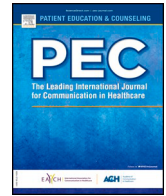




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I'm not putting on that floral gown: Enforcement and resistance of gender expectations for transgender people with cancer

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ABSTRACT

Objectives: Understanding barriers to care for transgender people with cancer is necessary to increase oncologic care access. Little has been published regarding the experiences of transgender people with cancer. We sought to explore these experiences, assess barriers to oncologic care, and elucidate potential solutions.

Methods: Using an interpretive descriptive approach, we conducted two group interviews with transgender people who had been diagnosed with cancer and one with physicians who treat patients with cancer. Two investigators independently analyzed verbatim transcripts and, together, refined themes, resolving disagreements with consensus. Member checking and peer debriefing were used to confirm and elaborate on findings.

Results: Seven people who had been diagnosed with cancer and five physicians who treat people with cancer participated in group interviews. Themes included: (a) experiences with cancer may uniquely impact transgender people; (b) enforcement of clinician and systemic gender expectations creates barriers to cancer care; and (c) resistance to gender expectations may facilitate care.

Conclusions: Gender expectations create barriers to oncologic care, which can be resisted by patients, clinicians, and institutions.

Implications for practice: Clinicians and institutions should create gender-inclusive oncologic spaces, demonstrate allyship, and support patient autonomy to decrease barriers to care for transgender people with cancer.

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1. Introduction

Transgender people face individual and systemic barriers to healthcare and report high rates of negative experiences with clinicians.[1–8]. One reason for this may be that clinicians do not receive adequate training regarding transgender health, and thus may be uncomfortable providing care for transgender people. [9,10]

Clinicians may respond to situations in which transgender patients know more than them, for example regarding the nuances of hormone therapy, by stigmatizing patients or using paternalism, both of which create barriers to care.[1,2,7,9–12] Barriers to care and shared decision-making may be especially detrimental in oncology because 1) given the aggressiveness of many cancers, oncologic care can be, quite literally, life or death; 2) oncologic surgeries may dovetail with transition and priorities of transgender patients may differ from anatomy-sparing oncology guidelines; [13] 3) testosterone and estrogen may increase the risks of specific cancer types, yet data are limited.

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Limited qualitative data suggest transgender patients with cancer face unique barriers that cisgender, or non-transgender, patients may not. [14–17] However, prior qualitative data from lesbian, gay, bisexual, transgender, queer, and/or intersex people (LGBTQI) have been reported in aggregate. Thus, little is known regarding specific experiences of transgender people with cancer. The purpose of this qualitative inquiry was to collaborate with transgender people with cancer to generate hypotheses about barriers to oncologic care and methods to eliminate them.

2. Methods

2.1. Research design

Underpinning this qualitative inquiry was interpretive description methodology, [18] an approach uniquely situated to generate knowledge applicable within clinical frameworks. Group interviews served as a means for people with shared experiences to discuss them collectively. The University of Rochester Medical Center and Cambridge Health Alliance Institutional Review Boards approved this study.

2.2. Participants

Inclusion criteria for patient participants were a transgender identity and a diagnosis of cancer of any type. The inclusion criterion for physician participants was clinical responsibility for treating patients with cancer. Participants under the age of 18, unable to provide consent, or unable to speak or understand English were excluded. We recruited patients using a convenience sample via flyers at Massachusetts-based clinics, emails to local SGM listservs and personal contacts, and website posts. Physician participants were recruited by emails sent by the investigators' colleagues and forwarded throughout physician networks in Massachusetts. Everyone who expressed interest in the group interviews participated in the study.

2.3. Data collection

A self-administered questionnaire given to participants before the group interviews included six demographic items: age, race/ethnicity, sexual orientation, gender identity, and cancer type. Informed consent was obtained verbally after reviewing risks and benefits of the study. Written consent was not obtained as unwanted disclosure of participants' transgender identity via misplacement of consent forms could have caused considerable harm. [19] Prior to interviews, participants chose or were given a pseudonym, which was linked to quotes and demographics.

All interviews took place at a hospital in Massachusetts between 2017 and 2018 and lasted between sixty and ninety minutes. Interviews were facilitated by the first author using a guide adapted from a prior qualitative study regarding the healthcare experiences of LGBTQI people. [7] The second author served as note-taker. Patient participants were asked to describe their experiences with cancer care as transgender patients and their suggestions for improving experiences. Physicians were asked what they thought they did well, how they could improve, and what their suggestions were for other physicians providing care for transgender patients.

The first author was a queer, non-binary, White, Jewish physician. The second author was a gender-nonconforming, South Asian physician. The conversations were audio-recorded and transcribed verbatim.

2.4. Data analysis

The first two authors explored their biases via journaling before the study began. They subsequently independently analyzed the transcripts. Open coding was applied to a segment of the first transcript to inductively identify codes, which were then discussed and refined. Using ATLAS.ti files created from the transcripts, the investigators then reviewed each transcript and generated a list of potential codes. After each transcript was independently reviewed, the codes were refined via comparison and discussion and re-organized into emergent themes until consensus was reached. Consistent with the iterative nature of qualitative inquiry, the analytic phases were repeated until all coding discrepancies were resolved and novel codes no longer emerged (i.e., saturation). At that point, a third coder reviewed and provided feedback regarding the coding scheme. Themes were reviewed by study participants and a group of uninvolved, clinically-oriented investigators and revised with their feedback. Reporting was guided by *Consolidated Criteria for Reporting Qualitative Research*. [20] Results are organized by key inductive themes and subthemes with illustrative quotes for each.

3. Results

3.1. Demographics

Seven transgender people in two group interviews and five physicians in a separate group interview participated in this study. The patient participants were White; ages varied from teens to fifties; two were women; one was a man; and four were non-binary and/or genderqueer. Three patients had hematologic malignancies. Four had solid tumors. Four physician participants were White, and one was South Asian; their ages ranged from thirties to sixties. One was a urologist, and the others were medical oncologists. All were cisgender and all but one were heterosexual.

3.2. Qualitative themes

Amid the terror and confusion of cancer diagnoses and treatment, gender expectations of oncologists and oncology care settings force patients to choose either corrective self-defense or abandonment of self-expression. Transgender participants described the ways loss of gender-related characteristics in the context of cancer treatment limited access to self-expression. Additionally, participants articulated the expectations of oncologic care systems: that patients are cisgender; prioritize keeping gender-associated anatomy and using it for procreation; and want gowns, surgical binders, and wigs associated with the gender oncologists expect. These assumptions, enforced with stigma and paternalism, create an untenable care environment, leading to emotional and structural barriers to care. To ameliorate this, participants recommended decoupling gender and anatomy in oncology and medicine broadly. See [Table 1](#) for additional illustrative quotes and [Table 2](#) for recommendations for inclusive oncologic care.

3.2.1. Unique impacts of cancer

Participants described the ways loss of gender-related characteristics such as hair and clothing caused anxiety and difficulty or, alternatively, fueled participants' articulation of their identities. One participant stated:

Being a trans person, especially a trans woman, going through treatment and being in the hospital and losing a lot of physical characteristics and hair and being in just hospital gowns is kind of hard and it gets kind of anxious sometimes holding onto that gender identity because you don't have the cultural aspects of it. (White, transgender woman, hematologic malignancy)

Table 1
Additional illustrative quotes.

Unique impacts of cancer	<p><i>My diagnosis kicked my transition into overdrive. Before that moment, I didn't care to be open with my coworkers,...but once I was diagnosed I knew that I would be losing the feminine characteristics I had enjoyed at least in my free time ...so I decided to come out as transgender in the work place...The fact that I would look like a shaved cat coming into the office [meant] that I needed an additional bit of information that everyone knew about me to help me feel more comfortable.</i> (White, transgender woman, hematologic malignancy)</p>
Enforcing gender expectations: Paternalism	<p><i>It's sort of weird how much your sense of loss...is assumed to be around "Oh, you poor thing you lost your ovaries. You can never have children," ...and you're just like, "No you don't understand. That part was a godsend. It was the short laundry list of other organs that they had to remove from me that I'm feeling a little weird about.</i> (White, genderqueer, solid tumor)</p> <p><i>If someone [has] a preferred name, their legal name is going to be on that bracelet that gets printed out because it has to match the insurance and then if you're waiting to get blood drawn, they call out the patient name in the waiting room and then, as a curiosity, people turn and look when people get up and then they're like "Oh, that person doesn't look like." whatever gender they associate with the name that just got called.</i> (White, genderqueer, hematologic malignancy)</p> <p><i>When I ... went to the registration area where they issue your patient information and eventually the bracelets ... it had biologic sex on the bracelet and, every time I came in, it was on my wrist in public view and that made me uncomfortable ... I understand that biologically speaking it's an important fact, but I don't think it needs to be advertised openly.</i> (White, transgender woman, hematologic malignancy)</p> <p><i>Binding and tucking and hospital gowns, right? They want you to be fully naked so they can have access to things but as trans folk it's...you don't want certain things showing...or having extra clothing available or making sure that you get...two gowns, for front and back, would be important.</i> (White, transgender woman, hematologic malignancy)</p> <p><i>I was concerned about how they were going to handle [inpatient stays] with rooms and I ended up having private rooms, which was fine. A lot of times for different things you get temporary rooms and I did get a clean room or whatever that's called, but ... I imagine at other hospitals there are shared rooms, right? And I've noticed being a trans woman that, even if there are shared rooms, I get my own private room out of a double room. So, you get segregated even though you're not trying to be segregated so it's like a denial of your identity in some ways and a protection of it at the same time.</i> (White, transgender woman, hematologic malignancy)</p> <p><i>There's a lot of stuff in cancer treatment and diagnoses is highly gendered. Like all of the breast cancer stuff is pink and there's like "What women need to know about breast cancer" as if men don't get breast cancer and there's people that have breast cancer that don't identify as either a man or a woman. [A] boutique ... I visited in case I was interested in getting a wig... everything there was very feminine and I felt pretty uncomfortable there. There were a lot of resources offered to me ... like wigs and how to feel feminine while going through chemo and makeup tips that were not useful to me and felt like pushing gender onto me...</i> (White, genderqueer, hematologic malignancy)</p> <p><i>I find that my patients that are in the midst of their transgender transition sometimes they're fighting the fight with themselves and that fight can be transposed to the fight with the medical providers, insurance, the system. "Why can't—this isn't cosmetic." I'm just saying that I see some of that frustration being transposed onto the medical system and our inability to appropriately categorize them.</i> (White, cisgender woman, urologist)</p> <p><i>A lot of my follow-up care is specifically at Women's Health Centers and it's very very gendered because it's a space that it's societally assumed that cis women are going to be there. On forms - there's no options for gender... Body parts are very assumed. Questions on forms are...super super gendered.</i> (White, non-binary, solid tumor)</p> <p><i>I remember somebody saying, "It's okay. You're still a woman. You can probably still have children" and uh...Thank you. No thank you.</i> (White, non-binary, solid tumor)</p> <p><i>I had a patient who had a transgendering orchiectomy and her day was shattered by the fact that in pre-op the nurse kept referring to her as a young man.</i> (White, cisgender woman, urologist)</p> <p><i>Making exceptions for trans people is not inclusion. Grouping trans and cis people together in health spaces based on the body parts you think they have, and still referring to bodies and care in cisgender/heterosexual, and binary terms is not inclusive. We are not and should not have to accept being considered "basically the same as ____" or "biologically ____"... "Accepting" us in gendered health spaces and not making changes to the systems and terminology in place is dehumanizing. "Allowing" us to exist in cis spaces is only a band-aid and not what inclusive healthcare looks like.</i> (White, non-binary, solid tumor)</p>
Enforcing gender expectations: Stigmatization	<p><i>I find that my transgender patients versus my gay patients are more emotionally labile...When I need to do an orchiectomy for a transgender patient, it's a requirement that you have two letters from a therapist supporting that change –they have to be treating therapists—and I've never had a problem getting those. There's a lot of struggle that they are going through or have gone through and...they need a lot of emotional support.</i> (White, cisgender woman, urologist)</p> <p><i>I had a friend who was recently denied admission to emergency psychiatric care because they didn't have any single rooms available and they refused to put her in a room with another female patient because she's trans.</i> (White, genderqueer, hematologic malignancy)</p>

(continued on next page)

Table 1 (continued)

	<p>While I didn't have a gendered cancer necessarily, I feel like a lot of my experiences were pretty gendered and the way that my doctor talked about my cancer was pretty gendered. One time she was like, "Well you should be a 60-year-old man, a man who's worked out in the sun all his life." There's an emphasis put on what my gender should be and how I was not that...</p> <p>(White, transgender man, solid tumor)</p>
Resisting expectations: Self-advocacy	<p>Early in the process I was looking for ways to recapture or maintain my feminine appearance regardless of hair loss so I actually did my chemotherapy treatments wearing formal gowns and that was my way of saying, "I'm celebrating the fact that I am female."</p> <p>(White, transgender woman, hematologic malignancy)</p> <p>Yeah, I remember it was like, "No definitely just take the whole thing. It's all covered in cancer. Could you please just get it out?"</p> <p>(White, genderqueer, solid tumor)</p> <p>I am not a woman. I'm also not "basically a woman", "female bodied", or "biologically female", and am not comfortable being grouped together as such. When I say this and you don't feel uncomfortable, when I say this and you don't feel like you need to fight me or correct me, when I say this and all you see is me and MY body, and you and YOUR body, and them and THEIR body, then there will be change.</p> <p>(White, non-binary, solid tumor)</p>
Resisting expectations: Allyship	<p>I was diagnosed at 18, 3 weeks after my birthday and most doctors specifically liked to talk to my parents and I really appreciated the doctors that talked to me as an adult like my body was mine.</p> <p>(White, non-binary participant, solid tumor)</p> <p>It comes up when a person—and it's almost like they're partnered with themselves as a transgender, that they feel comfortable with themselves. So, if they're not being validated [as in]... "Yes, we acknowledge that you are transgender male-to-female and your pronoun is 'she.' We should acknowledge that and we should respect that and call you a she."</p> <p>(White, cisgender man, medical oncologist)</p>
Resisting expectations: Policy changes and other recommendations	<p>I would want there to be support for non-gendered bathrooms in the hospital. If there's choices on colors of items to wear, offer the patient all the choices instead of deciding for them based on their gender or what you assume their gender to be. I just had top surgery and they gave me the compression vests for after and they're like, they came in a box that's "feminine breast binder" and it has frills on the top and comes in a choice of pink, floral, beige, or lavender and the box has "and here are our other products" and they clearly have a men's chest binder that is black and does not have frills and they didn't offer me a choice of even the color. I know they can't order all the colors and keep them in stock but I assume they could have asked me, "Is this one okay?"</p> <p>(White, genderqueer, hematologic malignancy)</p> <p>...a lot of medical histories that I've filled out say "If female, have you had any pregnancies? How many live births?" I don't want to have to fill that out after I just checked male on the other part of the form...</p> <p>(White, genderqueer, hematologic malignancy)</p> <p>Trying to say no to the questions and not having to come out as trans when it's, "Oh, I have a broken arm." "Oh, what's the last time you had a period?" "I don't have periods." "Oh, why not?" "Broken arm – why are you going down this line of questioning?" It's a question that forces you to disclose something that you don't need to disclose...</p> <p>(White, transgender woman, hematologic malignancy)</p> <p>...Making sure that when they do record stuff in the chart, they record it appropriately or only record what they need to record. They don't really need to record a lot of information about somebody being trans because it's not necessarily that relevant. It is, but how is it relevant medically? Like could it just be like "Hormone ranges should be in this range" versus "This person is transgender and...blah blah blah here's their story.?"</p> <p>(White, transgender woman, hematologic malignancy)</p> <p>It would be great to see pronouns on staff badges because it really opens up the confidence that somebody can ask for their pronouns when it's clear that...it's a thing that this organization is committed to doing right.</p> <p>(White, genderqueer, hematologic malignancy)</p>

3.2.2. Enforcing gender expectations

Participants described the ways that assumptions linking anatomy and gender or gender roles were enforced by various aspects of oncologic health systems including intake forms, identification bands, rooming policies in hospitals, gendered attire, gendered spaces as well as explicit and implicit messaging from clinicians and other medical staff. These expectations were enforced via a) stigmatization when patients' gender presentations or identities did not fit expectations and b) paternalism, whereby physicians implied they understood patients' needs and experiences better than the patients.

3.2.2.1. Stigmatization. Transgender patient participants and oncologists described or articulated stigma, which manifested in gestures, actions, and words that communicated disapproval, articulation of stereotypes, e.g. that transgender people are "emotionally labile," or refusal to room transgender patients with cisgender patients. One participant described:

As soon as I started asking for longhaired wigs, [the sales woman's] face kind of went white and she left the room.

(White, transgender woman, hematologic malignancy).

One oncologist described witnessing colleagues' stigmatization. He said:

We had a [transgender] patient that would call a lot...on the physician support line...She does need a lot of support, but then people became—the fellows, I tried to talk to people about it, but...they took it too glibly. I tried to talk to them about how they should...not make fun of the situation but it was hard for people to move to that point of compassion - get away from their notions of gender.

(White, cisgender man, medical oncologist).

3.2.2.2. Paternalism. Transgender patients described instances in which oncologists pushed them to fulfill expectations, including

Table 2
Patient and clinician-proposed trans-inclusive policies.

Policy	Example
Make gender-neutral bathrooms accessible	All bathrooms could be gender-neutral or all single-stall bathrooms could be converted to gender-neutral bathrooms.
Provide gender-neutral garments	Gowns, wigs, and surgical binders could be provided in various colors and styles or in gender-neutral colors and styles.
Ensure inpatients have enough clothing or gowns to maintain privacy.	Provide two gowns to inpatients for additional privacy.
Ensure patients' correct names and pronouns are used throughout the medical setting.	Ensure hospital bracelets contain correct name and gender or consider removing gender marker from hospital identification bracelets.
Provide staff education regarding inclusive language use of patients' correct name, pronouns, and preferred words for anatomy.	New staff should have mandatory training regarding inclusive practices.
Ensure forms and questions are inclusive and do not force transgender people to come out.	Medical forms could include gender options such as man, woman, non-binary, agender, and another gender.
Decouple aspects of care from gender.	Questions regarding particular body parts or functions should be asked only if relevant. If asked, these questions should be directed to people of all genders.
Create respectful and inclusive rooming policies	"Women's Health Clinic" could be renamed "Health Clinic." People will be roomed either with a roommate with the same gender (transgender and cisgender women roomed together) or based on the preference of the particular patients. Ideally, policies would be created in collaboration with local transgender community members.
Encourage staff to display their pronouns	Provide optional pronoun badges for clinic or hospital staff to wear.
Ensure transphobia is not tolerated in the hospital or clinic.	Non-discrimination policies should be in place along with processes to enforce them.
Share medical decisions with patients.	Practice explicit informed consent for all medical decisions related to cancer care. This could include exploring patient priorities in regard to potential surgical interventions, for example lumpectomy versus mastectomy in the setting of breast cancer. This could also include discussing what aspects of identity are recorded in the medical record.
Support patient autonomy	Ensure medical decisions are made by patients rather than family members or others.

reproductive expectations, based on anatomy, which were often at odds with patients' priorities to have procedures, such as hysterectomy or orchiectomy, that dovetailed with transition and/or decreased risk of recurrence. One participant stated:

Because I had a really large tumor, they talked about either doing a full hysterectomy...or just taking out the one ovary. I wanted the full hysterectomy but I was then seen as an 18-year-old woman and they were like, "Well you don't know. In a few years you might change your mind..." so they did fertility-sparing surgery. (White, non-binary, solid tumor).

Patient participants also described paternalistic policies that created barriers to care. For example, one described an instance in which an exam impossible for transgender women who have not undergone vaginoplasty was required to access services:

There was a requirement for a vaginal exam before I could actually see the sex therapist... I had to fight to get past that process. I almost was ready to just go and do it, like, "Okay." (White, transgender woman, hematologic malignancy).

Oncology clinicians who communicated paternalistic notions also used outdated language and misgendering:

I have a lovely patient who is male transgenerating to female who... comes into my office and the first thing he says is, "I've read about all the options for prostate cancer and I want an orchiectomy..." but he doesn't need [it]. (White, cisgender woman, urologist).

3.2.3. Resistance

Participants described mechanisms by which gender expectations were or could be resisted by patients, families, clinicians, and institutions. For example, patients advocated for themselves by expressing their gender or resisting misgendered spaces or clothing and clinicians intervened in transphobia.

3.2.3.1. Self-advocacy. Transgender participants' narratives offered vivid descriptions of resistance such as wearing formal gowns to infusion appointments. They explored why expectations did not fit and offered alternatives. One participant described:

I needed to have a lot of follow-up mammograms until I had top surgery and pretty much every time that was an aggressively gendered experience to the point of, "No, I'm not putting on that pink floral gown. You can't make me. You can do it in nothing. I'll put on this wrap I have or you can get me something else, but I'm literally not doing this." And having to push back really hard against "I don't want to change in the special women's changing room. I don't want to hang out in the special girl mammogram ward. Thanks. Surely, this is a whole hospital. No doubt you have other places I could sit." (White, non-binary, solid tumor).

3.2.3.2. Demonstrating allyship. Patient participants described clinicians who supported their autonomy by using their names and pronouns or resisting family members' stigmatization:

My family had to deal with me initiating my medical transition right before I got diagnosed with cancer and came to associate the two, so my doctors were really excellent in helping me have information for my parents and help keep them at bay and talking me through what kind of care I needed as opposed to what parental bodies who were concerned and love me very much might wish for me instead. (White, genderqueer, solid tumor).

Physician participants attempted allyship. One White, cisgender male oncologist corrected another physician who used the wrong pronouns for a patient. Another oncologist described her attempts to improve her care:

It's not comfortable for me to ask [how patients want to be addressed] ... but...you're going to be going through a particularly meaningful experience together.... They should know you are making an effort—that you are trying to know who they are. (White, cisgender woman, medical oncologist).

3.2.3.3. Inclusive policies. Patient participants called for inclusive cancer care, which they distinguished from trans-friendly care, explaining that inclusive care would not require transgender people to come out in order to get their needs met. Rather than "accommodating" transgender patients, which can be othering, participants asked for their presence to be "normalized" and

accepted. They recommended de-gendering oncologic care to render it inclusive. One stated:

People shouldn't have to know that we're trans or that trans people are in the space for them to be included in dialogue and for them to...be respected but also just be represented – the way cancer and medical problems and body parts are talked about in medical spaces and on forms.... Trans-friendly feels like people have to know I'm trans to respect me as a person...and that doesn't seem ideal.
(White, non-binary, solid tumor).

Another participant further distinguished friendly and inclusive by describing spaces that are segregated by gender:

I would describe trans-friendly as being a space where all self-identified women are welcome and trans-inclusive is more like "this is a space for people who have marginalized and minority experiences of gender regardless of their history."
(White, non-binary, solid tumor).

Another participant further clarified the distinction between allowing someone in a space while communicating it is not for them and changing the space so that it is inclusive.

Yeah, it almost sounds like the difference between it being normalized and it being accommodated.
(White, genderqueer, solid tumor).

4. Discussion and conclusions

4.1. Discussion

In this study, the following hypotheses were generated: 1) transgender people have unique experiences with cancer diagnoses and treatment, including the ways chemotherapy side effects and inpatient logistics restrict access to gender expression, 2) expectations that link anatomy, gender identity, and gender roles create barriers to care, and 3) self-advocacy, allyship, and policy changes could improve oncologic care access. Similar to prior data in which patients were asked to speak with psychiatrist to “justify my choice,” transgender participants in our study reported treatment priorities that conflicted with those of oncology clinicians and thus were dismissed. [13,15–17] A prior study hypothesized that physicians use stigmatization to reinforce their power when transgender patients know more than them. Similarly in our study, stigmatization or paternalism were coupled with lack of knowledge about transgender people and their health needs. [2] For example, doctors who expressed paternalistic viewpoints also used outdated terminology and misgendered patients. [21].

Participants resisted enforcement of gender expectations and recommended transformation of oncologic health systems so that they are inclusive of people of all genders. In such settings, care environments, intake forms, and clinicians' questions would acknowledge transgender people and not conflict with their identities. This strategy is distinct from querying patients' gender identities and “accommodating” transgender people. In inclusive care environments, transgender people would not have to come out to have their needs met. De-gendering oncologic care to make it inclusive would require an overhaul of the system, reorganizing and desegregating specialty care based on gender or anatomy; renaming clinics; and changing conceptual models about anatomy and gender.

While the study has several strengths, including being the first qualitative study to our knowledge regarding the experiences of transgender people with cancer specifically, several limitations are present. Though we tried to be broadly inclusive, important subgroups were not represented. All participants were fluent in English. None of the patient participants were people of color. Most physician

participants were cisgender, White, and heterosexual. All physicians were practicing in Massachusetts, and practice patterns may be different elsewhere. While further research is needed, the study adds to the literature by generating important hypotheses regarding the mechanisms by which access to oncology care may be limited or facilitated.

4.2. Conclusions

Expectations regarding patients' anatomy and gender roles are enforced with stigmatization and paternalism, both of which reinforce hierarchal relationships between patients and clinicians, creating multifactorial and deeply entrenched barriers to the health of transgender patients with cancer. Conversely, resistance to those expectations provides a path forward.

4.3. Implications for practice

Patient-centered care takes into account the values, needs, and desires of patients and prioritizes shared decision-making. [21] Cultural humility incorporates a lifelong commitment to self-evaluation and critique, redressing the power imbalances in the physician-patient dynamic, and developing mutually beneficial, non-paternalistic partnerships (p. 123) [22]. Based on our results, oncologists should provide culturally humble, patient-centered care by eliciting and appropriately using patients' names and pronouns; centering patient priorities in regard to oncologic treatments, fertility, and/or hormone therapy; and arriving at optimal oncologic approaches, for example orchiectomy in the setting of prostate cancer, that also meet transition-related goals. If all clinicians adopted these practices, relationships between patients and oncologists could improve and barriers may lessen. To support these shifts, cultural humility training should be available to oncology staff and tested to ensure it improves patient outcomes. [23] Structural changes are also essential. Oncologic care should not be segregated based on gender or anatomy. Intake forms should be rewritten. Processes should be put in place so that correct names and pronouns are used for patients throughout medical encounters. Gender-neutral garments and all-gender bathrooms should be made available. Transparent non-discrimination and grievance policies should be implemented. Policies that systematize gender identity data collection in oncologic settings will improve collective knowledge regarding transgender people with cancer [10,24–26] and may diminish the tendency to stigmatize patients, thus breaking the cycle. [2] Further research could test the effect of such interventions on patient satisfaction and health outcomes with the ultimate goals of eliminating cancer disparities and building gender-inclusive oncology care.

Ethics approval

The University of Rochester Medical Center and Cambridge Health Alliance Institutional Review Boards granted approval for this study.

Declarations

Funding: This research was supported by a grant from the Massachusetts Medical Society.

Consent: All participants provided informed consent prior to participating in this study.

CRediT authorship contribution statement

Ash Alpert: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Roles; Resources; Software; Supervision; Writing - original

draft. **Vikas Gampa**: Investigation; Formal analysis; Data curation. **Megan Lytle**: Validation; Writing - review & editing. **Charlie Manzano**: Conceptualization; Validation; Writing - review & editing. **Roman Ruddick**: Conceptualization; Validation; Writing - review & editing. **Tonia Poteat**: Conceptualization; Methodology; Writing - review & editing. **Gwendolyn Quinn**: Methodology; Writing - review & editing. **Charles Kamen**: Writing - review & editing.

Conflicts of Interest

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