Addressing a Gender Identity Crisis in Medicine

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"*What is your gender? Male or female?*" A seemingly innocuous question. Yet, I hesitated.

As a queer person of color, that binary gender question always makes me uncomfortable. Looking around the room, I searched for a hint that someone shared my anger at that moment. I could not quite get a read on people's faces, but I went for it anyway: "*I do not think that question is fair.*"

The group of 32 medical and surgical residents and fellows, who had volunteered to attend an early morning meeting with representatives of the Accreditation Council for Graduate Medical Education (ACGME) as part of the periodic Clinical Learning Environment Review (CLER) process, had expected a bland meeting and were ready to enjoy the break from clinical responsibilities. We had expected an open-ended conversation about our graduate medical experience, not a multiple-choice audience response questionnaire administered by an unfamiliar physician.

The caffeine had not even set in yet, but inadvertently, the moderator of the session had managed to wake us up. No one in that room wanted to hold things up on a morning that would be blissfully free of clinical responsibilities.

As I started sweating through my scrubs, and murmurs arose in the crowd, I thought about the other residents all around the country who had already been subjected to this question. Surely I was not the first trainee to push back? Or maybe I was just being unnecessarily stubborn?

Just before I relented, allowing my thumb to depress the clicker the final millimeter, a coresident raised his hand and said, "*I stand with him.*" Other residents chimed in, and after we had informally assembled into a small cohort of allies, we informed the moderator that we would be writing a letter to outline the ways in which the ACGME could do better. Then the meeting proceeded, and our cohort waited until after it had ended to gather our thoughts.

Although the ACGME focus group was where we faced this issue most immediately, we know this is a broader problem in medicine. What bothered us most about the CLER session was that the audience response system's binary forced choice for gender is exactly what many of our queer—and other gender nonconforming—patients face from medical professionals every day. Patients often do not volunteer intimate details about sexual orientation and gender identity (SOGI), either because they do not feel comfortable doing so or because they are never asked properly in the first place.

In 2011, the Institute of Medicine (IOM) published a comprehensive report on lesbian, gay, bisexual, and transgender (LGBT) health care disparities, and it identified a "lack of data" as the key barrier to serving these populations effectively.[1] One important recommendation was that all research supported by the National Institutes of Health apply evidence-based techniques to gather SOGI information about study participants, even going so far as to mandate this for all federally funded surveys. The authors of the IOM report cited numerous compelling reasons why we ought to take this approach: (1) the increased incidence of depression and suicide attempts among LGBT youth; (2) the higher rates of substance use and homelessness; (3) the relative lack of physicians knowledgeable about specific LGBT health needs; and (4) the high rate of hate violence committed against transgender individuals.[1] Furthermore, the authors highlighted the lack of corresponding data on physician trainees. This fact is even more alarming considering a recent, tragic, high-profile medical student suicide in New York, and the subsequent efforts by school administrators to refocus the national conversation regarding student well-being.[3] We cannot begin to address these issues until we have the requisite data to draw sound conclusions.

Not long after the IOM LGBT report was disseminated, the nonprofit Fenway Institute published a large study of 301 patients from 4 ethnically diverse health centers across the country,[2] testing the acceptability of a recently proposed 2-step gender identity question that had been adapted from an

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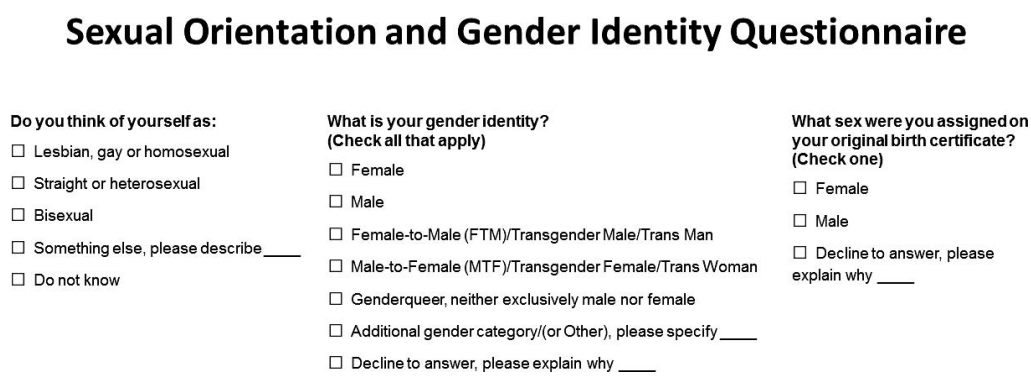
Editor's Note: The CLER program took feedback from the community into consideration in modifying the gender response options to include an additional category, "other." This change was implemented in September 2017.



Sexual Orientation and Gender Identity Questionnaire

Do you think of yourself as:

- ☐ Lesbian, gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else, please describe____
- ☐ Do not know

What is your gender identity? (Check all that apply)

- ☐ Female
- ☐ Male
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional gender category/(or Other), please specify____
- ☐ Decline to answer, please explain why ____

What sex were you assigned on your original birth certificate? (Check one)

- ☐ Female
- ☐ Male
- ☐ Decline to answer, please explain why ____

FIGURE

Evidence-Based Sexual Orientation and Gender Identity Patient (or Physician Trainee) Questionnaire

Note: Adapted from a landmark 2014 Fenway Institute study on LGBTQ health disparities.[2]

instrument endorsed by leading academics in the field of transgender studies.[4] The goal was to demonstrate a feasible way to incorporate collection of this important data in a way that was sensitive to gender diversity into emerging meaningful use requirements for electronic health records established by federal agencies, such as the Centers for Medicare & Medicaid Services. The results were encouraging. The vast majority of respondents reported that they want their physicians to know more about their sexual orientation and gender. More than 80% reported that they would not change the 2-step question employed in the study, which allows 7 choices for gender and 3 choices for sex assigned at birth according to one's birth certificate. The notion that patients want us to ask, and are willing to tell, has already made its way into the public discourse,[5] indicating that further delay would be inexcusable.

Residents often feel powerless in the face of the profession's institutionalized hierarchies. At this stage in our careers, my coresidents and I cannot expect to change everything about the medical profession and community; however, we can change some things. For this reason, I stand with my coresidents in recommending that the medical and medical education community bring itself in line with the standards set by a growing number of federal agencies and prominent medical organizations[6] by: (1) immediately removing the "male or female" demographic question from all future clinical, educational, and research materials, and (2) replacing it with the evidence-based, 2-step gender format outlined in the Fenway Institute study and endorsed by leading transgender researchers, a sample of which is adapted here and ready for use (FIGURE).[2] Our LGBT and queer (Q) patients and physician trainees deserve culturally competent care, and we cannot afford to alienate those among us who are best positioned to take on these challenges.

In this article, we have shared our personal and emotional experience to illustrate the real ways in which abstract principles of LGBTQ inclusion play out in the everyday lives of physician trainees. We hope to hear from other residents and fellows across the country who have experienced similar disappointment with how our institutions approach issues of gender identity. In light of the 2011 IOM report and its impact, it is imperative that reform start from within the medical community. As physicians, we must not squander this opportunity to change the way we study and treat both ourselves, as physician trainees, and the most vulnerable among our patients.

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