

# The inclusivity trap

Asking patients for their pronouns helps us treat them — unless they shut down



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*By Lala Tanmoy Das, February 19, 2021  
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10 “How’s your afternoon going so far?” I asked my patient, a man who’d come to get his blood drawn and his meds refilled, one afternoon last year. While sanitizing my hands, I noticed a Trump campaign slogan emblazoned on his T-shirt. I tried not to look down at the rainbow pin on my own white coat. I introduced myself.

15 “Hi, I’m Tom, a medical student, and I use he/him pronouns. Do you mind telling me your name and pronouns so I can confirm it in the chart?”

Immediately, my patient’s smile vanished. “What do you mean pronouns? Do I look confused to you?” he asked, visibly exasperated.

20 I apologized, but I knew I’d lost him. His responses were dismissive, and he seemed eager for the exchange to end. My intention to be inclusive had backfired, and unfortunately not for the first time.

As social attitudes shift, medical organizations are becoming more attentive to patients’ gender identities and encouraging providers to ask about them. A recent report from the Association of American Medical Colleges nudged schools to teach medical students to establish an inclusive clinical encounter by asking patients what pronouns they use, no

25 matter how they appear. I've seen how much this can do to build a rapport with the  
person I'm treating, especially young adults, more and more of whom use they/them  
pronouns in my experience.

At the same time, these interactions can be instantly alienating to a different set of  
patients, such as the man I met at the clinic. Many medical practitioners I've spoken to  
30 describe similar experiences. One medical student from the Southwest told me about a  
patient who clammed up when asked about pronouns, responding, "I refuse to answer  
that question." A supervising physician in California said he had no choice but to advise  
medical trainees at his institution to avoid the question altogether after hearing that  
35 patients responded poorly. Another doctor wrote to me: "I've backed off asking/probing  
systematically/routinely. Most patients were confused." And a med student from the  
West Coast described an experience similar to mine, telling me, "I had a patient who  
believed I was pushing 'an agenda' because of that question and whose tone toward me  
for the rest of the interview was condescending."

Studies show that alienating experiences — not all of them related to gender diversity, of  
40 course — may lead patients to share fewer pertinent clinical details, while also resulting  
in lower adherence to care plans, worse health outcomes and inefficient use of  
resources. They also make the patient less likely come back for follow-up care. In other  
words, doctors need the trust of their patients. Gender inclusivity can build that rapport  
— and also undermine it.

45 Decades of intolerance, stigma and discrimination have made the transgender and  
gender nonconforming (TGNC) community one of the most vulnerable and  
marginalized populations in American society. A recent study of transgender patients in  
the Veterans Health Administration found that they were significantly more likely to die  
from suicide than cisgender patients. Tragically, the medical establishment has at  
50 times perpetuated intolerance. Patients describe being routinely misgendered or  
otherwise disrespected in medical settings, experiences that can be extraordinarily  
difficult. As one respondent to a National Center for Transgender Equality survey put it,  
"I passed a kidney stone during that visit. On the standard 1–10 pain scale, that's  
somewhere around a 9. But not having my identity respected, that hurt far more."  
55 Consequently, these patients have hidden their gender identity from medical  
professionals, delayed seeking care for acute needs and avoided follow-up care.

One way health-care workers can help is by asking patients their pronouns. It's a sign of  
respect that not only builds rapport with TGNC individuals but helps them feel  
validated, less stressed and more supported. It can even be lifesaving for some. Without  
60 asking, providers run the risk of missing critical questions, such as those about changes  
to the use of hormones, mental health challenges like gender dysphoria, overall feelings  
of isolation and thoughts of self-harm. Doctors can also accidentally misgender a  
patient, an experience that can be stigmatizing in ways that may impede necessary care.

Unfortunately, some Americans are unaccustomed to — even hostile toward — this sort  
65 of question. New norms, although long overdue, have not yet caught up with every  
corner of a country where half of the population believes that people should use the  
bathroom associated with the gender they were assigned at birth and where many

70 politicians, including the previous president, oppose transgender military service. For the many who still conflate gender with biological sex, asking “What pronoun do you use?” can signal that they don’t present as the gender they believe themselves to be. Others may treat the query as an unwelcome intrusion of politics into the exam room. One patient told me that I needed to “stop the liberal lunacy.”

People who harbor these antagonistic views still deserve compassionate care.

75 Historically, the medical establishment has helped to shift cultural norms and beliefs, including some we had once enforced. We have, for example, at least partially normalized the once-contentious question “Do you have sex with men, women or both?” when taking sexual history. Harm-reduction principles — instead of castigation — have saved the lives of many people with substance use disorders: Where we once narrowly understood addiction as a “failure of willpower,” we’ve learned to think of it in more  
80 empathetic terms.

But such changes don’t take hold all at once. And though nearly all professional medical organizations acknowledge that gender plays out on a spectrum, we need to work together to figure out how to put that insight into clinical practice that lets us “do no harm.” How can we serve our mandate for compassionate care when people react so  
85 differently to that compassion?

The question demands creativity and experimentation. Perhaps the question about gender identity could come later in an interview, after doctor and patient have already established a rapport. Perhaps it should also come from senior clinicians rather than medical students and residents alone. Maybe we can ask patients what pronouns they  
90 use on standardized intake forms ahead of time. Or perhaps, as we document a patient’s social and/or sexual history, we can acknowledge the sensitive nature of the question but also normalize it by stating that every patient is being asked.

It would also offset discomfort to show that pronoun identification is normal in a clinical setting, the better to help patients understand that they’re not being singled out  
95 or challenged: Medical providers and staff members could wear pronoun pins or stickers and could answer any questions from patients. And instead of a one-time intake item, the question could be included in a patient’s annual physical, another matter-of-fact approach that would normalize it (while also reflecting the fact that gender identity can change over time).

100 Doctors cannot single-handedly alter social mores, but we can push for change by advocating for marginalized voices and bringing awareness to the experiences of disenfranchised communities. We are bound to hit roadblocks — particularly when we encounter restrictive beliefs and generational divides. But when it comes to asking pronouns, the goal is health-care equity. The discomfort experienced by a few cisgender  
105 individuals should pale in comparison to the lifesaving sense of affirmation that vulnerable gender minorities might feel.

If we proceed with thoughtful professionalism, we may be able to turn these obstacles into opportunities for dialogue and education. And that, in time, may improve the lives of all of our patients.