Act (2010). Trans* individuals can encounter additional health risks from hormone therapy treatments when transitioning (RCN, 2016). Guidance provided by the Royal College of Nursing for all staff emphasises close medical supervision, when undergoing treatment. Polycythaemia, venous thromboembolism, hyperprolactinaemia, increased cardiovascular disease, liver abnormalities and increased cholesterol are known ramifications of hormone therapy (BNF, 2016).

Evidence suggests that trans* individuals unable to obtain hormone therapy through standard NHS routes, may obtain them via unsafe alternatives, such as the internet (GIRES, 2015). Additionally, it is recognised that the trans* community have a higher prevalence of risk behaviours such as smoking, drug and alcohol consumption (PHE, 2016). Nurses should also acknowledge their role when caring for and managing ill people who are vulnerable and delivering healthy lifestyle advice (RCN, 2016).

Acting with discretion and sensitivity, allows a trans* patient to speak openly regarding their visit and ensure that they are cared for in a suitable environment such as a side room, or gendered bay (RCN, 2016). Health care professionals can ensure that they use non presumptive language when caring for patients across all mainstream and specialised health services within the NHS; and ensure published guidance is implemented where appropriate.

Public Health England note that there is a lack of specialised knowledge in mainstream national health services (PHE, 2016). By increasing education and knowledge surrounding trans* health, it could be suggested that health promotion in trans* communities will be more effective; reducing wider determinants of ill health and increasing wellbeing (PHE,2016).

Mental Health within the Trans* Community

The Department of Health acknowledge continued prejudice, resulting in limitations for access to healthcare and failure to provide equitable healthcare (Tweddell, 2008; DH, 2015). In a study reviewed by the Press for Change Organisation, 17% of respondents stated that they were refused treatment by NHS professionals who did not agree with gender reassignment, when seeking general health provision (Whittle, Turner and Al-Alami, 2007). The focus of inappropriate or abusive treatment by healthcare professionals was highlighted within the study, opposing the foundation “to bring good healthcare to all” (Tweddell, 2008; Whittle, Turner and Al-Alami, 2008). The fear of receiving prejudicial treatment by healthcare professionals could be suggested as a reason for trans* individuals delaying treatment, or seeking medical supervision (Whittle, Turner and Al-Alami, 2008).

Although the self-study by Dillon asserted that medical transition should be offered to trans* individuals opposed to treatment for mental illness (Henkin, 2008). The view adopted by many health care professionals is that of trans* being a “mental health issue” requiring mental health professionals input, however Henkin (2008) confirms the need for medical transition should be considered for each patient. The NMC Code of Conduct state that nurses treat individual patients as such with dignity to recognise diversity and patient

choice (NMC, 2015).

Mental health intervention is often associated with negative connotations by those with little understanding, implying something outside of the realms of ordinary psychological experiences for trans* individuals. Can a trans* individual not choose to adapt their body as they wish, regardless of cognitive distress? However, as the health budget is ever-strained, it could be argued understandable that anatomical modification is akin to the psychological distress of an individual., as with body dysphoria of women requesting breast augmentation; Similarly, trans* patients are required to undergo psychological intervention prior to referral for gender transition surgery. It is suggested that in both circumstances, indirect discrimination occurs, although this may be objectively justified by local policy. Consequently, trans* individuals are at a greater disadvantage (EHRC, 2016).

The stigma associated with gender nonconformity can have a profound effect. It is therefore deemed necessary to ensure that a person's ability to adjust to life after transitioning is taken in to account prior to surgical intervention (WPATH, 2016). The National Suicide Prevention Strategy recognised that the trans* community experience higher rates of mental health issues and self-harm (DH, 2012). However, over 96% of trans* individuals have positively proven to be satisfied with gender affirmation surgery and subsequently lead happier lives thereafter (Whittle, Turner and Al-Alami, 2007).

The psychosocial implications of trans* discrimination create social isolation experienced by the trans* community (Whittle, Turner and Al-Alami, 2007). Trans* individuals are less

likely to leave the house to exercise, or seek employment due feeling vulnerable to discrimination and stigmatisation. Thus increasing health risks both mentally and physically and furthering levels of social isolation (PHE, 2016).

The Future for Trans* Healthcare

The United Kingdom is recognised for being more advanced in attitude and provision of health care for trans* individuals, than countries such as the United States of America according to statistics formulated by the House of Commons (2016). There are still areas that can be developed further, such as diminishing discrimination and increasing awareness through education. In the United States, as seen in the documentary “Southern Comfort” featuring female to male trans* individual Robert Eads, discrimination appeared to contribute to his untimely death from metastasised ovarian cancer, a direct result of over 20 doctors refusing to treat him due to the impression it may impose on their practice and other patient’s view on trans* (Ali, 2011). Increasing awareness of circumstances such as Ead’s could lead to improvement in attitude and health provision to trans* patients in the UK.

Further research and education is needed in the UK to reduce unnecessary mortality and to ensure that the trans* community are equally represented and provided for, in accordance with the Equality Act, which remains to be fully adhered to (PHE, 2016). Increased data collection and peer reviewed studies, should be encouraged, alongside effective monitoring of engagement to current services. National data is currently under represented but essential in enabling the NHS to identify areas for further improvement (ONS, 2009).

To enable further progression education must also be provided. There is a need to educate student nurses at university level and eliminate prejudice from the offset. Incorporating the importance of trans* needs within a national curriculum, advances in health provision should follow. To conclude, campaigners within the trans* community have, since the 19th century, been made huge leaps in awareness and equity of care. However, it is evident that there is much further to go. It is clear that further research is necessary alongside widespread recognition of the current inequalities faced by trans* communities. The ability for nursing staff to effectively communicate with trans* patients in a manner that creates comfort and trust, will ensure individuals are utilising services and promote innovating future service provision. Progression is awareness, provision and society's attitude to eradicate this contemporary issue.

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