



# SOFFAs Interfacing with Healthcare Professionals

A publication of FORGE

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## Partners Interfacing with Healthcare Professionals

By michael munson

Partners oftentimes are the overlooked majority within the FTM+/butch/transmasculine community. Although this is not acceptable in any realm, it is especially significant within a medical context. Many people do not understand that a person *partnered* with a transperson might have their healthcare impacted - either negatively or positively—just based on our association with the transperson.

Medical settings are frequently unnerving and uncomfortable for even the healthy, non-trans, non-queer, “mainstream” medical consumer. As partners of transpeople, how can we assure that we will be treated respectfully, that *our* medical issues will be addressed and that we will receive appropriate and respectful medical care?

### General Issues

What are we willing to **sacrifice** for our healthcare? Can we live with our providers' prejudices? How does it affect our relationship to our transpartner if we cannot or do not come out about trans issues in our lives?

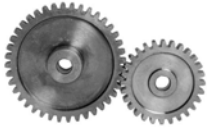
Some healthcare providers are very interested in trans issues (even if it's not an area of specialty for them). When presented with a situation where they can learn more about trans issues, the SO's issues may be ignored or not fully addressed, since the provider is asking questions to or about the transperson at the expense of the SO's care. Are we willing to educate our providers – taking our time and our money to inform them of the information that they should be willing and able to seek out on their own?

Many of us have established relationships with healthcare providers. When we are in an existing relationship with a partner who is just considering transition or exploring hir gender, it is often difficult to know just when is the “right” time to come out to our providers about our partner's gender identity. When couples/partners/families typically go to appointments together, partners may wish to address issues with our provider about the upcoming transition, or explain changes in appearance in our partner, or other issues that we might feel socially significant to our relationship to our healthcare professional.

Providers frequently get a “snapshot” impression of their clients through intake forms. These forms give them basic demographic data - age, race, marital status, major illnesses, employment status, etc. Unfortunately, many providers don't look far beyond what their client writes on these forms - often not asking clarifying questions to gain a fuller, three-dimensional picture of their client. Most intake forms try to reduce repetition of questions so clients don't spend so much time on paperwork. One area where this can be a bit problematic surrounds questions on insurance. Most forms do not have marital status questions in the demographic part of the form, but only ask about partnering status for insurance questions (since many insurance policies and payments are dependent on the correct boxes being checked on the HCFA medical billing forms the provider submits). Since the question is only asked once, there is no place that the patient/client can reveal that we are partnered (and what the gender of our partner is).

Another pervasive issue in working with any provider is when our partners are genderqueer and not expected to medically transition. Many providers are not able to understand the gray area of gender identity or expression. Most of us partnered with genderqueers are very careful in our language, often NOT using pronouns. It becomes difficult when the provider presumes a pronoun (even when one has not been used) and starts consistently using that pronoun. A provider may make this determination of pronouns based on what you look like. While this is very looksist, providers may assume that you are a gay man sitting in front of them, so you must obviously be partnered with a man/person who uses male pronouns. Other providers may perceive you to be a straight man and thus start using female pronouns to refer to your partner. Do we insist they use gender-neutral pronouns for our genderqueer partner? No pronouns at all? Do we continue to use the opposite pronoun of whatever they use, just to keep them on their toes?

For more information about FORGE (For Ourselves: Reworking Gender Expression), contact  
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## Mainstream/Western Medical Issues

One of the most common issues that arise for female partners of FTMs+ occurs when she visits her OB/GYN, Internist, or General Practitioner. A question frequently asked of women in “reproductive” years is what they prefer as their method of birth control. While this question presumes heterosexuality, this question may be difficult for both partners of trans clients, transclients, and lesbians. This question also presumes that heterosexual women are engaging in penile/vaginal-oriented behaviors that could result in pregnancy. When confronted with the question of what form of birth control is used (or desired), we need to decide how much we wish to reveal and how out we want to be. Some female partners wish to allow their physician to believe they are partnered with a biological male partner. Some prefer to maintain that they are lesbian-identified and that their partner is happily female, as well. When we choose not to reveal that our FTM+/transmasculine partner is transgendered, physicians may press harder for the woman to select a birth control method (if she states or it is assumed she is partnered with a man) and it may also place this woman in a higher perceived risk category for various forms of gynecological diseases and cancers that are more prevalent in women who have sex with biological men.

For those who choose to tell their physician that they are partnered with a “woman”, this may be stressful to her and feel disrespectful to her partner. Of course, partnering with a non-biological man also changes some risk factors for gynecological diseases.

Some may choose to claim a status of being single to avoid the issue all together. Once again, this may cause a lot of stress due to lack of honesty – for both partners. Physicians may also change their assessment of patients if they believe them to be unpartnered, or not sexually active (i.e. they may not realize that their patient may be at risk for sexually transmitted infections).

Gay bio-male partners may face similar issues. Their physician may perceive them to be at a higher (or lower) risk for certain conditions based on what gender they are partnered with (i.e. there is a perceived increased risk assessed for men partnered with other men including, for example, HIV and sexually transmitted diseases; while there is also a perceived increased risk for men partnered with women for conditions such as UTIs and HPV, etc.).

Of course, men who reveal they are partnered with another man (regardless of whether revealing if their partner is trans or non-trans) may, unfortunately, face discrimination and homophobia by their physician(s) or their office staff.

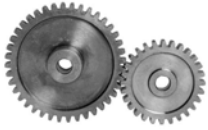
A partner of any gender may experience social challenges if they wish to bring their trans-partner along to medical appointments. Some physicians may not welcome unmarried partners of any gender. Some may only allow married partners into the room, or perceived same-sex/gendered partners into the room for genital-focused exams, etc. (i.e. they may only allow someone they perceive to be a female to accompany their female patient for pelvic exams, or someone they perceive as male to be present for their male patient’s prostate or testicle exams). Some may respect heterosexual-looking partners and treat them differently than what they perceive to be more queer or gay/lesbian looking partner. (Of course, this doesn’t take into account how the couple identifies, but only the healthcare provider’s *perception*.)

Some female/FTM+ or male/FTM+ couples wish to have children. Issues of pregnancy can be difficult for anyone who is not able to get pregnant the “old fashioned way”. It is common for many people to need “help” in getting pregnant – either through insemination, fertility testing, or other aspects of becoming pregnant. While queer couples have long faced issues regarding becoming pregnant, trans people have some unique, specific issues. It is probably the most similar to queer or “single” parents, when a female partner of an FTM+ wishes to be pregnant. However, things get a lot more challenging (socially) when a male/FTM+ partnership wishes to conceive. It may be possible for the biological man to inseminate the FTM+. The FTM+ may appear male/masculine or possibly still have some androgynous or butch appearance. The biological male partner may not be able to inseminate the FTM+, and other routes of insemination may still need to be pursued. Of course, most of the issues with pregnancy, regardless of who wishes to become pregnant, revolve around social issues and discrimination, not medical issues and safety. For example, some OB/GYNs may not wish to deal with what appears to be two men sitting in their waiting room – one notably pregnant – and having to “deal” with the consequences of the women in the waiting room who may be uncomfortable with a pregnant man in their midsts!

One of the most obvious medical situations that many partners of transpeople may experience is interfacing with hospital and/or surgical staff if their partner has opted for chest surgery, hysterectomy, vaginoplasty, metaoidioplasty, phalloplasty, or other surgery. Since we are often the ones caring for our transpartners during their early recovery, medical staff need to interact with us, telling us what we need to do and how we can medically care for our partner who has just had major surgery. Fortunately, most surgeons who work with trans+ clients are very eager to interact with partners, if only because they want to assure their patient has the best results and healing possible – so they might be more open to interacting with partners to assure the best aftercare for their trans-patient.

## Emergency medical situations

There are many ways that partners may have issues in emergency healthcare settings. The first might be if the partner of a transperson is injured and is in the emergency room (or other emergency setting). Questions may arise as to the nature of



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the relationship between hir and hir partner. Again, some emergency practitioners (EMTs, nurses, ER physicians, psychiatric intake workers, etc.) may not acknowledge partnerships that do not appear heterosexual and/or married.

Another area of concern for partners in an emergency setting is acting for the trans person. For example, if the trans person is unconscious, the partner may need to act on hir behalf. It may be important to alert emergency medical personnel that if they are cutting off the clothes of the unconscious transperson's body, they should expect to find x-genital configuration, or breasts, or other aspects of a body they might not be expecting. It may also be important to answer medical questions about the transperson's body; for example, that the scars on their chest are from chest contouring/breast removal not from any pathology or other thoracic surgery.

In cases where a trans person may have been raped or physically assaulted, it might be very important to medical staff to know if the FTM+ has had any surgery to remove ovaries, etc. so they can better assess the damage to their body. It might also be really significant for the partner to speak for the FTM+ during such a traumatic experience and/or explain the possible additional stress for the FTM+ if a pelvic exam is needed.

### Mental health issues

For partners who transition with their transgendered partner and are part of the exploration process, many may seek out mental health professionals for support and/or for gaining clarity about their own lives. Some mental health providers may not have had any experience with trans issues, so the partner may have to educate the provider or even, in some cases, *defend* trans existence. Some providers may encourage partners to leave their transpartner, since it may be causing them distress. These same providers, though, may not be so universal when suggesting that one partner leave another. For example, they may encourage partners to work out their differences when one partner spends too much money, has an affair, works too many hours, doesn't spend enough time with the spouse or children, etc. ad infinitum. Other mental health providers may need hours of explanation and discussion before they are able to get to the heart of the issues the client presents with.

Some therapists may not understand that not all issues that a client may bring to them center on trans issues. Oftentimes a couple or individual may be experiencing difficulty, challenges or lack of clarity in their life that stems from work, family, or other stressors. Some therapists may wish to pin all of the clients' issues on their trans-partner.

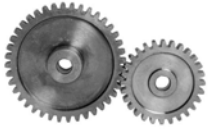
Some providers may be confused with some issues surrounding pronouns and names. Often, early in transition (or pre-transition or non-transition), partners may consistently use female pronouns to refer to their transpartner. Sometimes both female and male names might be used to refer to the partner. Sometimes pronouns will flip flop. This may prove disconcerting to some therapists and distract them from hearing the *real* issues the client wishes to discuss (which might be frustration at work or something totally unrelated to the partner's gender/pronouns/name).

It may prove equally difficult for both the client and therapist if one is using masculine pronouns and the other is using feminine pronouns. This, of course, can become especially difficult for partners and transpeople who use non-gendered pronouns that most therapists are not familiar with.

Some therapists may work within the gender community and may have experience working with SOs. Unfortunately, some therapists stereotype partners, often equating experiences of partners of MTFs with partners of FTMs. Many do not understand some of the historical differences (i.e. FTM SOs possibly coming from a lesbian history, possibly having gender issues themselves, having a greater queer sensibility or activism interest, etc.). Some therapists, who may frequently work within the trans community, also don't recognize issues that are specific to SOs, but assume that the SO is struggling with similar issues as their trans-clients.

Mental health may present huge issues for partners – for us to acquire good therapy for *ourselves*, focused on the needs and issues that are important to us. Recently I heard a partner discussing hir therapist's questions about hir partner's gender and hir sexual orientation. This therapist asked his client if s/he identified as a 'lesbian'. When s/he responded that s/he preferred "queer" to "lesbian", he pressed on with, "so you like women, then"? When s/he indicated that s/he did have a desire and liking for women and for FTMs+, he then noted that s/he must like hir partner because s/he looks like a man but thinks like a woman. Both the client and the client's masculine appearing trans-partner (who was also present), cringed at this provider's inability to understand the complexity of non-bi-polar gender, and his failure to grasp the concepts of gender, sexual orientation, and love within a relationship.

Partners interface with healthcare professionals for their own care, as well as in helping assure appropriate medical care for their transpartner. We are often in a vulnerable position when we seek out medical care – being sick, weak, not feeling well, or under emotional stress, or in an emergency medical situation. We frequently need to inform our medical providers at times we wouldn't necessarily want to reveal such personal information. It is difficult to balance getting the care we need and deserve, weighing the potential consequences of being out as part of a trans-partnership, and how that knowledge may adversely (or positively) affect our healthcare outcome.



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## Families of Trans People and Health Care Professionals

by Loree Cook-Daniels

How being the family member of a transperson affects the non-trans person's health care is a topic that is very seldom talked about. The only reason it would come up is if a visibly "trans" person accompanied the non-trans relative to the doctor or hospital and provoked an outbreak of transphobia, right? Wrong.

Probably the relatives most affected in the health care arena (aside from partners, who are discussed elsewhere in this issue) are our children. Family medical histories lie at the base of most patients' relationships with their doctors. Does heart disease run in your family? Diabetes? What about breast cancer? Although many children must distinguish between "blood" and other relatives due to adoption, blended families, Lesbian and Gay parents and the like, the kids of transpeople have additional issues. If hir parent doesn't want to be outed or if the child doesn't want to be outed how does a child explain that hir mom isn't actually related to hir, hir dad is? Sounds simple, right? But the child may worry that the doctor will ask a follow-up question sie doesn't know how to answer. What if DAD had the breast cancer? (Although men also get breast cancer, kids may still be nervous about discussing such a sex-linked condition.) What if a child's two dads actually are *\*both\** biologically related to the child? How does one explain THAT medical history? Do you say, "My mom's family..." when you're talking about your Dad?

Some FTMs also have children to whom they're not out. How do *\*those\** medical histories get handled? Is the doctor potentially led astray, perhaps even in a life-threatening situation, by being told a family medical history that is actually totally irrelevant? Or do parents in such a situation face pulling the doctor out of the room, freaking out the child, to explain that the child doesn't know, but Dad isn't actually a blood relative?

Other family members face similar family history dilemmas. Does a sister facing a gynecological crisis say that her brother also had uterine cysts? Does a dad going over his family genogram with a new mental health professional say he has one son or two? If he says two, will he have to remember to change pronouns when he later discusses pre-transition family memories? Or does he explain that his son is transgendered and thus open himself to the possibility the therapist will view *\*that\** as his problem no matter what he says subsequently? What if the son doesn't want to be outed? What if the child identifies as neither male nor female?

What a health care provider sees in front of her and then makes assumptions about can be very problematic in health care situations. For a few years, it seemed like every health care problem our young son had was somehow related to his penis. Although our primary pediatrician knew we were an FTM/female couple, one emergency visit was to a fill-in doctor who acted more than a little perplexed that this ostensibly heterosexual couple seemed so incredibly clueless about this piece of anatomy. We were faced with a dilemma: should we quit asking "dumb" questions and risk not giving Kai the best care, accept her assessment that we must have room-temperature IQs, or stop everything to explain that neither of us had seen a flesh-and-blood penis other than our son's in 20 years?

A similar but more easily handled dilemma came up recently when an elder in my extended family was hospitalized. Under stress, this elder frequently reverts to the pronoun and name the FTM in our family used for the majority of time she's known him. Faced with a bearded "son-in-law," the admissions staff could have easily noted that the elder was clearly suffering from dementia, had the FTM not been willing to explain the situation.

But explaining the situation has its downsides. As we all know, transphobia is still rampant among health care providers. What's less acknowledged in the trans community is transphobes don't just mistreat trans people. Just as some of the worst racist remarks and actions are leveled at white "nigger-lovers," SOFFAs of known trans people often bear the brunt of transphobia and ignorance, particularly from individuals who are otherwise too "polite" to ask outrageous questions or voice negative opinions directly to a transperson. Anyone who "outs" a trans relative within the context of hir own doctor's office knows sie's risking exposing hirself to poor care, outrage, unbridled curiosity, or, at best, a health care provider distracted by this unusual information.

When it comes to educating health care providers, it's more than just transpeople's health that is at stake.