**Transgender Sim A&E 2019**

**By Sarah Perkin**

**Foreword**

Sarah Perkin is one of our fantastic Registrars who at the time (of this SIM) was Education Academy Fellow for Emergency Medicine. She organised many training sessions for our team members including a wide variety of SIM scenarios – providing as close to a ‘real life’ experience as possible – often involving incredible acting skills, high tech equipment and SIM dummys. Dr Perkin is an active member of the LGBTQ+ A&E group where she also organised a Trans awareness training session for all staff members in A&E last summer. It was hugely successful and lead to discussions of designing a Trans SIM. Below is detailed the SIM itself and the learning points from it including key advice for medical professionals. We hope you enjoy reading about it! A massive thank you to Sarah and all the hard work she does advocating for the LGBTQ+ community – you are the definition of an ally.

 Siobhan Cockram, Staff Nurse, A&E, Royal London Hospital and LGBTQ+ co-site lead RLMEH and Prescott Street.

Thanks to everyone who took part in the Trans Awareness in-situ simulation on May 10th. Laura Bocking, ACP, took centre stage in assessing a 24-year old male patient, identifying as trans, presenting with right sided abdominal pain, vomiting, and dysuria. The patient remained stable (unusually, for sim-land) and alert. The patient had been through ‘top surgery’ (double mastectomy), but had no ‘bottom surgery’ (i.e. genital reconstruction or removal of internal reproductive organs). He was taking testosterone.

The main focus points of this scenario were communication skills and to look in a bit more detail at the challenges faced by a group of patients who can come to us with unique needs and potential vulnerabilities.

Thank you for contributing to a very open, honest debrief. We covered a lot, some of which I will try to condense here. I will also provide some further resources to use if you are interested in knowing more.

**Learning Sim;**

First off, what does ‘transgender’ mean?

Transgender is a term used to describe a person whose gender identity does not align with the biological sex they have been assigned. However, individuals may not always identify fully with one extreme of the gender spectrum, as patients may prefer to identify as non-binary – i.e. neither male nor female. In the context of this scenario, the patient identified as a trans man. A trans man is someone who identifies and lives as a male, but was assigned female at birth. Conversely, a trans woman is someone who identifies and lives as a woman, but was assigned male at birth. Whilst we don’t know exactly how many people identifying as transgender or non-binary live in the UK, it is estimated to be approximately 1% of the population (600,000 ish people).

What are ‘top’ and ‘bottom’ surgery?

Not all patients have easy access to, or want to have, gender reassignment surgery. For those who do, it is important to clarify what has been done if it has implications for management or referral in the ED. For example, abdominal pain in a trans woman who has not had an orchidectomy could indicate a testicular issue. You may also miss an ovarian problem if you presume all internal reproductive organs have been removed from a trans man.

Please ask if you are not sure what a patient has had done, as this will avoid any potential embarrassing assumptions. This may not always be appropriate to ask, as it may not be relevant. It would be if a patient is experiencing chest pain following recent chest or other major surgery, but not necessarily if they have twisted their ankle.

“Top surgery” tends to mean mastectomy in trans men, and breast augmentation in trans women. Some trans women also opt for facial feminisation surgery.

“Bottom surgery” can be more complex. For trans men it may include any of the following: a hysterectomy and BSO, phalloplasty or metoidioplasty (construction of a penis), scrotoplasty (construction of a scrotum) and testicular implants, and/or a penile implant.

For trans women, “bottom surgery” can include: orchidectomy, penectomy (penis removal) vaginoplasty, vulvoplasty, clitoroplasty (construction of a vagina, vulva, and clitoris respectively.)

This surgery is complex and may require multiple operations.

What effects might hormone treatments have?

Hormone treatment can feel as uncomfortable in the diagnostic process as surgical procedures you aren’t familiar with.

Are hormones relevant? Sometimes, yes. For a patient with chest pain and breathlessness on oestrogen, it is certainly important due to the increased risk of venous thromboembolism. The BNF can help you.

Don't forget that sometimes patients will take other medications for their effects. Drugs like spironolactone may be taken for the side effect of gynaecomastia. This is not routinely prescribed, but a desirable effect. Due its potassium-sparing effects, this can lead to dangerous complications from hyperkalaemia.

I don’t know anything about transgender patients’ medical or surgical issues…

Common things are still common, even if you come from a different country, ethnic group, or identify with a different gender than the one you were born into. Yes, there are specific problems that transgender patients will experience over other patient groups, but a chest infection is still a chest infection, renal colic is still renal colic, and a broken wrist is still – you’ve guessed it – a broken wrist.

If a patient has a specific problem related to their surgical site, they are likely to tell you. In that instance, do what you can do (treat pain or signs of sepsis) and discuss with the relevant team – please be aware that this service may not be available in your hospital. In other instances, abdominal and chest surgical complications may be manageable by the general surgical or breast teams – if you don’t know, ask.

Something we all *do* need to be aware of is the high rates of intimate partner violence in the transgender community. 80% transgender people have been physically abused by a partner or ex-partner. The rates of sexually abusive behaviour are higher too. This group of patients are **very** vulnerable, and if you suspect they are at risk **please**encourage them to open up and refer appropriately.

**Be aware of your own cognitive biases, and try not to anchor your diagnosis to the fact that a patient is transgender or taking hormones.**

Do I have to ask intimate questions?

Sometimes questions perceived as intimate or embarrassing are important to ask to differentiate why a patient has come to ED. Please be mindful that no matter how embarrassed you feel, it is far, far worse for your patient! If you need to ask a question that a patient perceives as irrelevant, it may help to follow up with justification (e.g. “the reason I am asking about your sexual activity is because I am concerned about pelvic inflammatory disease” or “I am enquiring about the possibility of pregnancy because hospital policy insists on a negative pregnancy test in anybody of child bearing age with female reproductive organs”).

A 2017 paper from the Annals of Emergency Medicine on emergency care experiences in a group of transgender and gender-nonconforming patients reported that patients felt questioning was ‘frequently…inappropriate and irrelevant to reasons for seeking emergency care’.  This can have a devastating effect on a patient’s willingness to seek care in an emergency, and they may avoid attending ED altogether.

Do transgender patients experience problems specific to them in the ED and wider hospital environment?

Yes. But what?

- Mismatches between old details held by the hospital and actual, current identity. Please ensure you manage patients sensitively when confirming details. Do not ‘deadname’ – i.e. use a name a patient no longer goes by.

- Pronoun confusion. What does a patient want to be known as? He/him? She/her? They/them? Please ask what they would prefer, and please document it so that other members of the team are aware. If errors occur, apologise to the patient and continue being your lovely selves. You can help normalise this by introducing your own pronouns along with your name, even with patients who you don’t assume are trans. E.g. ​“Hello, my name is Sarah, I go by she/her."

- Care competency. We know, in ED, it is impossible to know all there is to know about everything. However, it is our responsibility to know enough to be able to manage any patient who comes through the doors. Knowledge gaps can be frustrating for patients and make them feel as though they need to assume the role of educator when they are already in a position of vulnerability. Simulation scenarios like this one, and the work being done by the our RLH LGBTQ+ Advocacy team can help us to understand this group of patients better.

- Which toilets to use?! Fortunately, in ED our toilet are gender neutral, but please consider this issue with similar sensitivity when you are admitting patients to the ward. Should they be on a male or female bay? Do they need a side room? Liaison with the bed managers may be necessary – we want **all** of our patients to feel comfortable and safe.

- Fear of discrimination, both by other patients and by staff. Please continue to advocate for your patients’ safety. If someone is being harassed, move them to a place of safety and involve security where relevant.

There was a lot to think about with this sim, and thank you to everyone for taking part and sharing your experiences and worries in the debrief.

For more information, you can review the following resources:

1) The ‘Diversity Door’ – the back of the door to the Registrar Office in ED is a work in progress and has a lot of information about LGBTQ+ issues with relevance to hospital attendances.

2) [http://www.stonewall.org.uk](http://www.stonewall.org.uk/) has a lot of information about LGBTQ+ and a glossary of terms in case you aren’t sure of what terms are commonly used.

3) [http://www.galop.org.uk/](https://imsva91-ctp.trendmicro.com/wis/clicktime/v1/query?url=http%3a%2f%2fwww.galop.org.uk&umid=8FC3A303-8964-D605-A3D9-E5EA17D54C5F&auth=b526c4a3d60fce02240688a1c6e9776d4c778da0-8edf2b6045196eaad73b3e062069ee8d271f2e92) The LGBT+ anti-violence charity

4) The How2 safeguarding adults section (thanks Siobhan Cockram for setting this up)

5) Samuels, E. A., Tape, C., Garber, N., Bowman, S., & Choo, E. K. (2018). “Sometimes You Feel Like the Freak Show”: A Qualitative Assessment of Emergency Care Experiences Among Transgender and Gender-Nonconforming Patients. Annals of Emergency Medicine, 71(2), 170–182.e1. doi:10.1016/j.annemergmed.2017.05.002