

# GENDER IN MEDICAL RECORDS

## brief overview and commentary



by  
Dr Michal Pruski

### Abstract

In this article, I very briefly discuss current trends with respect to the recording of gender data in medical records. I then outline some of the advantages of the various options as well as a selection of challenges that some Catholics might associate with them. I then argue in favour of systems that allow for the recording of more complete information.

### Overview of approaches to recording the data

There have been three main approaches to recording gender data in medical records: the first is using a single field, the second is having separate fields for biological sex and gender identity, and the third is similar to the second but with additional fields e.g. specifying a patient's 'organ inventory'. There is a bit more to this, as some have also proposed other fields such as those describing any steps taken by the patients with regards to transitioning or hormone panels,<sup>(1-3)</sup> but for the present discussion this amount of detail is sufficient.

Currently, in NHS records, there is one field that describes gender data - there are no separate fields for sex and gender; in practice the field describes gender identity rather than biological sex.<sup>(4)</sup> Seemingly to protect patient privacy, if a patient requests a change in this field such a change results in the generation of a new patient NHS number with the aim of preventing the past identity to be easily discovered; if the patient then reverts to their previous gender identity, this does not revert the patient to their old NHS number, but generates a third number.<sup>(4)</sup> As such, this marker should be treated as describing the

patient's current self-described gender identity and not their biological sex. It is clear that this situation is not ideal for providing high quality of care, due to both the lack of easy access to a patient's medical history and to adjusting the care to the patient's biology.

An alternative to this is to have two fields: one for sex and one for gender. As biological sex is always stated in this record, there is no reason to hide the patient's medical history from practitioners. Moreover, as it preserves the information of a patient's biological sex, it can avoid situations like a pharmacist not dispensing medication that is medically appropriate for the patient's sex. Such situations might occur if the patient's gender description does not match their biological sex. Similar problems arising from incongruence between gender identity and biological sex (and how these are recorded in the medical record) can also occur with respect to patient inclusion into or exclusion from screening programmes.<sup>(4,5)</sup>

Another approach involves including an organ inventory.<sup>(2,3)</sup> Under this framework a patient might have their sex marked as male, gender as female, and then in the organ inventory e.g. have noted whether they do or not have a penis. This might be important for e.g. a practitioner being called to the female ward to insert a catheter. Essentially, organ inventories provide a summary of some of the surgical procedures a patient has undergone. If presented as structured data, such inventories could be used by healthcare software to automatically adjust e.g. which screening programmes a patient should be part of. Of course, such information might not be sufficient to predict what normal biochemical marker values might be for such patients, as their medication might also have an impact on this. Nevertheless, the more complete information a practitioner has, the better they can tailor their care for the patient.

Of note, currently there are developments in international interoperability standards, which aim to ensure that gender data can be more easily transferred between providers - the Health Level 7 Gender Harmony Project.<sup>(2,3,6)</sup> As such, it might be important from the patients' perspectives that their data can be easily transferred between localities. The interoperability between health informatics system is also an important feature in an increasingly globalised society and as we

progress to the era of a more digitised model of healthcare provision it will only gain in prominence.

### Potential Advantages and Disadvantages

On the face of it, it might seem that having just one field for gender information reflects best the simplicity of the truth described in Genesis 1:27 and 5:2, that humans were created male and female. This holds true, as I and my colleague argued elsewhere, even in the case of people with disorders of sexual differentiation.<sup>(7,8)</sup> Of course, the way in which a single field is used in practice does not reflect the truth regarding human sex as recognised by the Catholic Church – that it is an immutable characteristic of a person. But perhaps one could argue that consenting to having more than one field for sex and gender data somewhat affirms the notion that gender and sex do not have to be congruent, and hence having more than one field can be uncharitable as it can affirm a viewpoint that encourages another to live a falsehood with respect their own nature, which would be uncharitable. This I think is potentially the strongest objection to having more than one field describing gender data, and I will address it in more detail in the next section.

The above point aside, there seem no obvious practical drawbacks in having a more complete system; perhaps with the exception that more time is required to fill in all the fields relating to sex and gender in the patient's healthcare record. Having more complete information allows for the better provision of medical care, as noted in the previous section. This can also be the cases where a patient has detransitioned (so gender and sex are congruent), but had some past operations that would be of note in e.g. an organ inventory. Moreover, having it in the record that there is an incongruence between a patient's sex and their declared gender allows the practitioner to prepare in advance for the encounter.

Nevertheless, one potential practical drawback is that patients who do not believe in a separation between sex and gender might not be happy to answer questions relating to any additional information.<sup>(9)</sup> Though other patients might be particularly happy about being able to provide this additional information.

As such, the most important benefit of having more detailed records regarding patients' sex and gender information is that it allows us to provide appropriate medical care, ensuring that appropriate tests and treatments are given, as well as that we have the information to interpret any results correctly. We also should keep in mind the

broader impact of having unified information standards on healthcare delivery, and that recording this information in a standardised way will help with sharing information if this is needed for a patient's care.

### Responding to the objection

As noted above, the main drawback of supporting such detailed records is that it can be perceived as supporting a societal trend that is contrary to the metaphysical reality of human nature – that there is no separation between sex and gender, and that sex is immutable. Perhaps because of the recent events regarding the Tavistock clinic and Mermaids,<sup>(10,11)</sup> we should be particularly firm in affirming this truth, so as to protect the wider population from dangerous trends, which might not only be contrary to the truth, but also have little to do with evidence based medicine.<sup>(12)</sup>

Nevertheless, it seems to me that the use of such records does not intrinsically imply that the clinician using them agrees that there must be a meaningful difference between a patient's sex and gender. Using such a record might simply mean that the clinician recognises that other people think there is such a meaningful difference, even if the clinician disagrees with it, but that in a pluralistic society it might be the most generally acceptable tool to use. Hence, using such healthcare records systems might not be an expression of support for current trends in gender ideology, but simply a way of getting on with one's job. Nevertheless, it might seem to some that a clinician using such a record is conceding to these modern trends and hence be a cause of moral scandal.

Here I wish to defend using such detailed records, as opposed to the use of a single field system. I will do this using the framework of cooperation with/in evil,<sup>(13-15)</sup> and assume that if I can demonstrate that such cooperation is licit, the medical advantages offered by such a more detailed system provide enough of an incentive to favour this system.

The case of the clinician using the system but not believing (and not wanting to propagate the notion) that there is a meaningful difference between sex and gender, shows that if any negative effects originate from the clinician using this system, the clinician's cooperation was merely material, since the negative effect was not intended. Moreover, such a cooperation would be at most likely remote (in time and causality) and only contingent or occasional to it, as it is not the case that the use of such a system would intrinsically show agreement with a worldview that affirms a separation between sex and gender. The

act's influence is most likely of small effect on the final consequence of someone being reaffirmed in their belief regarding the difference between sex and gender. Furthermore, as the clinician is not explicitly stating agreement for the gender-sex dichotomy, the cooperation is unlikely to be positive.

Such a perceived cooperation is likely to be licit, if it is to facilitate some fundamental good.<sup>(16)</sup> Here this would be the provision of high quality healthcare, that might be impossible if the detailed information is not present, because e.g. the sex of the patient might not be otherwise obvious. Put simply, we need to know someone's biological sex to give them appropriate and holistic healthcare. It is possible that such information would facilitate what has been described as 'meeting people where they are', but as I have no experience in this field I will not comment further on this.

### Conclusion

After outlining some of the trends regarding recording gender data in patients' medical records and outlining the potential benefits of each approach, I have argued that systems providing more detailed information with respect to patients' biological sex and gender identity should be welcomed. I have argued, with the help of the framework of cooperation with/in evil, that the use of such systems does not intrinsically mean that one agrees with the current trend of separating sex and gender. Rather, such a system simply provides more detailed information about the patient allowing one to provide medical care of higher quality than a more simple system would allow.

**Acknowledgment:** I thank Gregory Jackson for helpful comments on a draft of this article.

### References

1. Marney HL, Vawdrey DK, Warsame L, Tavares S, Shapiro A, Breese A, et al. Overcoming technical and cultural challenges to delivering equitable care for LGBTQ+ individuals in a rural, underserved area. *J Am Med Inform Assoc.* 2022 Jan 12;29(2):372–8.
2. McClure RC, Macumber CL, Kronk C, Grasso C, Horn RJ, Queen R, et al. Gender harmony: improved standards to support affirmative care of gender-marginalized people through inclusive gender and sex representation. *J Am Med Inform Assoc.* 2022 Feb 1;29(2):354–63.
3. Baker KE, Compton D, Fechter-Leggett ED, Grasso C, Kronk CA. Will clinical standards not be part of the choir? Harmonization between the HL7 gender harmony project model and the NASEM measuring sex, gender identity, and sexual orientation report in the United States. *J Am Med Inform Assoc.* 2022 Oct 26;ocac205.

4. Armitage R. A threat to trans patient care quality: gender markers, patient records, and population screening. *Br J Gen Pract.* 2022 Apr 1;72(717):175–175.

5. Dahlen S. De-sexing the Medical Record? An Examination of Sex Versus Gender Identity in the General Medical Council's Trans Healthcare Ethical Advice. *New Bioeth.* 2020 Feb 3;1–15.

6. HL7 International. HL7 Informative Document: Gender Harmony - Modeling Sex and Gender Representation, Release 1 [Internet]. [cited 2023 Mar 5]. Available from: [https://www.hl7.org/implement/standards/product\\_brief.cfm?product\\_id=564](https://www.hl7.org/implement/standards/product_brief.cfm?product_id=564)

7. Gamble N, Pruski M. Why are there no platypuses at the Olympics?: A teleological case for athletes with disorders of sexual development to compete within their sex category. *South Afr J Sports Med [Internet].* 2020 Jun 22 [cited 2020 Jun 22];32(1). Available from: <https://journals.assaf.org.za/index.php/sajsm/article/view/7918>

8. Gamble NK, Pruski M. Teleology and Defining Sex. *New Bioeth.* 2018 May 7;24(2):176–89.

9. Gunning F. People who refuse to answer question on 'gender assigned at birth' will be prevented from donating blood [Internet]. *Gript.* 2023 [cited 2023 May 27]. Available from: <https://gript.ie/people-who-refuse-to-answer-question-on-gender-assigned-at-birth-will-be-prevented-from-donating-blood/>

10. The Guardian. Trans charity Mermaids investigated over 'breast binders given to children'. *The Guardian [Internet].* 2022 Sep 30 [cited 2023 Mar 5]; Available from: <https://www.theguardian.com/society/2022/sep/30/transgender-charity-mermaids-investigated-breast-binders-given-to-children>

11. Kirkup J. Why the Tavistock clinic had to be shut down [Internet]. *The Spectator.* 2022 [cited 2023 Mar 5]. Available from: <https://www.spectator.co.uk/article/why-the-tavistock-clinic-had-to-be-shut-down/>

12. Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clin Child Psychol Psychiatry.* 2011 Oct;16(4):499–516.

13. Flannery KL. *Cooperation with Evil: Thomistic Tools of Analysis.* Washington, D.C: The Catholic University of America Press; 2019. 296 p.

14. Fisher A. *Catholic Bioethics for a New Millennium.* Cambridge: Cambridge University Press; 2012.

15. Fisher A. Co-operation in Evil. *Cathol Med Q.* 1994;44(3):15–22.

16. Pontifical Academy for Life. *Moral reflections on vaccines prepared from cells derived from aborted human fetuses.* 2005.

Dr Pruski is a Senior Clinical Scientist and a Health Informatics Higher Specialist Scientist Trainee at the Cardiff and Vale University Health Board, and a DClinSci candidate at the University of Manchester.