

Q&A: Enhancing Inclusive Practice Training Webinars

Caring for trans and non-binary People: Understanding our patients

Wednesday 13 March, 19:00-20:30

- 1. I'm a student radiographer. I wear my pronoun badge on my lanyard and am a member of the community. We have only covered this topic slightly in lectures. I would love to know how to best help to implement this more into my practical sessions. I want the other 100+ students to be exposed to the language more as to hopefully make them feel more confident in using it out on clinical placement.**

Thank you for sharing what you are doing to support the education of students. Please signpost to our resources and those Tash has shared in each of their webinars.
- 2. Is it appropriate to compare regret surgery rates to knee surgery and prostate cancer surgery? These are surgeries which are performed because of a disease process and do not necessarily result in sterility in young people.**

There are assumptions that trans people regret transitioning a lot more than the evidence suggests. It is important to be accurate about this and think about other areas of clinical care where we balance the needs of patients. Additionally, not all gender affirming care results in sterility so this should be discussed appropriately where relevant.
- 3. The wait times for gender affirming care are interesting, why do you think Northern Ireland (2 years) has such a shorter wait time than England (5 years)?**

The gender clinic in Northern Ireland receives far fewer referrals than the clinics in England.
- 4. Thank you, such important insight, and creating a safe learning space. I've been using pronouns in my email footer in the hope it may support others. Have also explored some aspects of care and support as research with students. Held a cpd event recently and there was a range of reactions when exploring some terminology, assumptions, and impact on care in radiography.**

Wonderful to hear this excellent work, thank you for sharing.
- 5. Sonographer here - Should we be gendering /sexing foetuses? and if so what language should we be using? Another question I have is about language we should be using when asking trans gynae patients about their menstrual cycle and explaining transvaginal scans - is it offensive to use words such as vagina, period, ovaries, uterus/womb etc are there alternatives? I've heard chest feeding rather than breast feeding.**

It's important to be led by the patient. There is some excellent work that has been published by the gender inclusion midwives at Brighton and Sussex University Hospitals <https://www.bsuh.nhs.uk/maternity/wp-content/uploads/sites/7/2021/01/Support-for-trans-and-non-binary-people-PIL.pdf>. Patients have an information sheet and can share the language and terms they prefer to use. This can also be helpful to cisgender women. Different people have different experiences of language. Tash explained that most trans people will understand when scientific language must be used but when we are trying to

make patients feel more comfortable it is helpful to know their preferences. Information should be provided in a clear way, that may mean different leaflets for trans and cisgender people.

6. Are pronouns something that is already included on referral forms? So we can know how to correctly address the patient

We all use pronouns all the time when we talk about each other but their use cannot be mandated. It is of value to offer patients the opportunity to state pronouns. The inclusive practice guidance explains why referrers can only share gender reassignment information if they have the consent of the patient. It is also helpful to look at the work done on a project 'callme' because names matter.

<https://callmebecausenamesmatter.org/#:~:text=%23CallMe%20or%20Call%20Me%20Because%20Names%20Matter%20is,to%20be%20used%20every%20time%2C%20e%20verywhere%20in%20healthcare.>

7. My radiology department has recently introduced inclusive LMP forms, I'm totally supportive of this and understand the importance, but it is soooo difficult to ask people who do look clearly male about pregnancy status. Do you have any advice about how to normalise this, become more 'open' and break free of my own 'how I was brought up' bias (I'm over 55)

Thank you for being so honest and raising this valuable point. Training is very helpful here. We have made a couple of short video clips which sit under the guidance documents that show how to and how not to approach this. As radiographers we are skilled at communicating in a compassionate way with our patients. Perhaps as a team you could consider some phrases that help to introduce the form. Our pilot studies identified that patients appreciate when we provide information and time for people to understand what we are asking and why.

8. I find it easy to use gender neutral language and using a new inclusive pregnancy status check in my workplace, when speaking with non cis patients, however I find it difficult with cis patients and navigating their responses. any advice on how to go about this in a professional and respectful manner no matter who we speak to and care for.

Please see the above response. Training and practice are key.

9. I am setting up a new service. I have created a steering group for decision making & a means of holding me to account - how do I ensure inclusivity as far as the LGBTQ+ community are concerned?

This is an excellent idea. Could you include a representative from the community? Tash spoke about inviting a trans person to do a walk through your local department/patient pathway to highlight areas where they might experience problems.

10. How to address a trans person?

It's important to ask the person how they would like to be addressed. As you would anyone.

11. When considering messaging for NHS posters shouldn't minority groups whose English is poor be considered? If sexed language is erased the messaging is not

clear and lots of people will not understand that the message applies to them.

No one is suggesting sexed language is erased. It's not clear where this confusion has come from. We have a responsibility to ensure the way we communicate with people is appropriate for them. This includes people of all nationalities, ages, disabilities and those with any other protected characteristic.

- 12. Hi Tash. Whilst I completely understand that inclusive language may act like a short-term kindness strategy. However, in healthcare we have a very difficult balancing act. We have very vulnerable groups that exist, such as patients whose English is poor. Language becomes exclusive to this group of people if we erase all sexed language which they easily understand. I'll attach a peer reviewed paper on the importance of using sexed language in healthcare.**

<https://www.frontiersin.org/articles/10.3389/fgwh.2022.818856/full>

We're unclear what is meant by short term kindness. We promote kindness to trans people in the same way we do for all people. Tash explained that trans people are not asking for extra levels of care, just the opportunity to receive the same level of care as cisgender people. Please see the above answer and if you have joined the webinar late or missed previous webinars please watch all our webinars back as that may help. No one is suggesting erasing sexed language. It is important not to promote an inaccurate representation of this learning. As reported in the webinar, inclusive language has been found in research to support mental wellbeing and reduce suicidal ideation in trans people.

- 13. I was interested to note that the experiences of trans men were notably more negative when it came to inappropriate questions... do you think inclusive pregnancy checks have helped to reduce this or have they exacerbated this negative experience by forcing someone to disclose their gender/out themselves? It is important to note differences like this in the data and question what other variables may be at play. In the study you reference the population of trans men was a far younger group than the population of trans women, this could be a variable that is affecting people's experiences in healthcare- trans respondents aged 35 or above were three times as likely to identify as trans women (54%) than those aged under 35 (17%). We should be aware of where intersectionality may affect experiences - it may be that older patients are less likely to be asked inappropriate questions. We should also be mindful that we can't take away someone's lived experience of what has already happened to them in healthcare. Previous personal questions that have resulted in a negative experience will influence how anxious a person might feel on subsequent appointments, even if the current experience is a positive one. Trans people may feel it's not someone's business to know some things about them, particularly if they have disclosed their trans status in the past and this has had a negative impact on their care. Sometimes assumptions can be made that it is our business to know personal details even when they are not relevant. In some cases, a person's trans status can be seen as the reason behind their symptoms or presenting complaints. This is often referred to as 'trans broken arm syndrome'. This is why it is so important to give people autonomy by being clear about the reasons we ask for certain information so that people are informed and able to make the best decisions for their safety. Tash explained previously that when adequately informed, most trans people understand why they are being asked questions**

around pregnancy.

- 14. What is correct terminology with regards to having conversations with young people, would you still advocate using gender neutral terms? Further to this, in updating our policies, I note we moved away from gendered language in regard to adults however still refer to "girls". I wasn't sure if still appropriate to be gender neutral pre 18yrs?**

Please see the answer above. Regardless of age, asking about how someone would like to be referred to can make someone feel more comfortable and create a good rapport and trust. Gender neutral language should be an option where it is appropriate, and gendered language can be used where that is appropriate. It can be helpful to use broad inclusive language as a start and then specific language that works for each individual on a personal level.

- 15. I am having a little difficulty with getting my department on board with using more inclusive language and having gender neutral changing rooms/toilets. Any advice on how to get people on side? I have asked staff to attend these webinars, but I have had no luck.**

We are sorry to hear this. We would argue that inclusivity is an organisational responsibility and should come from the top down. We recommend discussing this with someone such as your Director of Nursing or medicine to ensure effective and positive cultural changes. Most healthcare professional bodies have clear guidance on this as Tash has shared in the resources section in their slides.

- 16. Do you feel that inclusive & LGBTQIA+ training is adequate within healthcare and education settings. I am completing my dissertation on this topic next year - so would love your thoughts.**

No. We have been unable to identify consistent evidence of training about the needs of trans and non-binary people in healthcare undergraduate programmes.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10052488/>. It is acknowledged that programmes are packed with rich and diverse content and creating space to consider the needs of people with protected characteristics is challenging. Is there a need to better understand the patients in our care by undertaking an element of self-directed learning? Many people on this call tonight will be doing just that.

- 17. Thank you for such important insight and creating a safe learning space. I've been using my pronouns in email footer and hope this may support others. It's important to develop understanding with students so have led this with student research. Recently delivered a CPD session and there was a range of responses when exploring terminology, assumptions, and impact on care in radiography.**

Excellent point and this is wonderful to hear. Student research is very much encouraged and welcomed in this area.

- 18. How is best to ask individuals their pregnancy status before Xray/CT/nm?**

Please see the IPS guidance <https://www.sor.org/learning-advice/professional-body-guidance-and-publications/documents-and-publications/policy-guidance-document-library/inclusive-pregnancy-status-guidelines-for-ionising>.

19. Should all patients be asked for their pronouns?

We all use pronouns to describe each other every day. We believe it is good practice to offer people the opportunity to share their pronouns, it should never be mandated to share pronouns, but the opportunity should always be there.

20. Can we answer questions. To the sonographer - it is vital that you use the correct sexed terminology, such as vagina, especially if you are about to perform a TV scan.

Tash agreed with this and explained that medical terminology is not the issue. When a trans person experiences only gendered language with no recognition of their needs it can be very difficult. Using anatomical language does not prevent us from asking what terms a person prefers to use about their own bodies when we are trying to make them feel more comfortable. It is important that even when using the correct language and trying our best to make people comfortable, the experience itself may still be traumatising due to the nature of the anatomy or bodily experience.

21. When teaching students anatomy such as the reproductive systems is there a inclusive/preferred way to discuss anatomy?

We hope this question has been answered by previous responses. Anatomy should be taught as a science, but it may be viewed as an important opportunity to introduce the concept that trans people may prefer to use different phrases/terms.

22. Would a patient be offended if I asked them what they preferred to be addressed as?

No this is good practice for everyone. Please see the work mentioned above at <https://callmebecauseyournameismatter.org/#:~:text=%23CallMe%20or%20Call%20Me%20Because%20Names%20Matter%20is,to%20be%20used%20every%20time%2C%20e%20verywhere%20in%20healthcare.>

23. Breast screening relies on patient details from GP's to generate list to call for screening. If GP information is not correct, patients may risk not being included in the list for appointments if details are not correct.

Good question and this is a problem being addressed by NHSE by creating a system that allows trans people to self-enrol to ensure they don't miss out on relevant screening opportunities. It is not a trans person's fault that IT systems do not represent them. The system is designed with a very blunt tool. It is especially upsetting for trans people who get illnesses associated with their previous gender as they have to navigate very gendered services. Men with breast cancer can feel similarly unrepresented. The screenings people will be called for can be seen here:

[https://www.gov.uk/government/publications/nhs-population-screening-information-for-transgender-people/nhs-population-screening-information-for-trans-people.](https://www.gov.uk/government/publications/nhs-population-screening-information-for-transgender-people/nhs-population-screening-information-for-trans-people)

24. Regarding cancer screening programs. If in the medical records the person has changed their birth registered record, then they may not get called for the screening service i.e. breast screening, prostate screening.

Thanks for raising this important point and please see previous response.

25. I get she/her, him/he, they/them but don't understand when they get mixed like they/he or they/her?

Mixed pronouns means someone is happy to use either so feel free to use either or mix them. For example if someone uses they/he you could say 'He is working with us on this project, they have been working here two weeks now'.

- 26. How do we walk the line between asking patients what language they prefer when referring to their body and avoiding being seen as satisfying our own curiosity as highlighted on a previous slide? Also how best to establish within a tightly times appointment.**

Education helps us to understand whether a question might be appropriate or not. Before asking any personal questions of anyone, we should carefully consider if we need to know this to manage effective care. Time should not be a blocker to effective communication. We would strongly argue that effective communication saves time and improves patient safety.

- 27. This is a very important topic. Why do you think inclusive pregnancy checks in radiography are slow to come into practice in hospitals? Especially as you've highlighted that you do not need a gender recognition certificate to change your gender on your health records and therefore the risk of irradiating a potentially pregnant trans individual is a real possibility.**

Thank you for asking this important question. We acknowledge it has been slow to implement and SoR has worked hard to support members during this time. Where radiographers, or groups of radiographers, have embraced the principles of safe, compassionate, and inclusive care we have seen fantastic improvements made. In some cases, there have been blockers due to fear of getting it wrong or lack of training and education opportunities. In our regular discussions with the IR(ME)R regulators we are confident employers are making good progress across the four nations. If your employer is not addressing this or you feel your procedures fall short of inclusive care at the standard, we have discussed over our three webinars please contact lyndaj@sor.org for support.

- 28. Question about gendered language, i.e. French il/Elle and gendered names for items. How does this impact trans community, particularly in France etc?**

We have no contacts in France or with the French speaking community, but it is an interesting question that requires further thought. Thank you for raising it. This is a page adapted from Amnesty Internationals Guide to Inclusive Language in French <https://www.epfl.ch/schools/enac/about/diversity-office/inclusive-language/french-inclusive-language-gender/>.

- 29. Do you advocate asking all patients their LMP status for Xray examinations? Is there a way to establish the necessity for this without transgressing protected characteristics so the HCP can practice safely and maintain the wellbeing of their patients?**

Please discuss this with your MPE. Risk groups should be identified that are appropriate to the exposures being delivered. Once your risk group is identified the IPS guidance explains measures to be taken to protect patients effectively and lawfully.

- 30. Do you have any advice on how we ask pronouns as part of the SOR IPS form?**

Pronouns should be offered as an opportunity for people to share something about

themselves. They are not mandated but it is good practice to demonstrate that staff understand why they might be particularly important to some people. Wearing name badges that include pronouns can be one way of doing this. You might like to watch our short video clips on this page <https://www.sor.org/learning-advice/professional-body-guidance-and-publications/documents-and-publications/policy-guidance-document-library/inclusive-pregnancy-status-guidelines-for-ionising>.

31. My friend is a detransitioner and asking pronouns would trigger her PTSD from what she perceives as medical harm. Isn't it safer to simply be led by patients who declare pronouns? Whilst seen as helpful to one group, it is definitely harmful to others.

It is always best to be led by the patient rather than make assumptions. Every person is an individual regardless of their sex or gender history. Please consider how you demonstrate to a trans person that you know what pronouns are and why they are particularly important to some people. If you wear a name badge that displays your own pronouns this can be helpful to make a trans person feel comfortable to share their own.

32. I would just like to clear the narrative around the suicide point as this is a very serious point to get right. Here is a published paper conducted in the UK for the Tavistock clinic. It is irresponsible to exaggerate the risk of suicide. This might actually exacerbate the vulnerability of transgender adolescents.

<https://link.springer.com/content/pdf/10.1007/s10508-022-02287-7.pdf>

The point, which both articles make well, is that transgender people are vulnerable and that poor experiences of care add to their vulnerability. SoR and CoR believe radiographers have the skills to consider a wide range of peer reviewed and published articles, to assimilate the information, and draw their own conclusions. This is part of being a registered healthcare professional. All data on suicide in the presentation was referenced from academic research. The article you have cited states that GIDS patients were 5.5 times more likely to commit suicide than the overall population of adolescents aged 14 to 17. It is unclear what you are referring to when talking about exaggeration but thank you for sharing the article.

33. And as this is an important point, I will include another paper. The only long-term study (40 years) performed on people after having sex reassignment surgeries. Unfortunately, it shows that suicide risk increases in this cohort. Again, this is something that I would like Tash and the CoR to fact check when publishing material on such a serious topic. <https://pubmed.ncbi.nlm.nih.gov/21364939/>

We are assuming this point relates to the link above, but it is difficult to be sure when someone posts anonymously and in two separate posts. This paper is from 2011 and the data used is from the years 1973-2003 so this paper would be considered out of date at this point. Obviously, many changes to gender care have occurred in this time so it would be recommended to access more recent literature. Additionally, it is important to acknowledge that even where trans people access affirming care, they cannot escape the reality of being trans in a transphobic society. Some more up to date articles include: [https://www.jahonline.org/article/S1054-139X\(21\)00568-1/fulltext](https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext) <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423> <https://pubmed.ncbi.nlm.nih.gov/35212746/>

These more recent articles give evidence that gender affirming care is associated with reduced mental ill health and suicide risk.

34. What was the SOR guidelines called? Could you provide a link please.

<https://www.sor.org/learning-advice/professional-body-guidance-and-publications/documents-and-publications/policy-guidance-document-library/inclusive-pregnancy-status-guidelines-for-ionising>.

Caring for trans and non-binary people: Practical tools for improving care

Monday 25 March, 19:00-20:30

1. If we write a reflective piece, will it count for CPD?

Yes this is an excellent idea and applies to all our webinars and recorded events. If you look at CPD Now on our website <https://www.sor.org/learning-advice/learning/cpd> it will help you develop a reflective piece.

2. In terms of the admin issues, we as radiographers do not always/pretty much almost always do not have access to full medical records. I am terrified of outing someone in this way... If my radiology admin system has not linked up with the patients' medical records and still has the patient listed as their deadname/gender and we have not previously met the patient... how can we avoid outing the patient when calling them in... just calling for their surname seems disrespectful but I don't want to use the wrong prefix or name!

This is a difficult situation. Tash advised training the receptionist or the first person who meets the patient. This avoids the situation arising when the radiographer calls the patient in from the waiting area. Machine sign ins can make this very difficult for the patient. Where there is no receptionist, call for the patient and then when in a more private space, the first thing to do is to say 'I just wanted to make sure these details are correct, is there a name you prefer to use'. Tash explained that the vast majority of trans people know IT systems don't work for them but are extremely appreciative to be given the opportunity to correct details. Although it is upsetting and disappointing for trans people that IT systems don't help, if you can be the person that breaks the cycle of repetitive incidents by asking the person 'is this what you want' it can be very helpful.

3. And if after we realise there has been an error, is it appropriate after apologising to follow this up and change our details on CRIS? What would be an appropriate language to use when documenting this on our system?

It is good practice to apologise and move on. Don't dwell on the mistake. In terms of correcting the incorrect patient record Tash advised that often the patient details that are pulled link back to the NHS spine which is changed at the GP surgery. If a hospital changes a record, it may be that old information is pulled back from the spine or may not link back to the NHS since. Tash advises contacting your medical records department to understand how this is managed in your organisation and ensuring patients are aware of this. You might give them the option of adding a preferred name on their record. Some people might not want their records change and others may have changed their records years ago, but old information keeps coming up. It is best to ensure that when records are changed, they are changed correctly. You will remember from the first webinar we

learned that when a person changes their gender marker with their G.P. they are issued with a new NHS number. That new NHS record might not have any clinical history unless the data have been transferred correctly. This can cause issues when the individual later visits a hospital, and no previous record can be found. These problems are likely to persist until we have widespread change in how our IT systems communicate. Please be aware that this can be very uncomfortable for trans people. For now, be as honest as we can and be understanding of an individual's feelings.

- 4. A QR code on the appointment letter/email that an individual could scan to see gender diverse options prior to examination would be good.**

Great idea.

- 5. Where no unisex toilets are is it acceptable to direct someone to an accessible toilet instead or would this also be seen as offensive?**

Tash recommended good practice if anyone asks where the toilets are to always say, men's are there, women's are there, and accessible toilets are there. You never know when a person has an invisible disability, so this means you are not making an assumption of anyone and it's helpful to the individual to have the choice to use the facilities they feel most comfortable in. It can be frustrating if the only toilets available to trans people are the accessible toilets as these can be limited in public spaces. Gender neutral toilets are also limited. Trans people often chose a toilet based on where they feel most safe.

- 6. How can you approach a conversation with someone who identifies as non-binary where their name is different on their GP records to their radiography history records but you want to check their correct name without making them feel uncomfortable?**

If you see names are different, please ask the patient which is correct and what they prefer. Don't avoid asking the question because it's awkward. Give control to the patient.

- 7. When introducing myself by using "hello my name is" would it be appropriate to add and my pronouns are she/her?**

Yes if you're comfortable doing this, it can help the person feel safe to share their own pronouns. Some people have pronouns on their name badges which can be really helpful and welcoming.

- 8. If a patient gives you consent does that consent pass from dept to dept?**

Consent usually applies to a single episode of care unless it has been made clear otherwise. The patient needs to know how we document, store and share information about their trans status and who has access to that information before asking them to consent. It can be very helpful to ask a patient if they would like you to communicate anything about their trans status or care to any onward care providers. Make sure this process is clear about consent and who the patient would like you to pass information to if relevant.

- 9. When x-raying radiosensitive organs (pelvis and lumbar as an example) would it be ok to ask if the individual's gender has changed since birth. my thinking is that it may help with having that conversation about pregnancy status/radiation**

protection. I am concerned that asking an individual if they are pregnant may lead to gender dysphoria or discomfort. though it is necessary from a medical perspective/radiation protection purposes. What language would be appropriate? What would be the best way to ask for lmp/pregnancy.

Thank you for this question. Please have a look through our guidance where we explain what questions should be asked and how to ask them. It is important to be clear about the clinical reasons for asking any such questions so that the patient has autonomy to decide about disclosure. It won't be possible to eradicate all discomfort for trans people because some medical procedures will be inherently uncomfortable, but the better educated we are on how to approach these questions the more we can improve care. We also spoke about double checking a person's details are correct and the names/pronouns held on record are accurate and up to date to give someone the opportunity to disclose any changes.

10. If someone does not disclose their surgery to you during the initial discussion of their clinical history but it is clear after imaging that they have had surgery are you able to ask when they had this surgery as it is potentially not clear that it is due to their trans status and could contribute to support any relevant following imaging?

This is a good question. We recognise the complex challenges when imaging appearances do not align with the persons registered gender marker. This can happen with trans or intersex people. While these were discussed by the expert group who developed the guidance, it was agreed to be out of scope. However, it is an important point and should be considered in employers local procedures. Misinformation can cause delays in care and potential breaches of confidentiality. The best solution is to gently speak to the patient and carefully explain what has been noted and ask them if there is any information they would like to share to enable their imaging to be accurately evaluated. Consent must be gained to share this further. It is not acceptable to ask just out of curiosity. Again, if you are clear about why this may be helpful information to know it allows patients to make informed decisions about disclosure.

11. Is it appropriate to include everyone in pregnancy asking rather than just asking women, trans men and certain non-binary? This is an idea that has been put across recently?

Yes this is what the IPS guidance covers in detail. Please do have a look.

<https://www.sor.org/learning-advice/professional-body-guidance-and-publications/documents-and-publications/policy-guidance-document-library/inclusive-pregnancy-status-guidelines-for-ionising>.

12. Are you aware of any experiences of intersex and ace people using imaging services?

Intersex people are people whose sex characteristics don't neatly fit into the sex categories of male and female or they have characteristics of both male and female. There are many different ways someone can be intersex. Some intersex people have genitals or internal sex organs that fall outside the male/female categories — such as a person with both ovarian and testicular tissues. Other intersex people have combinations of chromosomes that are different than XY (usually associated with male) and XX (usually associated with female), like XXY. And some people are born with

external genitals that fall into male/female categories, but their internal organs or hormones don't.

If a person's genitals look different from what doctors and nurses expect when they're born, someone might be identified as intersex from birth. Other times, someone might not know they're intersex until later in life, like when they go through puberty. Sometimes a person can live their whole life without ever discovering that they're intersex. Some babies may have had operations to make them more aesthetically aligned with their assigned gender and it was previously publicised that surgeries on babies and children with variations in sex characteristic were necessary to reduce increased cancer risks. However, increased cancer risk is only associated with some intersex conditions and this surgery has often been done on people with very low cancer risk and before an age where they were able to consent. For this reason, some intersex people might have experienced previous trauma. ACE stands for asexual/aromantic. ACE people may not experience any sexual/romantic attraction or less sexual/romantic attraction. This is separate to trans status and relates to their sexual orientation. It may be relevant to care but in a different way to trans status. Both intersex and ace people use all areas of healthcare and will be using imaging services.

13. If a colleague misgenders or uses the wrong pronouns of a patient, is it appropriate for me to correct the colleague or could this make the patient uncomfortable?

It is appropriate to acknowledge this and gently and briefly correct them and move on. If your colleague continues to use the wrong pronouns it may be better to have a separate conversation with your colleague later. You should also model using the persons correct pronouns to reinforce them. In all instances make sure that the patient is wanting those pronouns to be used in all areas of care (somebody may be out in a hospital setting but not to their local GP).

14. Following X's Q. I'm a 2nd year student and we were told that asking about the sex assigned at birth would be too invasive? is this not the case then?

It is always good to remember that questions around assigned sex at birth can feel very invasive. We should be asking this only to establish a safe caring environment and provide the best care we can. It is important the person knows why this question is being asked so they can make an informed choice about what they share and why this is relevant to their care. Patients have a choice to answer this or not.

15. Are there plans to have a separate gender and sex marker on NHS records so that these two characteristics do not get conflated?

It would be helpful if people could self-declare their gender. Interestingly the NHS marker is a gender marker not a sex marker. It was designed as an administrative tool rather than clinical information. It is important to recognise the difference and why this matters. NHS IT systems are a long way from being able to do this consistently. The MESSAGE project is investigating how to best make recommendations in this area: <https://www.messageproject.co.uk/>.

16. If a patient discloses to us that they are trans and have past medical history that would be relevant to our scan but we cannot see on their new record is it appropriate to ask the patient for their previous name/NHS number in order to

access this information? Comparison of previous and current imaging can be very important.

It is important to have all the relevant information. Sometimes records have not been changed correctly, either on the NHS spine or locally. It is necessary to gain a person's consent before accessing personal information about them. It is also important that a person knows when the information on their record is inaccurate so they can seek support to correct it. Rather than ask for their previous name or NHS number it is better to ask if they have had previous imaging or treatment and how you might be able to get a copy of that but you completely understand if they are not comfortable to share that information.

17. What are your thoughts on detransitioners who may have consented to sharing information in the past, but have since completely changed their mind and trans status, and now need to go through a reverse process of explaining the topic which is traumatic to them?

Consent should be seen as an ongoing discussion where details are checked regularly to ensure information is up to date. The principles of care, respect and dignity discussed over the two webinars apply equally to people who chose to detransition. It is recognised that these individuals represent a very small proportion of a small proportion of the population. Tash discussed additional considerations to bear in mind for people who have detransitioned. Please look into resources describing trauma informed care.

18. We just introduced Inclusivity pregnancy forms? we ask sex at birth and if possible they could be pregnant. we give the form and allow them time to fill in on their own, is this appropriate? we getting a few questions on it but also have SoR ips posters up?

As long as patients have all the information relevant to the exposure to ensure they give valid informed consent employers can decide how they structure their procedures.

19. Could giving a patient a questionnaire when they book in for a pelvis /chest/spine x-ray that basically asks pregnancy status/ if they're wearing any blinders /fillers/asking if they're gender diverse that way they can give this to the Radiographer and it may help with imaging /improvement of care.

It must be clear to the patient why we are asking the questions we ask and how it is relevant to the exposure. If gender is not relevant to the exposure it should not be asked. It would be useful to give people an optional space to provide any information they feel is helpful for the clinician to know e.g. previous experiences, access needs etc. It should also be possible for patients to call and ask questions about things they are worried about. This could be for a variety of reasons e.g. religious practices and concerns around undressing, gender affirming surgeries, previous trauma etc.

20. Sometimes it can seem like a minefield. Asking someone to confirm which gender they were assigned at birth can occasionally generate quite angry responses from someone who has always considered themselves to be male, almost as if you are challenging their masculinity. Just an observation, but something to be prepared for.

It is always good to remember that questions around assigned sex at birth can feel very invasive. We should be asking this only to establish a safe caring environment and

provide the best care we can. It is important the person knows why this question is being asked so they can make an informed choice about what they share and why this is relevant to their care. Patients have a choice to answer this or not. The way information is communicated can have a powerful effect on a person's emotions and response.

21. If someone refuses to disclose, can we still proceed with procedures?

We would advise you manage this in the same way as you would for a cisgender woman who chooses not to answer or does not know the answer to this question. It is important not to disadvantage trans people because of their trans status. This becomes a question of benefit and risk and should be a decision made by agreement between the patient, the IR(ME)R referrer, operator and practitioner.