

# Challenging the status quo of gendered cancer care

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## ABSTRACT

LGBTQTQIA+ patients are at a higher risk for certain cancers yet access relevant screening and healthcare less frequently than cis-gendered, heterosexual women. This can be attributed to fears of discrimination, feeling unrepresented, and past experiences of disrespect from healthcare professionals, especially in a gendered healthcare environment. The use of Women's Clinics in health endorses a viewpoint of binary gender, with an assumption of cis-gendered heteronormativity. As social workers we have responsibilities under the Code of Ethics and Core Competencies to advocate for change and challenge the status quo. We need to take action to improve healthcare experiences for LGBTQTQIA+ patients. These include the correct use of inclusive language, changes to the physical environment, and practical changes to how we undertake routine examinations and engage with LGBTQTQIA+ patients.

**KEYWORDS:** Transgender; gynaecology; equity; gender; sexuality; cancer

## A note on language

Whilst every attempt has been made to use inclusive language, the author recognises that these are highly personal terms with individual preferences. The author identifies as a pansexual, cis woman, using she/her pronouns.

## Gendered cancer care

"I showed up for my appointment and I was immediately told, 'You're in the wrong place, Sir'" (James, transman, queer, cervical cancer) (Bryson et al., 2020, p. 348).

Gendering healthcare and designating spaces that provide gynaecological care as *women's clinics* supports structural invisibility and the erasure of queer, gender-diverse, takatāpui and intersex patients (Taylor et al., 2016). Unfortunately, a number of studies have shown that many health professionals do not recognise

understanding their patients' gender identity as critical to providing quality care. This lack of awareness and acknowledgement by the health professional then leads to further invisibility of that individual within the healthcare system, and diminishment of their identity (Burton et al., 2020).

We know from research that LGBTQTQIA+ people are at a higher risk for certain cancers and experience higher morbidity and mortality related to specific cancers. Research has also found that LGBTQTQIA+ patients are less likely to feel that they have been treated with respect and dignity when accessing hospital care (Buchting et al., 2015; Peitzmeier et al., 2017). The study by Peitzmeier et al. (2017) found that as many as 31% of transmen had avoided seeking necessary healthcare in the past year due to a fear of discrimination. Many participants spoke of balancing long-term risks of developing cervical cancer over short-term risks of being treated disrespectfully by

healthcare providers. Non-cis patients also reported the added pressure of needing to educate their healthcare provider—which can then create even greater power imbalances between a patient and the healthcare professional, who is often seen as the expert. This pressure results in higher rates of missed appointments and feelings of invisibility within the system (Taylor et al., 2016; Temkin et al., 2018).

It is apparent that accessing healthcare is not necessarily safe for all. This can be seen most strongly in gynaecological cancer care where treatment and assessment are based on a cis-gender, heteronormative identity and expression (Taylor et al., 2016). Why does our medical system ignore gender as a social construct which acts as a structural barrier to quality health outcomes? Why do some patients say they have to use a different narrative in order to become *treatable bodies* and fit into a binary system? And why are we continuing to use outdated viewpoints when we know that the gendering of cancer environments can cause significant distress? We need to challenge the binary view of gender equated with biological sex in how we deliver healthcare (Sledge, 2019). If we view our systems and biases through a different lens, we can challenge these dynamics, and also consider the intersectional nature of them.

### The social work role

As social workers, our role is to advocate, not just for our individual clients, but for systemic change and equitable access to services. These are fundamentals of the Social Workers Registration Board (SWRB) Core Competencies, and the Aotearoa New Zealand Association of Social Workers (ANZASW) Code of Ethics. The ethical principles of *mātātōa* (acting with moral courage), *kotahitanga* (solidarity and challenging injustice and oppression), and *manaakitanga* (supporting mana with respect, kindness and compassion) call us to ensure safe spaces, challenge injustice, oppression and marginalisation, advocate for equitable

access to services, and engage in action to change the structures that perpetuate injustice in society (ANZASW, 2019).

How many of us working in healthcare truly act on the principles to which we have signed up as registered social workers? Are we doing all that we can to push for change to heteronormative healthcare? As social workers, we cannot remain ambivalent or complacent in these matters.

Being complacent to heteronormative healthcare goes against the core values of social work and makes us complicit with the status quo. Social change does not just happen, it requires us to engage with our social work competencies and ethical principles, to bring attention to issues, and to join with others to effect change. Everyone has the right to access appropriate healthcare in a safe and equitable manner. Human rights are non-negotiable and not for discussion based on individual beliefs or biases.

We have responsibilities to ensure that we are competent in working “respectfully and inclusively with diversity and difference... including sexuality, gender and transgender” (SWRB, 2021, n.p.). We have the opportunity to lead change and increase awareness in relation to the importance of gender and sexual identity. We must take responsibility for educating ourselves and other health professionals to provide the best care for patients. Gender identity is a complex and constantly evolving issue. As social workers, we must keep upskilling so we can work respectfully and inclusively.

### Patient perspectives

To make gynaecological oncology safer for all patients and healthcare professionals, we need to challenge the cis-gendered, heteronormative assumptions that are inherent in healthcare. This is necessary to improve health outcomes and to increase equity for LGBTIQ+ patients who are at a higher risk for certain cancers and who experience less equitable access to

Table 1. Summary of Patient Suggestions

| Recommendations |  |
|-----------------|--|
| Language        | Use gender neutral language ( <i>people</i> rather than <i>women</i> )<br>Use medical/biological terms over gendered terms<br>Check with people about their individual terms   |
| Identity        | Ask patients about their pronouns and gender identity (not just binary gender options)<br>Make forms inclusive and allow patients to enter their correct identity details<br>Check with patients about their preferred terms   |
| Environment     | Use non-verbal indications of inclusivity (e.g., rainbow signs)<br>Use posters and leaflets that are representative of all patients, not just cis-gender females<br>Use signage with gender-neutral terms/medical terminology (e.g., <i>gynaecology</i> over <i>women</i> )<br>Advertise inclusive, non-discriminatory policies and practices<br>Support staff to welcome all patients and to not make assumptions based on presentation   |
| Sexuality       | If relevant, ask patients about the type of sex they have (if any), without assuming that penetrative sex is occurring<br>Ensure the patient is fully informed in ways that meet their individual self-knowledge<br>Do not assume the possibility of pregnancy   |
| Practical       | Consider booking appointments for early or late in the day to reduce waiting times<br>Call patients by their correct name, especially if different to their medical records<br>Avoid titles such as <i>Mr</i> or <i>Mrs</i><br>Consider a female-presenting support person to attend and to stand when the name is called<br>If appropriate, support the patient to have more control over the examination (e.g., self-insertion of speculum)<br>Consider admitting patients to a general ward, rather than a gynaecology ward<br>Patients may experience gender dysphoria and require additional time and support |

(Buchting et al., 2015; Burton et al., 2020; Gibson et al., 2017; Johnson et al., 2020; Potter et al., 2015; Taylor et al., 2016; Weyers et al., 2020)

healthcare. We may do this by changing our own practice and advocating for individuals and systemic change.

Table 1 draws together various authors' recommendations and research on inclusive and responsive care of LGBTTQIA+ patients based on patient suggestions.

## Conclusion

As social workers we have a responsibility to challenge unjust and ineffectual systems. Remaining with the status quo of gendered clinics perpetuates a system in which some communities within Aotearoa most at risk for certain cancers feel unsafe accessing appropriate care. Research shows that our environments for cancer support and treatment are inadequate to treat LGBTTQIA+ patients and can contribute to the systemic invisibility of these patients

and diminishment of their identify. We have an opportunity to support better care for all by educating ourselves and others and using a human rights lens on the way we currently provide care. When we make our healthcare environments more inclusive for LGBTTQIA+ communities, we take nothing away from cis-gendered women. What we do is create a space that is safer for all patients and improve healthcare outcomes.

*He kakano i ruia mai i Rangiaatea, e kore ia e ngaro.*

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