

ANALYZING HEALTH DISPARITIES OF TRANS MASCULINE POPULATIONS WITH POLYCYSTIC OVARY SYNDROME

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Introduction

Polycystic Ovary Syndrome (PCOS) is a hypothalamic, pituitary, and/or ovarian impairment that causes an increase in bioavailable androgen production, leading to hyperandrogenism, irregular menstruation, and insulin resistance (Witchel et al., 2020). PCOS is one of the most common menstruation-related disorders, yet researchers know little about its etiology and there are no sustainable, long-term treatment plans for it (Witchel et al., 2020). Instead, healthcare providers often utilize medical fatphobia and queerphobia tactics to advise PCOS patients to lose weight, start oral contraceptives, and/or start medication to suppress traits such as weight gain, acne, and body hair (Witchel et al., 2020). In researching and treating people with PCOS, healthcare providers and researchers focus on the experiences of cis women. As a result, trans masculine populations face significant health disparities when seeking gynecological care for PCOS, which can limit their PCOS treatment options, access to gender-affirming treatment, and autonomy over medical decision-making.

As a trans masculine person with PCOS, I experienced fatphobia, transphobia, and ableism in my diagnosis and treatment process, which motivated much of this research. Over the semester that this paper was researched and written, I was diagnosed with PCOS and faced consistent roadblocks in accessing hormone replacement therapy (HRT), which provides life-saving treatment of my gender dysphoria. Although not all trans masculine people start HRT and the use of biomedical intervention is by no means necessary to being trans, my experience with PCOS diagnosis and treatment cannot be divorced from this barrier to transitioning. For the scope of this paper, I wanted to approach a topic I experienced first-hand to intertwine the concept of feminist embodiment into my work. It was my lived experience navigating the medical system that sparked my need to research this experience of oppression that was bigger than my own story.

This series of mistreatment was not exclusive to my individual experience; rather, it is one instance in a larger problem of OBGYN care for marginalized populations. Despite many gynecological care facilities incorporating aspects of feminism into their practices, they are not immune to the recreation of oppressive forces such as transphobia. Being part of the larger medical institution means more progressive facilities remain intertwined with societal structures designed to oppress trans people. The gynecological system also has a dark past of abuse, violence, and racism that impacts how it functions within the institution of medicine today. Addressing trans experiences in gynecology is a crucial yet overlooked step in determining how to improve healthcare for people living with menstruation-related impairments and rebuild from the oppressive legacy possessing modern gynecology. It is the responsibility of healthcare providers to do no harm, thus researching transgender health disparities to better serve the trans community is a pivotal aspect to that intent.

Audre Lorde (1984) argues that feminism demands the complete and innovative alteration of the “old structures of oppression,” requiring revolutionary change in the deepest parts of our institutions (p. 123). Through this feminist mindset, PCOS, as it relates to transgender identities, must be reevaluated outside of biomedicine to incorporate its sociocultural context. It is not enough to create trans-inclusive healthcare, but to readdress why factors such as weight gain and hair growth define gender. It is not enough to demand more PCOS treatment research, but to recognize that trans people might experience gender euphoria from their PCOS traits and would prefer social

support over a cure. A trans-inclusive feminist future includes the responsibility for healthcare providers to hear, respect, and support their trans masculine patients with PCOS, even if their needs deviate from expected biomedical goals. This will not only improve the health disparity for trans masculine populations, but will create practical social support for all people living with PCOS traits and generate better communication within the patient-provider relationship. Moreover, it will readjust the power of PCOS treatment from providers to patients, and work to restore bodily autonomy to those targeted within gynecological service.

Findings

Medical Transphobia

Healthcare providers create hostile environments for transgender patients through overt acts of transphobia. Whether through transphobic decision-making, the use of gender-exclusive language, or denial of service, providers often create unsafe environments within their offices that actively harm the physical and mental health of their trans patients (Potter et al., 2015). In most centers for gynecological care, patients often attend a “woman’s clinic” for their annual “woman’s wellness visit” (Potter et al., 2015). In framing gynecology as a woman’s concern, providers are misgendering trans masculine patients, which isolates trans populations. This is not to argue that all information regarding womanhood should be erased; however, excluding gender neutrality not only creates discomfort in trans patients, but can confuse trans populations about whether the clinic offers their desired services. Additionally, the confusing and vague language of “woman’s wellness” excludes the information that the visit includes services such as Pap tests or STI testing. Gender neutral framing maintains the sentiment of professional care and provides explicit explanations of care without equating the patients’ genitalia to their gender identities.

During appointments, healthcare providers overemphasize health risks to dissuade their trans patients from pursuing wellness. Healthcare providers are more likely to discuss risks, including those that are unfounded, with trans patients than with cis patients (Nelson, 2019). This concept is rooted in the idea that trans people are incapable of caring for themselves and are less likely to understand the consequences to their medical transition. If a trans person wishes to start HRT, providers emphasize the risk to cardiovascular health, possibility of weight gain, and potential to develop impairments such as diabetes (Nelson, 2019). In contrast, health providers are more likely to find the discussion of risks to be unnecessary when working with cis patients such as post-menopausal women on HRT, despite the risk being the same and sometimes greater (Nelson, 2019). Health providers largely view cis people’s use of HRT as necessary and trans people’s use of HRT as selective even though physical transitioning reduces the rates of suicide, self-harm, and gender dysphoria.

When the patient possesses a family history of cardiovascular issues or a cardiovascular-related impairment, this dissuasion is exacerbated. Doctors repeat their risk warnings at higher rates to patients with PCOS, often emphasizing that if patients are already predisposed to cardiovascular health risks and diabetes due to their insulin resistance, they should not risk an additional hormonal intervention (Millington et al., 2021). When overemphasizing risks, providers are not considering the necessity of HRT for their trans patients or weighing the psychological risk of not proceeding with HRT. Providers who try to dissuade patients from starting HRT or rule that HRT is too risky for a PCOS patient until they manage their PCOS, often through weight loss or the use of oral contraceptives, are merely gatekeeping necessary care. In doing so, medical providers perpetuate transphobia and fatphobia, which prevents trans masculine patients with PCOS from maintaining their bodily autonomy.

Despite healthcare providers’ power to determine their patients’ access to treatment, they are often ill-informed on trans health. This puts the brunt of the providers’ trans health education onto

the patient. Trans patients are more likely than cis patients to research medical treatments prior to appointments because of the reputation that providers possess a substantial gap in trans medical knowledge (Peitzmeier et al., 2014). In other words, trans patients must try to teach themselves complicated medical terminology to advocate for themselves and ensure proper treatment. Their subsequent attempts to educate providers on trans health concerns are met with varying openness as, despite trans patients' self-advocacy, providers are less likely to test, diagnose, and follow up with trans patients coming in with specific menstruation-related concerns (Shim et al., 2020). As a result, medical transphobia prevents patients from receiving appropriate medical care for their PCOS, if they are even given the opportunity to be tested for it.

Misconceptions

Beyond healthcare providers' overt transphobia from their creation of harmful environments and the denial of proper treatment, they also often perpetuate covert forms of transphobia through their continued use of medical misinformation. Providers may not intentionally neglect trans patients, but may not access evolving trans health research, thus incidentally spreading misinformation from outdated research (Millington et al., 2021). Trans health research has accelerated as the last two decades witnessed an uptick in funding for medical studies on trans populations, which has finally opened the floodgate for social scientists to understand the depth of trans health disparities (Nelson, 2019). Despite the increase of research, this knowledge is not being transmitted to most healthcare providers. The busy schedule of the average gynecological healthcare provider combined with the business model of United States healthcare demotivates providers from learning more about trans health. Moreover, healthcare providers who do possess the ability and time to engage in newly produced healthcare would rarely choose to engage in information on a population that they do not already serve. These factors create a cycle of misinformation as providers cannot replace their former preconceptions with new and correct research nor desire to because they do not see trans populations as the largely underserved population that they are.

From 2005 until 2015, a large amount of research on trans people with PCOS supported a theory that PCOS caused a predisposition to being queer. Since PCOS causes an increased androgen production, providers believed PCOS patients would exhibit opposite-sex behaviors and desire same-sex relationships (Liu et al., 2020). The idea that PCOS and queerness are biologically linked oversimplifies the relationship queer people have with their bodies, gender, and sexuality. Even if PCOS caused someone to think differently about their gender or their role in society, gender is a socially constructed concept that does not have a biological determinant. Moreover, this research enables the false assertion that causation can be deduced from statistical correlation between transness and PCOS. When this same research was repeated using a larger population, a clearer definition of PCOS, and proper queer terminology, researchers found that there was no correlation between someone having PCOS and identifying as trans or queer (Liu et al., 2020). Nevertheless, providers with only knowledge of the earlier studies use this concept frequently to invalidate a trans person's identity (Agénor et al., 2016). If the trans patient is not already on HRT or had gender-affirming surgeries before their PCOS diagnosis, their provider might try to prevent them from beginning HRT on the basis that PCOS might cause someone to temporarily experience hormone-driven gender dysphoria. As such, the provider can advise or coerce patients to pursue steps to reduce the effects of PCOS instead of supporting their patient to pursue HRT. Providers can and do deny their patients gender-affirming surgery and treatment over a misconception that there is a false manifestation of queerness in the mind of someone with PCOS. This is based on a fundamental misunderstanding of both transness and PCOS and the reduction of both instances to biology as opposed to their biosocial reality.

Another misconception that providers hold against trans people wishing to start HRT is that there is not enough concrete evidence regarding the interaction between PCOS and HRT. On the contrary, there is a wealth of data from the last few years that documents the benefits of using HRT to reduce physical suffering. Providers often compare the textbook cardiovascular and cancer risks of HRT with the insulin resistance and cardiovascular risk of PCOS to argue that their combination is too dangerous to pursue (Nelson, 2019). This misconception was disproven over time and now there are stronger understandings about HRT as a short-term treatment for negative PCOS traits (Nelson, 2019). Although the long-term risks of HRT are still being researched, it is well-known that trans people, like all patient populations, have a wide variation of both hormonal and nonhormonal risk factors for various impairments (Braun et al., 2017). Providers and researchers alike often deprioritize this interpopulation variation in favor of medical generalizability to create a streamlined system of care, but this leaves people behind, particularly those with preexisting impairments like PCOS.

Moreover, just as providers hold misconceptions on trans health, their information on PCOS is often based on similarly outdated research, which has undesirable consequences for patients with PCOS. It is well-researched that PCOS does not cause any more of an increased cardiovascular risk than an individual's lifestyle factors, such as diet and exercise (Chang & Wild, 2009; Millington et al., 2021). However, providers use this concept of risk to undermine the ability for trans masculine people to be stewards of their health. It also excludes the positive effects of HRT on patients with PCOS. Although people can possess a high quality of life with PCOS traits, biomedicine necessitates a reduction of symptoms. To better develop goals for their patients to reduce negative traits of PCOS, providers must consider the interaction between mental and physical well-being. When people are more comfortable with their bodies, such as when they receive gender-affirming treatment, they often are more willing to practice self-care and create healthy relationships with food and exercise (Millington et al., 2021). The assumptions that HRT for someone with PCOS only facilitates risks create barriers to care without addressing the benefits to the patient's overall wellness.

If providers do support their trans patients' efforts to start HRT, their misconceptions can impair preventative care of PCOS side effects. Healthcare providers carry a misconception that all trans masculine patients detest going to the gynecologist and view it as unnecessary; however, most trans people report that they overlook their discomfort in gynecologist appointments because of their understanding that these appointments are necessary for preventative care (Agénor et al., 2016). Without communicating this understanding, gynecologists hurry through appointments with trans patients, rarely ask questions about bodily concerns, and do not make as much space for their patients' questions. When healthcare providers do not invest time into their patients, it creates distrust and barriers to wellness. It also makes patients feel deprioritized during appointments and can create hesitation to pursue follow-up care.

Additionally, providers are less likely to clarify their trans patients' relationship status and tend to assume that trans masculine people's sexual partners are cis women (Agénor et al., 2016; Peitzmeier et al., 2014). This contributes to the assumption that trans masculine people do not need frequent pap tests because they are at lower risk for cancer. Similarly, another misconception is that most trans masculine people will choose to get a hysterectomy in their lifetime (Agénor et al., 2016). The combination of these misconceptions makes healthcare providers less likely to address concerns related to their patients' overall wellness and comfort. This can make PCOS diagnosis and management difficult because PCOS care does not fit into providers' image of what trans masculine health looks like, especially if it is then extended to topics such as sexuality, pregnancy, or cancer risks. These misconceptions fuel an overall poor treatment for trans masculine patients and invalidate their concerns when they seek out gynecological care.

Patient Distrust

While transphobia within the medical institution is abundant, there are doctors who care about and try to make space for trans patients; however, repeated experiences of transphobia create medical distrust among trans patients. Since patients are unable to know whether providers are offering legitimate advice or are expressing medical transphobia, there are further barriers to communication even if both parties have good intentions (Nelson, 2019). For example, a doctor might be well-read on recent studies discussing the relationship between HRT and PCOS but may still hesitate to endorse a significant change in hormones before comprehensive testing for ovarian cysts and blood work. This is a standard practice to not exacerbate any physical abnormalities such as ruptured cysts provoked from hormonal change or to intercept increased cholesterol rates. However, trans patients with ample experience with medical gatekeeping will see this as another barrier to physically transitioning. Trans patients can then become unwilling to heed their providers' advice because they assume ill-intent based on their prior experiences of medical transphobia (Agénor et al., 2016; Nelson, 2019). When patients regularly experience transphobia inside medical centers as well as in their everyday lives, they can be more defensive and assume their provider is coming from a place of malice instead of caution.

Patients also distrust providers because of the lack of attention to their experiences with PCOS. PCOS takes several years to officially diagnose, which can cause patients to feel invalidated and dissatisfied with their healthcare provider, especially if it serves as a barrier to transitioning (Witchel et al., 2020). Numerous expensive visits, tests, and exposures to potential transphobia do not guarantee concrete results for patients who have PCOS and want to start HRT. If providers do not offer substantial evidence for their claims, patients will assume this is another way for providers to control treatments and displace their bodily autonomy. Additionally, trans people can have a complicated relationship with PCOS as it confuses the expression of sex and gender. Trans masculine people may not want to suppress PCOS symptoms as it often suppresses menstruation and creates secondary sex characteristics, creating gender euphoria (Guss & Pitts, 2018). When providers view PCOS as a disorder that needs to be cured, their perspective undermines the role of PCOS for trans people. This forces trans people to come up with means of resilience in the face of medical oppression, intentional or not.

To maintain their health and learn to manage PCOS traits, trans masculine people with PCOS turn to community support instead of relying on medical providers. This is largely because intercommunity support does not prioritize cures or focus on traits such as reducing hair or weight distribution. Instead, online forums and social media provide social support and community as sources of helpful and straightforward medical knowledge. Healthcare on a community level is highly individualized since it acknowledges that different people have different health needs. Blogs and social media are rich avenues of knowledge in accessible language, so trans masculine people can build community surrounding their diagnosis. These sites create the opportunity for people outside of academia to conduct interviews and research their own community to develop concrete conclusions about the trans PCOS experience that is then widely distributed on the internet (Athey, 2021; Bell, 2018). Communities developed on Reddit such as on r/ftm and r/ask_transgender contain posts with dozens of interactions from trans masculine people seeking advice from other trans masculine people about navigating medical situations. This form of radical community support provides the language that people need to talk to medical providers and self-advocacy techniques when they face medical transphobia. Furthermore, trans people who navigated the medical system provide their informed opinions on public forums for trans people who otherwise cannot seek out formal medical care for financial or emotional reasons.

This method of community support has a long history in marginalized communities, but online social network reimagine the ways people share medical information. Audre Lorde (1984)

discussed the significance of solidarity work as a means of survival and resilience against oppressive institutions, and it is through these networks of support that trans masculine people find wellness despite oppression. It is through these webs, bound together with shared experiences of medical transphobia, that community can thrive. It is from this information transmission that trans masculine people can equip younger trans folks with PCOS in self-wellness techniques that they can use in place of biomedical treatment. In radicalizing the way trans people make and share knowledge, there is a decentralization of the medical institution and a recentering of bodily autonomy, choice over treatment, and a priority of social support above all else. In this way, trans people are innovating radical forms of healing outside of the medical institution.

Conclusion

The significant barriers to care for trans masculine people with PCOS exhibit how gynecology is not intended to support trans people. It works with all societal institutions in maintaining the oppression of targeted groups, especially those living with multiple targeted identities. It is a human right to seek healthcare and decisions about treatment without discrimination from providers, and it is the responsibility of healthcare providers to offer support and innovative treatment for their trans patients. Gynecological providers remove access and choice of treatment from trans masculine patients to reduce risks without considering how this impacts the overall wellness of their patients. The interaction of transphobia and fatphobia in gynecological care creates barriers to trans health and prevents the creation of supportive treatments for trans masculine people with PCOS. The combination of overt transphobia, medical misconceptions, and the creation of patient distrust contributes to the overall phenomenon of trans masculine people's avoidance of healthcare.

Trans people will always be the authority of our bodies. To deny trans masculine people with PCOS a comfortable healthcare environment, appropriate treatment, and bodily autonomy is a violation of their human rights. Future research on trans masculine populations with PCOS is necessary for creating long-term treatment plans that are inclusive to trans experiences. Although much is known about providers' perspectives on PCOS in transgender populations, including the misconceptions about both PCOS and trans identities, there is little empirical research on the perspective of trans patients with PCOS. This is not to say the information does not exist, as the widespread posting of the lived experience of trans people could provide valuable information for medical professionals. Researchers should source information from the transgender community as it is spread through the vectors of social media sites because it creates life-saving self-advocacy techniques. The use of trans medical knowledge can develop trans-inclusive treatments that suit the needs of patients while preventing the spread of misinformation.

With this being said, too much individual responsibility of wellness currently falls onto the shoulders of trans patients instead of the providers who can create medical change. Instead of relying exclusively on biomedical professionals or the labor of transgender patients with PCOS for information, there must be a willingness to facilitate open communication between both groups. Providers must be responsible for seeking education through known sources of trans knowledge online as well as the research of their trans peers in the medical field to understand more about trans people's lived experiences and medical trauma. Moreover, researchers of PCOS treatment must focus more on social support rather than working with the assumption that all patients want to suppress PCOS traits. Not only would this better serve trans masculine patients who find gender euphoria through PCOS traits, but it creates the opportunity to confront the predominant culture of biomedicine in gynecological care. Instead of devoting all attention to cures, researchers can shift their focus to creating community and social support for patients living with PCOS. This will also allow people without constant access to biomedical treatments, due to rurality, socioeconomic

status, or other access barriers, to have a sustainable treatment program for long-term living with PCOS.

Beyond the scope of this paper, researchers must address the lack of representation in their research populations. Trans health is still an emerging topic in interdisciplinary health and often overrepresents upper-class white trans men. Moreover, most of these studies pertain to research on the effects of HRT instead of the wider array of trans health, especially related to other impairments. There is a limited ability to develop a comprehensive evaluation of health disparities for trans masculine populations based on the current literature and there are still many questions to be asked before understanding the depth of health inequity. In expanding the ways we research trans health to include more patient narratives and understand the biosocial manifestations of menstruation-related impairments such as PCOS, we can ensure patients receive proper health care and treatment while validating their identities.

Easton Brundage (he/they) recently graduated from the University of Florida with a double major in anthropology and women's studies and a minor in history. They hold a deep passion for political organizing, trans health, and disability justice. Easton believes in the power of personal storytelling in his research and hopes everyone can learn something new from his work.

References

- Agénor, M., Peitzmeier, S. M., Bernstein, I. M., McDowell, M., Alizaga, N. M., Reisner, S. L., Pardee, D. J., & Potter, J. (2016). Perceptions of cervical cancer risk and screening among transmasculine individuals: Patient and provider perspectives. *Culture, Health & Sexuality*, 18(10), 1192–1206. <https://doi.org/10.1080/13691058.2016.1177203>
- Ahmed, S. (2017). Bringing feminist theory home. In *Living a Feminist Life*, 1-19. Durham: Duke University Press.
- Athey, D. (2021, September 27). *A long road to PCOS diagnosis: One trans patient's story*. Gay Parenting Voices. <https://www.gayparentstobe.com/gay-parenting-blog/long-road-to-pcos-diagnosis/>
- Bell, J. (2018, September 12). *What it's like to have PCOS when you're trans*. HelloClue. <https://helloclue.com/articles/cycle-a-z/what-s-it-like-to-have-pcos-when-you-re-trans>
- Braun, H., Nash, R., Tangpricha, V., Brockman, J., Ward, K., & Goodman, M. (2017). Cancer in transgender people: Evidence and methodological considerations. *Epidemiologic Reviews*, 39(1), 93–107. <https://doi.org/10.1093/epirev/mxw003>
- Chang, A. Y., & Wild, R. A. (2009). Characterizing cardiovascular risk in women with polycystic ovary syndrome: More than the sum of its parts? *Seminars in Reproductive Medicine*, 27(4), 299–305. <https://doi.org/10.1055/s-0029-1225257>
- Guss, C. E., & Pitts, S. (2018). Remember to ask about gender: Management of polycystic ovary syndrome in transgender male adolescents. *Journal of Pediatric and Adolescent Gynecology*, 21(2), 182-183. <https://doi.org/10.1016/j.jpag.2018.02.060>
- Liu, M., Murthi, S., & Poretsky, L. (2020). Polycystic ovary syndrome and gender identity. *The Yale Journal of Biology & Medicine*, 93(4), 529–537. <http://www.ncbi.nlm.nih.gov/pmc/articles/pmc7513432/>
- Lorde, A. (1984). Age, race, class, and sex: Women redefining difference. In *Sister Outsider: Essays and Speeches*, 114-123. Trumansburg, NY: Crossing Press.
- Millington, K., Hayes, K., Pilcher, S., Roberts, S., Vargas, S. O., French, A., Veneris, J., & O'Neill, A. (2021). A serous borderline ovarian tumour in a transgender male adolescent. *British Journal of Cancer*, 124(3), 567–569. <https://doi.org/10.1038/s41416-020-01129-4>
- Nelson, B. (2019). Troubling blind spots in understanding cancer risks among transgender patients. *Cancer Cytopathology*, 127(8), 487–488. <http://doi.org/10.1002/cncy.22168>
- Peitzmeier, S. M., Reisner, S. L., Harigopal, P., & Potter, J. (2014). Female-to-Male patients have high prevalence of unsatisfactory paps compared to non-transgender females: Implications for cervical cancer screening. *Journal of General Internal Medicine*, 29(5), 778–784. <https://doi.org/10.1007/s11606-013-2753-1>
- Potter, J., Peitzmeier, S. M., Bernstein, I., Reisner, S. L., Alizaga, N. M., Agenor, M., & Pardee, D. J. (2015). Cervical cancer screening for patients on the female-to-male spectrum: A narrative

- review and guide for clinicians. *Journal of General Internal Medicine*, 30(12), 1857–1864.
<https://www.ncbi.nlm.nih.gov/pubmed/26160483>
- Shim, J., Laufer, M. R., & Grimstad, F. W. (2020). Dysmenorrhea and endometriosis in transgender adolescents. *Journal of Pediatric and Adolescent Gynecology*, 33(5), 524–528. <https://doi.org/10.1016/j.jpag.2020.06.001>
- SisterSong. (n.d.). *What is reproductive justice?* <https://www.sistersong.net/reproductive-justice>
- UN General Assembly. (1948). *Universal declaration of human rights*. 217 (III) A.
<https://www.un.org/en/about-us/universal-declaration-of-human-rights>
- Witchel, S. F., Teede, H. J., & Peña, A. S. (2020). Curtailing PCOS. *Pediatric Research*, 87(2), 353–361.
<https://doi.org/10.1038/s41390-019-0615-1>