Good Doctors, Bad Patients: The Construction of Transgender Patients in Medical Textbooks

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A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Arts

University of Washington

2026

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Program Authorized to Offer Degree:
Sociology

University of Washington

Abstract

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There is a growing consensus that medical schools are insufficiently educating students about transgender care. Drawing on a content analysis of textbooks assigned in top American medical schools, this thesis examines the representation of transgender patients in medical education. Focusing on sections which discuss transgender health and medical treatment, I show that transgender patients are constructed as either conforming to normative and medicalized expectations, or problematized as "bad" patients. While transgender patients are always at risk of being viewed as "bad" patients, physicians are taught that simply adopting an unbiased attitude towards these patients will make them a "good" doctor and result in competent medical care. I argue that these representations contribute to the reproduction of medical uncertainty and provider hesitancy to treat this population. These findings suggest that improving transgender health care likely requires not only more inclusion in the curriculum, but also a re-evaluation of how transgender patients are framed within the medical narrative.

ACKNOWLEDGEMENTS

I would like to extend my sincerest gratitude to my thesis committee for their time and guidance. Dr. Rosalind Kichler, thank you for your mentorship and support throughout this project. Your theoretical insight shaped this thesis from its earliest stages, and I am especially grateful for your role in developing the title and helping me refine the project's direction. Dr. Jelani Ince, thank you for your insightful feedback and encouragement over the course of this thesis. Your methodological insight and analytical guidance challenged me to think more critically about my research, helped me refine the research question and strengthened the entirety of my project. Dr. Patricia Louie, thank you for your thoughtful contributions, feedback and support. Your perspective helped me deepen my analysis and your suggestions on the literature improved the foundation of this research.

I would also like to thank the UW Sociology Department, including my cohort (and adopted members) for creating a supportive and intellectually engaging community. Thank you Dr. Alex Brewer, for inspiring me to go to graduate school, and helping me get there. Finally, I would like to thank my friends, inside and out of grad school and my family, especially my mom, for her thoughtful edits. You have all been instrumental in shaping me as both a person and a scholar.

INTRODUCTION

Transgender (trans) people experience significant barriers to obtaining medical care, both related and unrelated to their transition (Gonzales and Henning-Smith 2017). In 2022, 25% of trans people reported delaying healthcare due to fear of discrimination, and of those who did see a doctor, 48% reported having at least one negative experience due to being trans (Rastogi et al. 2022). Healthcare providers often cite feeling unprepared to address the unique needs of trans patients as a reason for denying them care (Grace and Doan 2024). This unpreparedness likely stems from failures in medical education (Liang et al. 2017), as well as a tendency to treat trans people and trans healthcare as wholly unique from other types of medical care (shuster 2021). In fact, only 71.3% of surveyed medical students felt comfortable participating in the care of trans patients and only 27% felt confident in their knowledge of trans people's health needs (Karpel et al. 2023). Moreover, when trans people do seek medical care unrelated to their transition, doctors often mislabel their symptoms as related to being trans (Wall, Patev, and Benotsch 2023).

The lack of preparedness many doctors feel concerning the treatment of trans people is likely amplified by the fact that trans medicine, or gender affirming care, is seen as a particularly medically uncertain field (shuster 2016). Medically uncertain conditions are those that lack a clear physiological cause, diagnosis, and treatment (Kim and Lee 2018). Physicians' experiences of medical uncertainty, and their general intolerance of it, have been found to result in stress for providers, as well as worse outcomes for patients. Yet, strategies for navigating medical uncertainty can be taught in medical school (Kim and Lee 2018).

Medical school is not only a place where physicians learn to perform medical treatments, but also a place of professional socialization, where future doctors learn to internalize the ethics, norms and values of their field (Becker 1976). Thus, to understand why current physicians feel underprepared to treat trans patients, it is important to examine the role medical education plays in socializing doctors around these

patients. While there is ample scientific evidence to suggest that trans-related medical education is lacking at both the classroom and clinical level (Dubin et al. 2018; Liang et al. 2017; White Hughto, Reisner, and Pachankis 2015), few studies[1] to date have analyzed the discussion of trans patients in medical textbooks specifically, and medical education more broadly.

The goal of this study is to analyze how transgender patients are portrayed in American medical education, specifically in medical textbooks. I analyzed 97 textbooks from top American medical schools, coding for discussions of trans and LGBQ patients. I included descriptions of how to provide care to them, the portrayal of "unique" health needs of this population, and imagined doctor interactions with trans patients. By filling this gap in the literature, this study aims to further illuminate the pathways by which medical students come to feel unprepared to treat trans patients and, as medical doctors, become more likely to deny care to these patients.

LITERATURE REVIEW

Medical institutions currently play a large role in constructing sex, gender, and transgender identity (Stacey, Wislar, and Reczek 2025; Gill-Peterson2018). Transgender (trans) people are often subject to extended contact with the institution of medicine, not only for gender affirming care, but also for general medical care, unrelated to their transition.[2] Even so, trans people experience worse health outcomes than their cisgender (cis) peers, stemming not only from societal stigma and discrimination, but also from structural inadequacies in medical education (van Heesewijk et al. 2022; White Hughto, Reisner, and Pachankis 2015). This literature review synthesizes scholarship on stigma, medical uncertainty, and trans studies to examine how medical education prepares—or fails to prepare—medical students to treat transgender patients.

[1]De Guzman et al. analyze LGBT representation in textbooks broadly, however since trans people are represented as uniquely uncertain, it is important to analyze them alone (2018)

[2] In this thesis, I will be discussing both transition related (gender affirming) care and general medical care, as trans people often access both types of care (Wall, Patev, and Benotsch 2023).

Trans and queer populations experience discrimination across multiple dimensions of social life, extending to their interactions with doctors in clinical encounters (Casey et al. 2019; White Hughto, Reisner, and Pachankis 2015). Queer people, including trans people, face unique types of discrimination in healthcare, including a lack of culturally competent care, medical paternalism, and hesitancy to seek care due to increased stigmatization (Hsieh and shuster 2021). Structural stigma, which comes from society, culture, and institutions, also limits access to health-promoting resources, such as: wealth, quality healthcare, social support, and power, contributing to health inequalities (Hatzenbuehler, Phelan, and Link 2013). Scholars of medical education have argued that doctors have a responsibility to develop "structural competency," or an understanding of how patient health outcomes are shaped by broader social and institutional forces (Metzl and Hansen 2014). While providers have an ethical obligation to provide culturally competent care to all patients, the responsibility is particularly high for medical providers—and by extension, medical educators— to ensure heavily stigmatized groups, like trans people, receive equitable, non-biased care. Yet transgender people remain more likely to have unmet healthcare needs, and forgo routine care compared to cisgender people (Gonzales and Henning-Smith 2017), underscoring the inadequacy of current medical training. If not properly addressed, the medical education students receive regarding trans people may fail to combat, or even serve to increase, the healthcare barriers trans people already experience.

Medical Discrimination and Medicalization

While some health disparities between transgender and cisgender people are undoubtedly shaped by broader experiences of discrimination and the resulting socioeconomic differences (Hsieh and Shuster 2021; Hatzenbuehler et al. 2013; Gonzales and Henning-Smith 2017), evidence suggests that discrimination by health care providers also plays a critical role. In fact, trans people are less likely to have a primary care provider and less likely to access specialty care than their cisgender counterparts (Ehrenfeld, Zimmerman, and Gonzales 2018). Nearly one third of trans participants report delaying or not

seeking medical care due to discrimination in previous health care encounters (Jaffee, Shires, and Stroumsa 2016). Furthermore, when trans people do seek medical care, their concerns are often dismissed, with doctors being overly focused on their medical transition or gender identity, ignoring other conditions- a phenomenon known as “trans broken arm syndrome” (Wall, Patev, and Benotsch 2023).The tendency to attribute legitimate medical complaints of trans people to their gender identity demonstrates the intertwined relationship between stigma and clinical decision making.

Additionally, medical providers tend to view trans people and trans medicine as fundamentally different from cis people and their care. This phenomenon, known as “trans exceptionalism” (shuster 2021), is often cited by physicians as a reason why they feel unequipped to provide care to trans patients (Grace and Doan 2024).

It is not atypical for transgender people to strategically rely on or be subject to medicalization, or the defining of their everyday experiences as medical problems (Fausto-Sterling 2019). From 1968 to 2013, being trans was labeled as a disorder in the DSM (White Hughto, Reisner, and Pachankis 2015) and today, trans people still experience pathologization, especially if they display nonnormative goals or transition desires (Hsieh and shuster 2021). The burden to demonstrate certainty in their gender to medical providers is placed on transgender people before they can receive gender affirming care. To assure certainty, trans people are often expected to go through extensive counseling and to describe their experiences in a way that aligns with specific, binary medical descriptions (shuster 2016). In addition to this, trans people, like cis people, experience medical illnesses unrelated to their transition, and rely on the medical field to access care (Wall, Patev, and Benotsch 2023). Therefore, it is valuable to understand how physicians learn to provide care to trans patients, with whom they will almost inevitably interact.

One place doctors learn about treating trans patients is through medical textbooks. This is an important source where messages about trans people are conveyed, which may in turn impact their future care. In being unable to tangibly address the ways in which trans people face medical disparities, medical

textbooks, a foundational resource for medical education, may fail burgeoning doctors and their future trans patients.

Medicine's Role in the Development and Regulation of Trans Identity

Medical authorities have historically been the arbiters of gender, which they have, in part, constructed through the "diagnosis" and "treatment" of transness (Gonsalves 2020). Historically, transition-related medical care was only officially offered to those who were able to easily "pass" as a cis man or cis woman, with many trans people opting to obtain hormones and other forms of gender-affirming care through their own networks. In many ways, as long as transness has been medically recognized, physicians have been gatekeepers to medical transition (Gill-Peterson 2022). By playing such a large historical and modern role in the creation of sex and gender, the medical field has shaped—and often constrained—how trans people access gender affirming care.

Transness has been constructed in medicine as a misalignment between the body and mind. This places trans medicine at odds with most other types of medicine, which see illness as separate from the mind (shuster 2021). As a result, gender affirming care is a particularly unique classification of medical care. Doctors are taught to view the role of trans medicine as 'normalizing' sex and gender variation by bringing the sexed body into alignment with a binary gender identity, making the patient appear as cisgender as possible (Davis, Dewey, and Murphy 2016). Often, this 'normalizing' mission directly conflicts with patients' desires, who may not want every available aspect of medical transition. Even so, doctors, and society at large hold trans people accountable to strict, medicalized, and binary presentations of transness. This is a concept known as transnormativity (Johnson 2016). Patients who do not fit a transnormative narrative are often subject to delayed care and further pathologization (shuster 2021; Davis, Dewey, and Murphy 2016).

Many trans people are aware of these constraints, and strategically comply with strict ideas of what it means to be trans, providing physicians with familiar narratives to receive the gender affirming

care they desire, such as: “knowing since childhood” and being “in the wrong body” (Stone 1987). By employing this strategy and being able to provide doctors with assurances that they are “truly” trans, trans people are able to somewhat resist the construction of unnecessary barriers by doctors. However, this continues to harm and stigmatize those who do not fit a normative narrative.

Medical Uncertainty

Medical uncertainty, or the lack of a clear physiological cause, diagnosis, and treatment of an illness has been widely studied in medical sociology (Kim and Lee 2018). When presented with medical uncertainty, doctors often experience distress and frustration, resulting in poor patient outcomes (Kim and Lee 2018). If medical students are not taught to tolerate ambiguity, they are more likely to express negative attitudes towards underserved populations, for example, trans people (Wayne et al. 2011).

Medical care providers often use the same techniques to respond to uncertainty in trans healthcare as they use to respond to uncertainty in other medical fields, despite the fact that being transgender is not a biomedical illness (shuster 2016). Poor ability to cope with medical uncertainty has been found to lead to worse patient outcomes and care (Scott et al. 2023). This is especially relevant, given transgender medicine is a uniquely uncertain field; there are no diagnostic tests to verify a patient’s gender identity (shuster 2016).

Due to the medically uncertain nature of being trans, trans people may be especially vulnerable to the medical discrimination found in the current health care system. This access extends beyond transition-related care, to general medical care. Access to general medical care may be even more difficult for transgender individuals if medical students are not given adequate training, as this will amplify medical uncertainty in an already ambiguous field.

When providers feel uncertain about trans people, they sometimes rely on stigmatizing questions and attitudes to reinforce their medical authority, degrading their patients in the process (Poteat, German, and Kerrigan 2013). In addition to directly stigmatizing patients, physicians have been found to make

moral judgments of them, based on a variety of social, institutional, and provider factors, including perceived patient trustworthiness, stereotypes, and perceived compliance (Hill 2010). The moral evaluation of patients, based on their perceived social characteristics, directly affects the quality of care they receive (Roth 1972), with patients who are deemed "difficult" by providers receiving lower quality care (Kao and Liu 2025). One way patients are labeled difficult is if they increase medical uncertainty (Schwartz 1958). Thus, if medical training in trans healthcare fails to reduce uncertainty, it may result in more trans patients being seen as "difficult" and result in worse medical treatment.

Medical School Socialization

Medical school has long been thought of as a site of professional socialization, where aspiring physicians learn to internalize the ethics, norms and values of their field (Becker 1976; Vaidyanathan 2015). Medical school textbooks offer us unique insights into the current values, gaps and concerns of the field, as well as the ways in which new physicians learn medicine (Morning 2008). Therefore evaluating medical textbooks' discussions of trans people provides a sense of the medical field's values and future treatment of these individuals.

Currently, medical education about trans people is often constrained to a singular "diversity day," wherein medical students are taught about LGBTQ populations broadly and briefly (shuster 2021). While Hana et al. (2021:299) have noted medical school's recent inclusion of singular "lectures, online modules, and panels with sexual and gender minority people," it is still necessary to include trans people in the permanent medical curriculum. By reducing education about trans patients to a single lecture or panel, medical educators risk providing doctors with a surface level understanding of their patients. Without explicit training on the needs of trans patients, doctors may fall back on stereotypes, rely on gatekeeping practices to reduce uncertainty, or further perpetuate stigma and harm. Medical schools themselves are often sites that perpetuate a culture of cisnormativity, including through a variable and inadequate trans

curriculum (Butler, Yak, and Veltman 2019). If this culture is not addressed through adequate medical training, doctors will continue to feel underprepared to treat their trans patients.

Clinical and didactic education on both LGB health and trans health is minimal and subpar (Dubin et al. 2018). In clinical settings, it is common for medical students to have 0-5 total hours of exposure to trans patients (Obedin-Maliver et al. 2011). Medical doctors, including generalists and even endocrinologists, who frequently monitor the prescription of hormones for trans patients (T'Sjoen et al. 2019), report feeling underprepared to treat and interact with transgender patients (Davidge-Pitts et al. 2017; White Hughto, Reisner, and Pachankis 2015; Liang et al. 2017). Often, doctors are hesitant to treat transgender patients, citing this lack of preparedness. Many doctors are forced to learn the nuances of trans medicine while treating their patients for the first time (shuster 2021). This highlights a systematic deficiency in current medical curricula regarding the preparedness of doctors to effectively treat trans patients.

While several studies mention the dearth of medical education about trans people, few studies to date have analyzed the existing content of the medical education surrounding trans people (Dubin et al. 2018; Liang et al. 2017; White Hughto, Reisner, and Pachankis 2015). This thesis attempts to fill this gap, with a comprehensive analysis of medical textbooks taught at the top 52 American medical schools.

Knowing that physicians feel unprepared to treat trans people, who experience a wide range of health disparities and experience further marginalizing encounters with the medical system, it is sociologically necessary to analyze the presence of trans people in medical textbooks. This work seeks to illuminate one process by which doctors may become uncertain about the medical care of trans individuals, through an inductive content analysis of medical school textbooks.

METHODS

Sample

*US News and World Repor*t in 2025 ranks medical schools in three tiers. I sampled textbook lists and syllabi from the top two tiers of American medical schools, specializing in research. The top research universities are well positioned to be aware of and disseminate the most up to date information about trans medicine, as the medical field often treats trans medicine as a relatively new and specialty area of medicine. Out of the 52 schools sampled, 8 schools responded.

This low response rate is likely due to a variety of factors. Firstly, I began conducting this research at the beginning of 2025, when many institutions were moving much of their previously public information behind school logins, due to increased political pressure. Furthermore, while I attempted to use the Freedom of Information Act to request the syllabi from institutions, only 16 of them were public and subject to FOIA. Many institutions denied the FOIA request, or did not respond to email inquiries. However, the goal of this thesis is to provide a descriptive account of the representation of trans patients in medical textbooks, rather than to make generalizable claims about all medical schools.

In total, the universities listed 178 books, 46 of which were used over multiple schools. I excluded 33 anatomy atlases from my final sample, after surveying 5 and finding they only mentioned binary, sex-based anatomy. Two of the resources from the schools were websites, which were excluded due to having too many links to external content to analyze. Two books were excluded due to being unavailable in my library. The final sample of 97 books encompassed a substantial portion of the medical school syllabi. **Figure 1.** (see appendix A) presents my inclusion criteria.

Analysis

I performed an inductive, qualitative content analysis, which was an ideal method to answer the research question, allowing me to closely analyze materials used to teach medical students about trans people. To determine if textbooks contained mentions of trans or LGBTQ people, I developed a list of search terms related to trans and queer people, as well as hormone therapy, generally. The search terms

were developed after conducting the literature review, taking into account common terms used to refer to trans people. Search terms included: *Trans…; Gender affirming care; Gender incongruence; Gender nonconforming; Gender dysphoria; Gender identity disorder; Hormone replacement therapy; HRT; Nonbinary; Non-binary; Testosterone therapy; Estrogen therapy; Puberty blockers; Anti-androgens; Antiandrogen blocker; Androgen blockers; Sex reassignment; Top surgery; Bottom surgery; Queer; Lgb…; Gay; Lesbian; Sexuality; Sex and gender minorities; MSM; Homosexual; Bisexual; Minority stress; HIV; Prep; Sexual orientation; and Intersex.*

Of the 97 textbooks analyzed, 30 contained mentions of trans or LGBTQ+ people. I coded the final 30 textbooks in InVivo15. Seventeen textbooks included specific mentions of trans people, and three included representation of intersex conditions, which I included originally as a possible comparison case. The codes were developed inductively, using methods from *Qualitative Research Methods* (Hennink, Hutter, and Bailey 2010).

I underwent two rounds of coding, collapsing and expanding codes as was relevant to the data. For example, "Addressing discomfort to treat" and "denial of care" were collapsed into "necessity to treat". Eighteen codes emerged, and I focused my analysis on the nine that were most relevant to patient care and medical uncertainty. Quotes presented in the results were selected for their representativeness of the selected themes.

FINDINGS

Figure 2. (see appendix B) presents the percentage of my total sample that mentioned queer people. Less than one third (30.9%) of my original sample contained any mention of LGBTQ people and 17.5% mentioned trans people specifically. This finding is consistent with previous literature, which documents queer, especially trans, people's underrepresentation in medical education (van Heesewijk et al. 2022; White Hughto, Reisner, and Pachankis 2015).

Although discussions of transgender patients were most often absent from these medical textbooks, when they were included, they were presented in a limited set of recurring narratives.

Specifically, trans people were constructed as either idealized subjects who could provide clear, normative accounts of their gender, or as challenging and uncertain patients, who complicated clinical care. **Figure 3.** (see appendix C) Summarizes the frequency with which major themes appeared across the analyzed textbooks.

Today's medical textbooks may work to increase the hesitancy doctors face when asked to provide care to trans patients. I found they outline the expectations for doctors as little more than to refrain from transphobic discrimination while expecting trans patients themselves to behave as medically certain and normatively trans. They do so while implicitly framing the doctor/patient relationship as combative. Taken together, these representations frame "good" trans patients as those who can provide medical certainty to their providers, while describing most trans patients and treatments for trans individuals as inherently uncertain. This ultimately stigmatizes trans patients as "bad" patients.

"Good" Doctors

The responsibilities of doctors are implicitly outlined in many of the textbooks and often fall short, advising doctors simply to avoid transphobia. This may suggest that doctors' main obligation to their trans patients is to be informed of and avoid bigotry rather than to provide quality medical care to their patients. Describing a "good doctor" as one who has good bedside manner could fail to prepare medical students for the reality of treating trans patients.While important, knowledge of good bedside manner alone lacks the nuance needed to provide care to marginalized patients.

There was one major exception to the textbooks' implications that a good doctor should merely refrain from discriminating against trans and other queer patients. In *Smith & Tanagho's General Urology* by Jack W. McAninch and Tom F. Lue they state*,:*

> It is highly likely that the urologist of today will see transgender patients in her/his practice. Although genital gender-affirming surgery is emerging as a subspecialty within urology, the general urologist, who may be called on to provide routine urologic care to a transgender patient, or to refer the transgender patient to an appropriately trained

> urologic reconstructive surgeon, should also be familiar with the care, needs, and surgical anatomy of the transgender patient.

In this book, the authors emphasize the importance for urologists to have medical knowledge of trans people, whether or not they expect to specialize in trans healthcare. Even general urologists should be able to provide routine care to trans people. The use of *routine* care is especially important here, highlighting that while the trans population may have some unique urological needs, providers should be able to perform basic medical treatment for trans people as well. This addition could help combat the "trans broken arm" bias many providers exhibit (Wall, Patev, and Benotsch 2023). Importantly, authors of the textbook also describe detailed medical training for doctors who have patients that had gender affirming genital surgeries. However, *Smith & Tanagho's General Urology* is unique in framing a doctor's responsibility. The remainder of the textbooks emphasize that doctors' main duty to trans people is to merely refrain from bringing any personal homophobic and transphobic biases they may have to their medical practice.

These textbooks focus on the imperative to treat all patients, despite the stigma the providers may feel. In one such book, *Lifelines* by Leana Wen*,* the author discusses the treatment of LGBTQ patients and the introduction of a new law that allows physicians to deny care to queer people, *"*It is our job—and our privilege—to take care of patients. We don't judge the people we serve. We don't allow our beliefs to override their needs. And we certainly don't deny lifesaving care."

This book urges providers to medically treat trans people, sometimes in spite of their bias. The moral imperative described here is not about providing trans patients with specialized or generalized care, or to being up to date on the needs of the patients, but simply not turning these patients away. In excluding calls to be informed of the needs of trans patients, the textbook frames the goal of trans healthcare to be non-refusal, rather than providing adequate care. The author then goes on to share a personal story of working in a prison, and having to provide care to child sex traffickers and rapists, implicitly linking the feelings of hostility she felt towards those patients to the feelings some providers may feel towards LGBTQ people.

Another case of this is in *Medical Management of Vulnerable and Underserved Patients: Principles, Practice, and Populations* by Talmadge E. King, Jr. and Margaret Wheeler. Above a section entitled “Creating a Welcoming Environment for LGBT Patients," the author reminds readers that “laws and policies prohibiting discrimination against LGBT people are often worded to forbid discrimination related to both sexual orientation and gender identity and expression.”, highlighting the legal importance of nondiscrimination. This reminds doctors that they are, in fact, obligated not to discriminate against queer people, possibly increasing tension in the patient-provider relationship. Furthermore, it could increase provider anxiety when treating trans patients, by making them hyper aware of the legal consequences of failing to provide unbiased care. It further lowers the ethical bar of trans medicine to nondiscrimination, rather than competence. The author then goes on to advise:

> A woman who resembles a provider’s grandmother could well say that she is a lesbian. A young male athlete, who has previously mentioned only sexual relationships with women, may say that he has recently become sexually active with men. And a woman whose husband has accompanied her to take notes on future treatment may indicate that she was “assigned male” at birth. In all of these situations, it is critical not only that health care be unaffected by learning a patient’s LGBT status but also that provider–patient rapport remains strong after LGBT status becomes known.

Once again, *Medical Management* simply argues that patient-provider rapport should remain unaffected once learning a patient is queer. The book suggests doctors should focus on making it overwhelmingly clear they are not uncomfortable treating trans patients. The emphasis on the interactional aspects of treatment obscure the details of the patients’ medical needs. It also implies that the highest standard of care a doctor can offer a queer patient is to simply not react negatively. The focus on remaining unaffected by their queer patients, highlights the interactional responsibility of the provider, but not the medical responsibility.

Additionally, it is notable the author lists several “everyday” people who could be queer. The specific examples, a grandmother, an athlete and a woman with a husband tell us a lot about the expected audience. Is it surprising that a trans woman could have a husband? This reliance on very heteronormative

examples could be an attempt to “normalize” patients in the eyes of the provider. However, this attempt at normalization could actually reinforce stigma towards patients who do not fit this narrative. The book also discusses the possibility of longer wait times and “gawking” from physicians, advising against this blatant form of social discrimination. However, focusing on the most extreme forms of bias can obfuscate the more subtle forms of discrimination- doctors' hesitancy to treat trans patients at all.

It is notable that *Tangelo's Urology* and *Life Lines* frame the obligation to treat trans patients as a moral imperative whereas *Medical Management* highlights avoiding interactional discrimination. In later sections, *Medical Management* does highlight trans patients’ specific medical needs, but it is notably absent when discussing the *obligation* of a doctor.

Overall, the textbooks present the treatment of trans patients as an “unfortunate” necessity. With the exception of *Tangelo's Urology*, medical textbooks see the need to prepare future doctors to fight any potential biases they may have against trans patients, encouraging them to provide the bare minimum: non-discriminatory care. For example *Fitzpatrick's Dermatology* by Sewon Kang encourages doctors to provide “Culturally competent and patient-centered care to LGBT persons” and an “inclusive environment". While this is, of course, important, when viewed in the larger context of medical providers who often feel so unprepared to treat trans patients that they turn them away, it is inadequate. Often doctors refuse to treat trans patients not because of personal hatred, but rather a perceived lack of medical knowledge (shuster 2021), and many of these textbooks lack specific examples of what culturally competent care looks like for trans patients.

While ten textbooks in the final sample present doctors as obligated to treat trans patients, the *type* of care expected and the specific way that trans care is presented varied. On the more comprehensive side, *Tangelo's Urology* discusses the necessity to provide routine and specialized care. The other nine textbooks simply recommend doctors provide non-discriminatory care. This lacks the specificity of the urology textbook. While urology is a field trans people might come into contact with fairly often, trans

people need to seek all available types of routine medical care, and doctors across specialties should be equipped to provide this care to all patients. In addition to outlining the behavior of a "good" doctor, several of the textbooks I analyzed discussed expectations of "good" patients.

"Good" Patients

The textbooks position trans patients as bearing a different type of responsibility than physicians when seeking medical care. The burden of providing medical certainty, and "proving" their legitimacy to doctors often falls upon the patients, as evidenced by the textbooks' descriptions of "good" patients within the clinical encounter. Authors depict examples of a mythologized "good" patient, highlighting the expectations that doctors can place upon their trans patients. In being the "good" trans patient, trans people become responsible for providing a sense of medical certainty to their doctors. Even when the textbooks attempt to offer medical certainty, they rely heavily on untestable biomarkers, ultimately producing a framework where the burden of providing medical certainty remains with the patient.

Frequently describing cases of trans people who are extremely certain of their gender, or attempting to describe biological causes for transness, the authors of the textbook seem driven to reassure burgeoning doctors that medical certainty is obtainable in the treatment of trans patients. Two of the textbooks I analyzed describe provider interactions with an imagined trans patient. In one case, relying heavily on a transnormative narrative, *Health Systems Science* by Susan E. Skochelak describes the patient,

> "I identify as a man, and I want to talk about starting hormone therapy." G.C. goes on to say that when he was 7, he started to realize that he did not feel like the girl everyone told him he was. He started to dress and act like a boy at around 10, but his parents were never supportive ... .For the last 2 years he has been living as a man, working odd jobs, and feeling happier with his new peer group.

Doctors are often taught a patient is “truly” trans if they have felt like another binary gender for a long time (shuster 2021). With the medical field often encouraging or even requiring trans people to live socially as their gender for a year or more before medically transitioning, it is telling that the book describes a patient who has already socially transitioned and has been confident about his gender since childhood. This “good” trans patient is both extremely certain of himself and has demonstrated that he is willing to participate in the lengthier, delayed approach to medical transition encouraged by many physicians. Furthermore, a trans patient who knew they were trans from an extremely young age, or at least claimed to, was historically the benchmark of credibility for trans patients. Including a fictionalized patient who knew he was trans since childhood seems to reinforce this ideal. In attempts to provide an imagined, certain patient, the book is falling back on a very normative example of an imagined trans person.This reproduces a narrative in which doctors are taught to expect trans patients to conform to normative, medicalized expectations.

The idealized trans patient, described explicitly eight times across two different textbooks, is believable because they present certainty by conforming exactly to the normative, historical expectations of a trans patient. “G.C.” conforms so well to this narrative that he even surprises the doctor by being trans. However, trans patients might not always align with the doctors’ expectations of normativity. In failing to represent a diversity of patients, there may be a gap between the expected patient and the actual trans patient.

When exclusively presenting the idealized patient, the textbook risks framing them as the *only* believable patient. This may constrain patients’ presentations and limit what they reveal to doctors. By establishing a rigid framework for trans presentation, doctors, as the gatekeepers of trans healthcare, may further limit healthcare access to non-normative patients.

Another textbook, *Greenspan's Basic and Clinical Endocrinology* by David G. Gardner and Dolores M. Shoback, also relies on this narrative by stating, “The natural history of gender dysphoria in adults has not been well documented although when most adults present for hormone treatment they

describe the occurrence of symptoms beginning during childhood." While providing some uncertainty by stating that the history of gender dysphoria in adults is not well documented, the textbook attempts to offer a sense of legitimacy in stating many trans adults have known they were trans since childhood. In doing so, they rely on a very restrictive expectation of trans people. Once again, the imagined patient in the textbook is one who conforms closely to the expectations of medical institutions. In shaping students' expectations for trans patients, the medical institution is effectively regulating trans people's histories and narratives. When a doctor is formally trained to expect a normative, medically certain patient, they may not only be unable to treat non-normative patients, but they may also feel negatively towards them. This constrains trans patients and their future doctors. Holding the belief that trans patients should be certain of their gender from childhood may stigmatize trans people who do not fit this narrative. At best, it risks leaving providers feeling unprepared to offer transition-related care to patients who present as less certain.

However, some textbooks offer an alternative form of certainty. Several describe biomedical origin for transness. For example, in *Greenspan's Endocrinology*, authors note, "Numerous studies from a variety of biomedical disciplines—endocrine, genetic, and neuroanatomical—have begun to shed light on the biologic underpinnings of gender identity. Results of these studies support the concept that gender identity is not simply a psychosocial construct, but likely reflects a complex interplay of biologic, environmental, and cultural factors."

The book appeals to a sense of biomedical certainty by suggesting a biological and endocrinological pathway to transness. However, ultimately, this might not result in more medical certainty. In reality, one cannot perform a medical test to determine if a person is trans, or to determine biological origins (shuster 2016). Expecting to administer a "trans test" both reduces patient autonomy, and is outside the scope of the medical field's capacities. The result of pointing to nebulous biological factors, while no such test for these factors exist, could delegitimize patients' own gender experiences. Even while hinting at medical certainty, these textbooks could inadvertently cause more medical

uncertainty for providers. This highlights the importance of presenting as a "good" patient, because a sense of medical certainty can only come from providers' interactions with patients, not a "trans test."

Comparing the vignette in *Health Systems Science* with the descriptions of certainty in *Greenspan's Endocrinology*, reveals notable differences in how the patient is presented. In *Health Systems Science,* the onus of providing certainty falls directly on the patient. While the expectations of normativity are problematic, the patient's words and actions can provide a sense of "proof" of "real transness." Theoretically following this model, with enough cultural health capital, a trans patient could convince a provider they are truly trans. A "good" patient could exist. However, in *Greenspan's Endocrinology* attempts to create a sense of certainty gesture at intangible, immeasurable biological markers or another doctor's diagnosis of gender dysphoria. These examples and descriptions of trans people seem to suggest that a doctor can gain certainty from factors outside the patient, possibly reducing the validity of the patient's own claims and knowledge.

Overall, the responsibility of the ideal patient is clear. An ideal trans patient will be able to provide their physician with a sense of medical certainty by conforming to medical expectations of a trans experience. With the lack of trans biomarkers and verifiable transness, and with some medical textbooks still gesturing at this as a form of certainty, the necessity of presenting as a good and certain patient is clear. However, in reality, doctors come across a spectrum of patients. The reality is, many may not conform to the ideal narrative.

"Bad" Patients

Contrasting the idealized and imagined "good" trans patient, the textbooks also present examples of "bad" patients. Here, the category of "bad" patient is a relatively broad one, which I outline below through three major themes: medically uncertain patients; risky patients; and patients who are seen as hesitant to seek care. Even with two of the textbooks describing imagined "good" examples of patients, *both* of those textbooks present trans people generally as "bad" patients. Overall, the repeated

presentation of trans patients as “bad” can increase provider stress when treating a trans patient, and may contribute to doctors’ hesitancy and medical uncertainty around the treatment of trans people.

Uncertain Patients

Whether describing uncertainty in the identification of transness, the process of prescribing hormones, or uncertainty in treating trans patients for unrelated medical conditions, the messaging in many of these textbooks is that trans patients are far from the ideal patient.

One of the most clear examples of uncertainty regarding the treatment of trans patients is in *Goodman and Gilman's The Pharmacological Basis of Therapeutics,* by Laurence Brunton, Bjorn Knollmann and Randa Hilal-Dandan:

> In the past 10 to 20 years, sex steroids have been used more frequently in transgender patients. Because no significant clinical trials have been performed, a great deal of variability exists in the approaches taken in both male to female and female to male transgender patients.

Here, the discussion of Hormone Replacement Therapy (HRT) as it relates to transition care is presented as untested via clinical trial, and variable. This instance clearly illustrates the potential for medical uncertainty, presenting both a lack of scientific evidence and a wide variability of approaches (Kim and Lee 2018). Despite presenting HRT as having “a great deal of variability,” authors continue on to describe very specific treatment options .“The primary medication used in femaletomale transitions is some form of androgen, whether it be injectable, such as testosterone enanthate or cypionate” and ,“the primary medication used for maletofemale transition is some form of estrogen, whether it be oral estradiol (2–6 mg/day), transdermal estradiol (0.1–0.4 mg every 24 h), or injectable estrogens such as estradiol valerate or estradiol cypionate (5–10 mg IM every 2 weeks).” While giving readers clear and specific treatment options for trans patients seeking HRT, the authors still frame trans medicine as uncertain, representing it as highly variable. This framing does not seem to reflect medical reality, but could be an attempt to defuse the responsibility of the provider administering HRT. Framing HRT as inherently variable and untested can foster clinical hesitation around treating trans patients, even when guidance is

presented (Johnson et al. 2022). The resulting stigma from viewing a procedure as uncertain can attach itself to trans patients.

This section is present in a chapter on ”Estrogens, Progestins, and the Female Reproductive Tract,” which is notable on its own, considering that both trans men and trans women are mentioned. However, because of the discussion of other hormonal treatments in this chapter, it provides a useful point of comparison with how trans hormones are discussed. For example, the chapter also talks about hirsutism, a condition characterized by unwanted hair growth, often in cis women (Mayo Clinic Staff 2025). Despite having multiple possible causes and treatments, the book explicitly describes it in certain terms, “After excluding serious pathology such as a steroid producing malignancy, the treatment largely becomes empirical.”

In *Goodman and Gilman's* description of approaches to treatment for both hirsutism and trans patients, hirsutism is presented as having empirical certainty but HRT is presented as lacking clinical certainty. Hirsutism is often treated with anti-androgen medication, including the same hormones prescribed to transgender women, for a period of over six-months (Mayo Clinic Staff 2025). Trans medicine in general is well-researched and prescribing HRT to trans people often mirrors the protocols of prescribing HRT to cis people (Sudhakar et al. 2023). Yet in this textbook, HRT for trans people is represented as uniquely uncertain and variable while a typically cis condition is described as empirical.

The authors of *Medical Management* also provide areas of uncertainty surrounding the medical treatment of trans people. Authors begin a section titled “Medical Risks of Transgender People” noting, “In general, care of acute and chronic diseases does not differ in transgender people." This is extremely important and the only textbook I analyzed which mentions that trans people’s conditions and care are not generally medically distinct from cis people’s. However, later on, when discussing that trans men who have undergone top surgery have a chance of getting breast cancer, they note, “It is unclear what, if any, breast cancer screening beyond awareness should be offered to this group.” While of course constrained

by current medical knowledge, an underlying theme of these books is introducing areas of uncertainty in trans medicine, without providing a medical protocol or information on how to deal with uncertainty.

Another example of an uncertain patient can be found in *Greenspan's Endocrinology*, where the patient themselves and the validity of their transness is called into question, noting, “Once puberty has begun, the majority of gender dysphoric prepubertal youth will no longer meet the mental health criteria for gender dysphoria.” This inevitably casts doubt of the trans patient into the mind of the provider, possibly making them question the necessity to believe a population which is already heavily scrutinized. In bringing up feelings of uncertainty around trans identity, the textbooks may also be implicitly producing uncertainty around trans medicine, and ultimately general medical treatment for trans patients. They go on to discuss:

> While gender fluidity may be a contributing factor, the lack of persistence of gender dysphoria in the majority of gender dysphoric prepubertal youth likely reflects the heterogeneous nature of this group. Many such individuals will turn out to be homosexual (natal males, in particular) rather than transgender. Investigators have attempted to identify factors that predict gender dysphoria “persisters” versus “desisters.” Persisters reported relatively greater degrees of gender dysphoria and were more likely to have experienced social transition (to their affirmed gender) during childhood. In addition, persisters believed they “were” the other sex, while desisters “wished they were” the other sex. The limitations in prediction of persistence, coupled with the observation that most gender dysphoric children will not become transgender adolescents or adults, have led some investigators and/or practitioners to promote efforts to encourage gender dysphoric children to accept their natal gender. In contrast, a model of care that affirms a child’s gender expression is thought to have a more optimal mental health outcome.

Unfortunately, the representation of trans patients, especially trans youth, as risky patients, who are likely to change their minds is relatively common misinformation (McNamara et al. 2022). However, it is important to note that even in modern textbooks, this representation of trans patients exists. Despite later saying that affirming trans children is optimal for their health, the authors go to great lengths to call into question the validity of the trans children. They present them as possibly homosexual rather than trans, as well as most likely not to grow into trans adults. This heavily implies trans children are “bad”

patients, in that they are inherently uncertain of their gender and may possibly grow up to be "desisters." The presentation of trans children in this manner can make doctors, who are already hesitant to treat trans patients, feel even less prepared to offer care to this population (Kao and Liu 2025; Hill 2010).

In an entire section labeled "Areas of Uncertainty/Barriers to Care/and Priorities for Research," *Greenspan's Endocrinology* goes on to describe more medical uncertainty for trans youth:

> Areas of uncertainty and barriers to state of the art practice limit the ability to provide optimal health care to gender dysphoric/transgender youth. Currently, there are only limited safety and efficacy studies, with virtually no published data on the use of pubertal blockers in gender dysphoric individuals less than 12 years of age or crosssex hormones in transgender youth less than 16 years of age. In addition, randomized controlled trials for hormonal interventions in gender dysphoric youth have not been considered feasible or ethical. Current clinical practice guidelines are based on best available evidence, with significant reliance on expert opinion.

Here the book introduces uncertainty regarding hormonal treatment for trans children. It is interesting to explicitly name medical uncertainty in a book, especially because medical uncertainty leads to physician stress and lower quality care for patients (Scott et al. 2023). Calling out uncertainty could be beneficial; however, in this section, the authors do not provide a tangible way to manage this uncertainty, or provide current best practices for how to treat trans youth. Explicitly calling out the uncertainty, while failing to suggest a treatment approach likely contributes to doctors' feelings about being unequipped to treat trans patients. Also, specifically calling out this uncertainty for trans *youth* seems to tacitly encourage delayed access to treatment, which has been denounced as harmful to trans youth (Pitts-Taylor 2019).

While trans kids are commonly discussed as a uniquely uncertain population, both in medicine and in the broader social sphere, youth are not the only patients who are presented as uncertain in *Greenspan's Endocrinology*. On guidelines for treating trans adults, the book advises:

> The first step is confirmation of the diagnosis, gender dysphoria, assessment of readiness of the person to begin treatment and evaluation of risk factors for medical treatment. Rarely, adults with psychological and/or developmental problems may present with gender problems but are not confirmed to exhibit gender dysphoria.

This places the responsibility of determining transness not on the patient themselves, but the doctor. The doctor is given the power to assess patient readiness. This informal authority to evaluate the patient's gender also asks the doctor to call into question the trustworthiness and capacity of patients to assess themselves and their needs. By offering the idea that a patient can have "gender problems" without being trans, the textbook places disproportionate authority on doctors to question their patients' transness. Furthermore, adults with "psychological and/or developmental problems" can be trans, and singling out this population magnifies scrutiny on an already marginalized population. Once again, the book provides no guidance for differentiating "gender problems" from gender dysphoria, introducing uncertainty without any tangible medical protocol. In this way, trans patients are presented as "bad" in that they are incapable of being able to determine their own gender.

Whether these textbooks present trans people themselves as unreliable or treatment options for trans patients as uncertain, the messaging is clear— the reality of treating trans people is difficult and uncertain. Unlike the fictionalized "good" patient, most trans people will not wholly conform to doctors' expectations of normativity. In presenting trans patients and trans medicine as untested, and unreliable, without giving providers the tools to resolve medical uncertainty, trans patients are implied to be unideal patients, and in many ways, an obstacle. This is made even more explicit in some textbooks, which describe an inherent tension between trans patients and their providers.

Risky Patients

Trans people in these textbooks are very frequently described as unideal patients, engaging in risky and medically unadvised behavior. Referring to them in this manner may contribute to the stigma against them, presenting them as unreliable patients or even as a danger to themselves. This frames the goal of trans medicine as risk surveillance and emotion management, rather than providing quality care. Throughout the textbooks, the concept of trans people engaging in risky behavior arises in several ways; the most glaring of which is participating in health harming behaviors.

Three of the textbooks, *Harrison's Principles of Internal Medicine* by Hauser et al., *Health Systems Science* (introduced above), and *Braddom's Physical Medicine & Rehabilitation* by David X. Cifu reference higher rates of smoking, suicide, substance abuse, alcohol abuse, depression, anxiety and suicide attempts among LGBT+ individuals. The presentation of trans people as being more likely to abuse substances, smoke, and have mental health disorders, such as anxiety and depression, can stigmatize them while obscuring the underlying social cause for these disparities. It presents them as a population that is problematic, potentially difficult and less invested in their health than cisgender, heterosexual people. While health disparities are important to mention, the causal factors for these disparities—stigma and discrimination— are rarely mentioned. In neglecting the causal factors, the "blame" for these risky behaviors is placed on the trans people, presenting them as exceptionally difficult and risky patients.

Trans people and other queer people are portrayed as engaging in health-harming behaviors, such as smoking, without an accompanying analysis as to the systematic, social drivers of these behaviors. Once again, this may contribute to the stigma against them, framing them as having poor health and making poor health choices. Interestingly, the advice for doctors regarding queer people in this section is mostly interactional, and unrelated to mitigating health risk:

> It is important that health care providers be aware of these disparities as well as familiar with basic terminology regarding sexual orientation and gender expression. It is recommended to clarify a patient's preferred pronouns rather than relying on appearance or what the medical record may indicate.

Empty calls for "awareness" and proper pronoun usage do very little to address their health needs. The absence of medical advice is very notable here, especially considering higher rates of health harming behavior is presented as a medical problem. The authors seem to imply that refraining from engaging in discriminatory treatment will sufficiently address the medical needs of trans and queer patients.

Another risk associated with trans patients is engaging in unlicensed medical treatment. In *Fitzpatrick's Dermatology*, the authors state, "Lack of treatment access has led many transgender

women— up to 16% in San Francisco, 40% in Lima, and 68% in Thailand—to receive “silicone” or “filler” injections to buttocks, hips, breasts, face, and calves from unlicensed low-cost “pumpers.” While the authors do mention this stems from a lack of treatment access, and later go on to suggest doctors can combat this by offering safe gender affirming treatments to trans women, they are nevertheless presented as frequently engaging in unlicensed medical treatment, possibly suggesting they are noncompliant and uninvested in their health. The framing of a patient as risky or noncompliant can often frustrate doctors and lead them to provide worse care (Heszen-Klemens 1987). The book goes on to describe many possible side effects of botched fillers, further framing the use of unlicensed gender affirming care as dangerous, and a bad decision. However, in response to inequitable access to institutional transition care, trans people have been using their own networks to access gender affirming care for decades. Some scientific evidence suggests this practice of DIY transition care is often safe and well researched by those who use it in the trans community (Gill-Peterson 2022; Baker, Cusanno, and Dean 2023). However, the textbook refers to the providers as “pumpers,” framing the decision to get this type of care as frivolous and risky.

In addition to being presented as engaging in dangerous medical procedures, the textbooks often highlight the HIV risk trans people face. One book, *Harrison’s Principles of Internal Medicine,* mentions trans people have a higher risk of getting HIV on *four* separate occasions, stating, for example, “Members of certain high-risk populations are disproportionately affected [by HIV]. Sex workers, people who inject drugs, transgender people, prisoners, gay men, other men who have sex with men, and their sexual partners accounted for 34% of all new HIV infections in 2015.” This is an overemphasis of the HIV risk for trans people, grouping them with multiple other stigmatized populations and counting the combined total HIV risk for all of them. Furthermore, in grouping them with other stigmatized populations, the authors may be inadvertently stigmatizing them further. *Fitzpatrick's Dermatology* mentions HIV and trans people together on *five* separate occasions, either noting a higher risk or recommending providers test trans people for HIV more frequently. While three other textbooks mention trans people in relation to

HIV risk, *Sherris & Ryan's Medical Microbiology* by Kenneth J Ryan, is particularly notable; the only reference to trans people in the entire text occurs in the context of their increased risk for HIV. In so heavily associating trans people with HIV, an already stigmatized illness, these textbooks may be further indicating that trans people are a risky population.

On its own, highlighting the medical risks faced by trans populations is not inherently problematic, but continually highlighting them as engaging in health harming activities, likely to have HIV, and willing to participate in unlicensed medical treatment risks presenting them as a particularly deviant population. Discussion of these socially influenced health disparities, without being able to provide doctors with advice for how to mitigate risk for their patients, implies poor health and risky decision making are an inevitability for trans patients.

Hesitancy to Seek Care

Often, the textbooks present the possibility of a tense provider-patient relationship, based on trans people's hesitancy to seek medical care. They describe instances where the patient themselves may feel negatively about seeking medical treatment, or uncertainty about the attitudes of the provider. In the cases I analyzed, the textbooks describe the relationship from an imagined patient perspective. Utilizing imagined case studies to frame trans people as hostile to physicians further constructs them as "bad" patients, without considering the structural factors which may limit a patient's willingness to seek care.

One example of textbooks outsizing blame onto patients is in *Fitzpatrick's Dermatology, "*LGBT patients also encounter barriers in accessing health care that result from disparities in health insurance coverage, real or perceived discrimination by health care providers, and delayed or inappropriate care from providers unfamiliar with their specific health concerns." Importantly, the book says patients could be experiencing real discrimination or merely imagining it. In some cases, the textbook implies, the barriers they face are their own. While this textbook acknowledges other reasons trans people might have

a valid reason to not seek medical care, such as delayed or inappropriate care from providers, it still shifts some of the responsibility onto the patient.

Health Systems Science describes a "case study" of patient G.C.

> He has not been screened for sexually transmitted infections in the last 8 years. After his experience with the health care system, he has been hesitant to see a doctor and has not had any age-appropriate vaccines or screenings since he was 16….He has cut back drinking to about two to three times per month and never more than four drinks at a time [Since beginning to socially transition].

Notably, G.C. is hesitant to see a doctor, and thus is preventing himself from receiving age-appropriate care. This clear description of a "noncompliant" patient portrays trans people as not only relatively unconcerned with their health, but also as the primary barrier to their own healthcare. The book does note G.C. 's fears stem from " his experiences with the health care system," but never elaborates what these experiences were, or why he has felt this way. Thus, he could be seen as unreasonably afraid of going to the doctor and as an obstacle for medical care providers. G.C. is also referred to in the"good patient" section, which is extremely notable. Even a medically certain, "good" patient is described as being hesitant to see a doctor. He is stigmatized as not knowing what is best for himself, despite being certain of his transness.

In another case study in *Medical Management,* an imagined patient is once again described as hostile towards the doctors and staff:

> [Dr. Good] is in the middle of her busy family practice clinic. She enters the room to see her new patient "Mr. John S." and is puzzled to see the notation "due for Pap" among the reminder notations. The patient is male appearing and appears quite apprehensive and angry. Dr. Good asks what she can do to help and Mr. S explains with some hesitation that he is a transgender man and has female anatomy and therefore requires a Pap smear. His previous medical provider was uncomfortable with this and suggested that Mr. S. see a "gay friendly" doctor. Dr. Good was listed on a Web site so Mr. S made an appointment but is now upset because the front desk staff had loudly stated, "there must be a mistake, it says here you need a Pap smear" and then began to stare at Mr. S and laugh nervously.

It is important to note in this medical vignette, the authors choose to mention genital specific care. While this type of care could be sensitive or difficult for some trans patients, the focus is not how to provide patient-centered or competent care, rather the focus is on the anger and apprehension of the patient. Descriptions of what a “good doctor” would do in this situation are notably absent. Additionally, the patient’s anatomy is described as “female anatomy." The relevant anatomy for a pap smear is a cervix, yet the book describes “female anatomy” for a trans man.

Furthermore, the patient, Mr. S. is presented as “apprehensive and angry.” From the beginning of the case study, the trans patient himself is described as an obstacle. It is interesting that Mr. S is there for a pap smear, a type of routine, preventative care. On one hand, this inclusion is relatively unique in the textbooks, as the majority of textbooks frame trans healthcare requirements explicitly as gender affirming care. Exposing medical students to the idea that trans people will also need routine medical care, unrelated to their transition, is rare. On the other hand, the patient is hostile and “upset” at the appointment, ultimately being a barrier the physician will have to manage. While it is not unlikely a patient would be upset having to undergo a possibly dysphoria inducing examination and would prefer if medical staff handle the examination in a gender affirming way, the main focus of the vignette is on Mr. S’ negative and hostile emotions, contributing to the larger theme in medical textbooks of presenting trans patients as an obstacle.

These examples portray trans patients as resistant to care and emotionally volatile. While some authors attempt to contextualize patient behavior by describing previous instances of discrimination or transphobia, the emphasis on the patient and their perceived lack of interest in their health ultimately frames patients as obstacles in the clinical encounter. In minimizing the structural barriers trans people face and representing imagined patients as difficult, these textbooks construct patients as in conflict with doctors and the medical system more broadly.

DISCUSSION AND CONCLUSION

This work builds on studies in transgender medicine and on medical uncertainty, illuminating a possible pathway by which medical students come to feel unprepared to treat trans patients. By analyzing the content of medical textbooks about trans people, I hope to highlight areas where these textbooks present trans people as particularly difficult and medically uncertain patients. In better understanding the way trans people are presented in medical education, I hope to offer a clearer picture of trans medicine more generally.

Doctors often claim they feel a lack of preparedness to treat trans patients (Davidge-Pitts et al. 2017; White Hughto, Reisner, and Pachankis 2015; Liang et al. 2017). This perceived lack of training has led many doctors to hesitate or outright refuse to treat trans patients (shuster 2021). There seems to be some validity to this feeling of unpreparedness, with very little classroom and clinical training focusing on the medical needs of queer and trans patients (Dubin et al. 2018; Obedin-Maliver et al. 2011; Liang et al. 2017; White Hughto, Reisner, and Pachankis 2015). My findings support this, with less than one third of the textbooks in my final sample even mentioning trans or queer patients. However, even the textbooks that do mention trans patients could exacerbate doctors' hesitancy around providing medical care to trans patients.

Overall, the textbooks construct two opposing ideas of trans patients. "Good" trans patients are medically legible, certain of their transness, and conform to normative expectations. "Bad" trans patients are medically uncertain. In their construction of "bad" patients, authors focus on the risks and lack of clinical certainty in prescribing HRT. They discuss a lack of consensus on which medical screenings should be offered to trans people, and call into question the validity of individual trans patients' claims to transness. "Bad" trans patients make risky medical decisions and may even avoid medical care altogether. Given previous findings that doctors tend to provide worse treatment to patients who are seen as "difficult" (Kao and Liu 2025; Hill 2010) or when facing medical uncertainty (Poteat, German, and

Kerrigan 2013; Kim and Lee 2018; Wayne et al. 2011; Scott et al. 2023), this construction of trans patients as uncertain and risky merits concern.

Furthermore, the idealized framing of trans patients shifts responsibility onto the patient to provide medical certainty, rather than the doctors to provide quality care. This narrative is then reinforced, as many textbooks describe the role of a provider as simply avoiding blatant transphobia. Consequently, even while including trans people explicitly in medical training, these textbooks still may contribute to the larger pattern of doctor hesitancy when it comes to treating trans patients, as doctors are primed for interactional training, but not the nuances of medical care for this population.

As medical providers continue to function, in many ways, the gatekeepers of transness (Gonsalves 2020) and given that trans people need to access routine medical care regardless of whether they seek medical transition (Wall, Patev, and Benotsch 2023), it is important to analyze how emerging doctors are being taught to think about trans people. These findings show that often, trans people are conceptualized as in opposition to doctors and as solely responsible for providing certainty within the clinical encounter. Because trans medicine is constructed as uncertain in medical textbooks, future practitioners may be further socialized to feel uncertainty to treat trans patients in any medical setting (Wayne et al. 2011). With doctors already misattributing unrelated medical conditions to trans people's transition (Wall, Patev, and Benotsch 2023), the continued reinforcement of the idea that trans medicine is uniquely uncertain will inevitably lead to the construction of trans people as uncertain in any clinical encounter.

In discussing trans people and the very real social and medical inequities they face, medical textbooks tend to place the responsibility for these inequalities on trans people, rather than discriminatory social systems. Overall, medical education seems to either stigmatize trans people, or neglect to teach future doctors about them altogether. Thus, doctors may begin to think of trans people as a particularly

challenging population. Ultimately, trans people may be thought of as responsible for their health disparities.

This study has limitations. First, the sample was restricted to medical textbooks and thus I am unable to quantify what students are learning outside of the classroom. However, previous studies indicate that they are learning very little about trans people during clinical rotations (Obedin-Maliver et al. 2011; Dubin et al. 2018). Additionally, while I exclusively focused on textbooks which were assigned in medical school syllabi, it is impossible to guarantee the medical students read the sections which discuss trans patients. Finally, only 15% of medical schools responded. It is possible the medical schools that didn't respond used different textbooks from those that did. However, for schools that did respond, there was often an overlap in assigned textbooks, suggesting at least some of the textbooks analyzed here are used across medical schools.

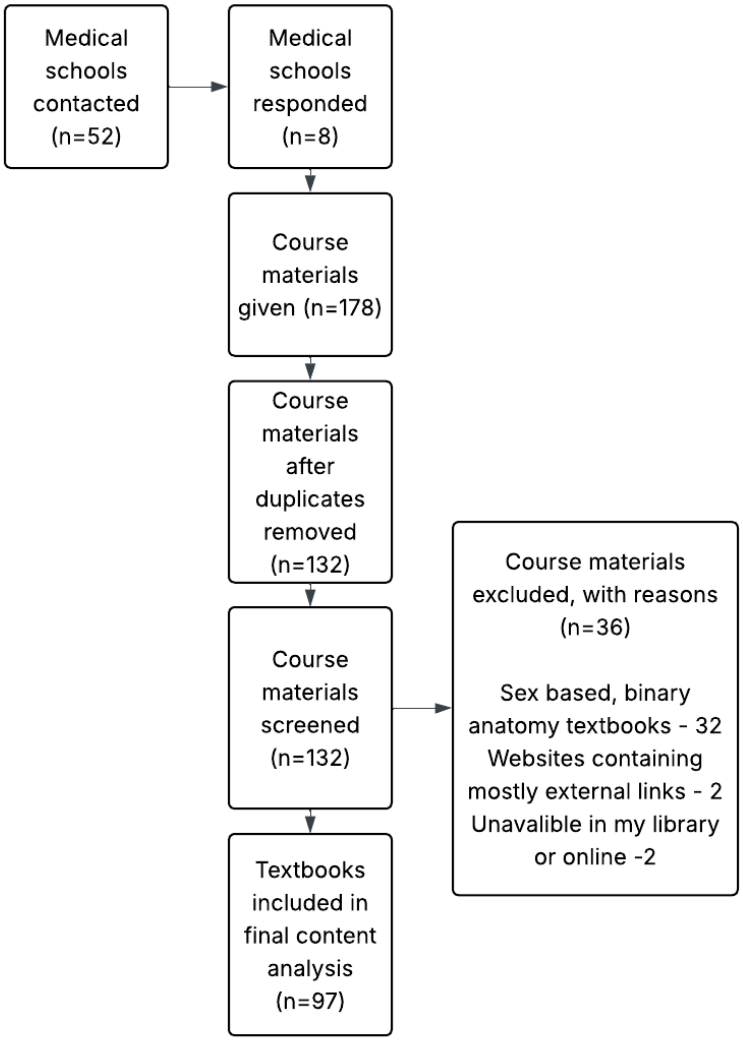
Future studies should examine how medical students are taught to interpret these textbooks. Researchers could conduct an ethnographic study of medical school instruction. By investigating in-classroom medical education, social scientists can observe how medical educators counter or reinforce the portrayals of trans people included in medical textbooks. Additionally, future research could compare these modern representations of trans patients to more historical representations or to representations of trans patients across specialties. In doing a comparative analysis, social scientists could gain more insight into how portrayals of trans patients have evolved over time and across specialties.

Future medical textbooks and medical education could reduce feelings of trans exceptionalism and medical uncertainty by stressing areas where trans and cis medicine is similar. Much like in *Medical Management of Vulnerable and Underserved Patients*, more textbooks can mention that treatment generally doesn't differ between cis and trans people. In fact, providing most medical care to trans people is the same or a similar process to providing medical care to cis people (Grace and Doan 2024). In emphasizing this, providers may be less likely to refuse care to trans people on the basis of being

unprepared to treat them. Future textbooks can also reduce stigmatizing language by highlighting the sociological causes for health inequalities and trans people's possible hesitancy to seek care, wherever possible. In my sample, while social determinants of health were mentioned, they were mostly disconnected from descriptions of "bad" trans patients. *Smith & Tanagho's General Urology* can be seen as a positive example of a textbook which discussed the unique needs of trans patients. Finally, future medical education should discuss the necessity for providers to be able to provide competent, comprehensive care to all patients, including transgender patients, regardless of their specialty.

Appendix A.

Figure 1. Sample inclusion material



Appendix B.

Figure 2. Textbook Representation of LGBTQ+ People

Category	Count (n)	Percentage
Total Textbooks Analyzed	97	100%
LGBTQ+ Representation	30	30.9%
Transgender Representation	17	17.5%
Intersex Representation	3	3.1%

Appendix C.

Figure 3. Major Themes and Codes

Code	Theme	Occurrences
Addressing discomfort to treat	"Good" doctor	7
Certain case	"Good" patient	9
Culturally competent/inclusive care	"Good" doctor	15
Risky behavior	"Bad" patient	19
Hesitancy to seek care	"Bad" patient	11
HIV	"Bad" patient	12
Interactional training	"Good" doctor	51
HRT risk	"Bad" patient	18
Uncertain case	"Bad" patient	15

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