Understanding clinicians’ strategies for providing gender-sensitive care: an exploration among pediatric rehabilitation health care providers

Sally Lindsay and Kendall Kolne

Bloorview Research Institute, Holland Bloorview Kids Rehabilitation Hospital & Department of Occupational Science & Occupational Therapy, University of Toronto, Toronto, Canada

ABSTRACT

Purpose: Although there is an increasing awareness of the critical role of gender within pediatric rehabilitation, little is known about the strategies that clinicians use to provide such care. The purpose of this study was to explore clinicians’ strategies for providing gender-sensitive care within a pediatric rehabilitation hospital.

Methods: We used a qualitative needs assessment design and a convenience sampling strategy to recruit clinicians from a pediatric rehabilitation hospital. We conducted interviews with 23 pediatric rehabilitation health care providers from various disciplines. We applied a thematic analysis to the interview transcripts.

Results: Our analysis revealed the following themes regarding clinicians’ strategies in providing gender-sensitive care: (1) awareness of gender biases and not making assumptions; (2) recognizing gender-based vulnerabilities; (3) respecting patient values, preferences and needs; and (4) advocacy.

Conclusion: Health care providers working within pediatric rehabilitation have several strategies for providing a gender-sensitive care approach to clients.

IMPLICATIONS FOR REHABILITATION

- Clinicians should seek training (i.e., appropriate terminology, creating inclusive spaces) in how to recognize gender-based health vulnerabilities, especially among patients who identify as non-binary or transgender.
- Clinicians should make an effort to try to be aware of their own biases and not make gender-based assumptions.
- Advocacy, respecting patient values, preferences and needs are important aspects of providing gender-sensitive care.

Introduction

Gender refers to socially constructed roles, behaviours and identities, whereas sex refers to biological and physiological bases that make male, female and intersex individuals distinct from one another [1,2]. Gender is a multifaceted and fluid construct that is influenced by social and cultural contexts to create gender norms [3,4]. Many gender identities exist such as transgender (i.e., having a gender other than male or female, having multiple genders or not having a gender) (see Liszewski et al. [5] for further discussions about gender identities). Gender norms often influence common behaviours of how people perceive themselves and others, their interactions and distributions of power and resources within society [3,4,6,7].

Sex and gender play a critical role in health maintenance and outcomes [8–11]. For instance, women are more likely to be misdiagnosed and less likely than men to receive more advanced diagnostic and therapeutic interventions with the same symptom severity [12–14]. As a result of such health inequities, the World Health Organization [15] supports a gender-based approach to health care including developing strategies to prevent gender-related inequalities [16,17]. The importance of gender as a social determinant of health is also recognized by funding agencies in the US, Canada and Europe [15,18–20]. Despite this body of evidence, little is known about the extent to which such gendered health inequities exist within pediatric rehabilitation.

Gender-sensitive health care

There is an increasing awareness of the important role of gender within pediatric health care [21–23]; however, there are few existing gender-sensitive approaches [24]. Gender-sensitivity, a key component of patient-centered care, refers to health care providers being knowledgeable and competent about perceived existing gender norms and differences and how this could influence their decisions and potentially bias treatments [25,26]. It also involves addressing gender-based inequalities, stereotypes and characteristics of care that display relational and other preferences including same-gender clinician-patient paring, physical environment, communication style and privacy or safety needs [18,27,28].
Clinicians’ attitudes towards gender can influence their behaviours and might bias their evaluations of their patients [25,29]. Gender-sensitive care involves understanding various gendered and health disparities while considering the socio-political and cultural context of where care takes place including clinician-patient relationships [25,30]. A gender-sensitive care approach aligns with patient and family-centered care in that it focuses on interacting with patients in a respectful and supportive manner, working in partnership, providing continuity of care, and sharing information to make informed choices [31,32]. Gender-sensitive and gender-specific approaches (i.e., tailored specifically for men, women and gender diverse persons) consider particular health care needs while addressing the causes of gender-based health inequities and ways to transform harmful gender norms, roles and relations while focusing on promoting gender equality [3,15]. Gender transformative approaches, recognized by the World Health Organization, are part of a continuum of gender-responsiveness, showing a progression from the exploitative use of gender stereotypes and inequalities (i.e., gender-blind and unequal) through to accommodation (i.e., gender-sensitive and gender-specific) and eventual transformation to gender equity (i.e., gender transformative) [3,15].

The field of gender-sensitive health care is a small but rapidly growing literature. For example, O’Dwyer et al. [33] conducted a qualitative study to explore health professionals’ perceptions of how gender-sensitive care is implemented across acute psychiatric inpatient units for women who are survivors of sexual violence. They found that many health professionals had a simplistic understanding of gender-sensitive care and often avoided practicing it [33]. Clinicians reported limitations in what they could do and a lack of training or application of gender-sensitive care. They also noted that when it was applied it was often reactive rather than preventative [33].

Another qualitative study of health professionals’ understanding and application of gender-sensitive care delivery for victims of sexual assault found that there was a fragmentation of health services and limited follow-up that hindered integrated delivery of care [34,35]. This study reported that only 3/15 hospitals differentiated their sexual assault care protocol based on the victim’s gender, gender identity and sexual orientation [35]. There was a lack of awareness of sexual assault in male victims and gender and sexual minorities, hindering the implementation of a gender-sensitive care approach [35].

Meanwhile, in women’s veterans’ health care, Brunner et al. [36] conducted a qualitative study to explore local leaders’ perspectives on providing gender-sensitive care. Their findings highlighted the need for gender-specific health care (e.g., separate primary care services, the need for childcare, expanded reproductive health services, geographic accessibility, physical appearance of facilities, fostering interest in women’s health across staff) [36].

To our knowledge, only one study has focused on gender-sensitive care within rehabilitation, which explored adult health care providers specializing in traumatic brain injury [37]. Their findings showed a lack of education about the topic and inconsistent evidence that hindered clinicians’ attention to sex and gender within their practice [37]. They highlighted a need for further research in gender and rehabilitation [37].

In one of the few studies focusing on youth, Rahaman et al. [38] conducted a cross-sectional needs assessment for gender-sensitive reproductive health services for adolescents in Iran. They found that health care services need to be reformed with regards to processes, structure, and policies of gender-sensitive care services. Their findings highlight that gender appropriate educational and care needs are priorities for reforming the services [38].

Although the body of research in this area is growing, most studies focus on the need for gender-sensitive care or exploratory qualitative research with specific adult populations (e.g., mental health, veterans’ health care, reproductive health).

**Gender and youth with disabilities**

Focusing on gender-sensitive care approaches within pediatric rehabilitation is relevant because, in Canada, the majority of pediatric rehabilitation clinicians are women, and they provide care to a population where the majority of the patients are boys and young men [39,40]. Such gendered trends are salient because they could influence clinician-patient rapport building and ultimately, patient health outcomes [10,11]. Focusing on children and youth with disabilities is valuable because more than 1 in 10 youth in Canada have one or more disabilities [41]. Research highlights that sex and gender play a critical role in the incidence, clinical presentation, manifestation, and health outcomes; yet among children and youth with disabilities, they are often viewed and treated as without gender and non-sexual [42–46].

Research on gender and youth with disabilities highlights gender differences in autonomy and independence where girls and young women with disabilities are more likely than boys to limit their activities due to safety concerns [47]. Among the studies that explore gender differences in activities, research also illustrates that girls and young women with a disability participate more often in leisure and social activities whereas boys and young men participate more in physical activities [48–51].

Some evidence indicates that young women with disabilities often lag behind men with disabilities on a variety of health outcomes [23,27] and are at an exceptional risk for social isolation, poverty, psychological distress, physical and sexual abuse, addictions and inappropriate access to health care services (especially for sexual and reproductive health), compared to people without a disability [52–54]. Additionally, research shows that among young men, they often experience gender role conflict and worse health outcomes when they feel they cannot live up to traditional masculine gender role norms [55]. Health vulnerabilities also exist among the LGBTQI+ population and gender diverse individuals who often encounter significant challenges within the health care system including discrimination—potentially influencing inequalities and health outcomes [56].

Of the limited research on gender and youth with disabilities, studies indicate that most programs and interventions for youth with disabilities are designed as gender-neutral (i.e., one-size fits all) and may not be considering their gender-specific needs [21,23]. Thus, it is critical to understand clinicians’ strategies for providing a gender-sensitive care approach within pediatric rehabilitation.

Focusing on gender-sensitive care strategies within pediatric rehabilitation is salient because youth and young adults with disabilities, especially those who identify as lesbian, gay, bisexual, transgender and queer (LGBTQI+) or gender diverse, have been mostly overlooked within health care and pediatric rehabilitation [21,22,25,27]. A lack of attention to such youth is worrying because those who identify with a sexual or gender minority group commonly encounter barriers within the health system including inappropriate access to health services, and stigma [21,56,57]. For example, research shows that individuals who identify as transgender or nonbinary often experience disadvantages regarding accessing health care, especially within mental and sexual health services [58]. In Melendez and Pinto’s study, they highlighted that 61% of transgender individuals delayed or avoided medical care because of concerns about gender-related discrimination from their health care
providers [59]. Such discrimination and exclusion is often linked to negative health outcomes especially psychological distress and violence [34]. Additionally, individuals who identify as transgender or nonbinary often experience higher rates of psychological challenges (i.e., elevated rates of depression and suicide) compared to those identifying as cisgender [60–62]. Therefore, it is critical for health care providers to address such health related inequalities and reflect on strategies that may help to create a more inclusive environment.

Gaps and novelty of the research

Our study addressed a crucial gap in the literature by exploring strategies for providing gender-sensitive care amongst pediatric rehabilitation clinicians. Although research on gender-sensitive care is growing, it focuses mostly on adults and acute care populations with little mention of pediatrics or rehabilitation [55]. Many health care providers in pediatric rehabilitation report lacking training and knowledge about gender-sensitive care, which can influence health outcomes and health inequalities [21,27,63]. Lacking knowledge could lead to gender and sex-based stereotypes that may affect symptom recognition and delivery of health care services [64]. Additionally, recent needs assessments with youth who have a disability highlight a demand for gender-specific and gender-sensitive care within pediatric rehabilitation [21]. Most programs and interventions for youth with disabilities are gender-neutral and as such, do not consider the specific needs of boys and young men, girls and young women and gender-diverse individuals [21,23]. Gender also influences how children and youth cope with their condition, especially as they transition to adulthood [21,22]. Thus, by examining the strategies that health care providers use in providing a gender-sensitive care approach within pediatric rehabilitation we aim to showcase areas that are working well to help strengthen gender as a determinant of health [26, 65].

Methods

Objective and design

Our objective was to describe clinicians’ strategies in providing a gender-sensitive care approach within pediatric rehabilitation. Our design involved conducting individual interviews with pediatric rehabilitation clinicians. A research ethics board at a pediatric rehabilitation hospital approved this study. We also followed the consolidated criteria for reporting qualitative research guidelines [66]. We aimed to have representation of different disciplinary fields within pediatric rehabilitation.

Recruitment

We used a convenience sampling strategy to recruit participants through invitation letters, referrals or advertisements through a pediatric rehabilitation hospital. They met the following inclusion criteria: a pediatric rehabilitation clinician (e.g., physician, pediatrician, nurse, social worker, occupational therapy, physiotherapy, speech therapy, psychology etc.) who is currently practicing at the pediatric rehabilitation hospital or satellite clinic. Participants who were interested in the study received an information package from the researcher. After obtaining written consent two female researchers with training in qualitative research, pediatric rehabilitation and gender-sensitive care interviewed participants at a time and location of their choice. The researchers did not have any prior relationships with the participants. We conducted interviews with 23 pediatric rehabilitation health care providers (see Table 1). This sample size is considered suitable for a qualitative study to capture the depth and breadth of issues surrounding gender-sensitive care approaches [67,68].

Sample characteristics

Our sample consisted of 23 pediatric rehabilitation clinicians (19 women, 3 men, 1 transgender man) from the following backgrounds: occupational therapy, nursing, physiotherapy, speech language pathology, therapeutic recreation, social work, medicine, and assistive technology consultant (see Table 1). Most participants (n = 21) reported a lack of formal training in gender-sensitive care. Nine participants had some informal training and three had formal training in sex and gender-sensitive care.

Table 1. Overview of participants.

| Participant | Gender | Occupation                                      | Training in gender-sensitive care |
|------------|--------|-------------------------------------------------|----------------------------------|
| 1          | Woman  | Occupational therapist                          | No                               |
| 2          | Woman  | Registered nurse                                | Yes                              |
| 3          | Woman  | Physio and occupational therapy assistant      | Some                             |
| 4          | Woman  | Occupational therapist                         | Yes                              |
| 5          | Woman  | Communicative Disorders Assistant              | No                               |
| 6          | Woman  | Occupational therapist                         | Some                             |
| 7          | Woman  | Occupational therapist                         | Some                             |
| 8          | Woman  | Physiotherapist                                 | Some                             |
| 9          | Woman  | Communicative Disorders Assistant              | No                               |
| 10         | Woman  | Therapeutic recreation specialist               | No                               |
| 11         | Woman  | Assistive Technology Consultant                | No                               |
| 12         | Woman  | Physiotherapist                                 | No                               |
| 13         | Woman  | Occupational therapist                         | No                               |
| 14         | Woman  | Speech-Language Pathologist                     | No                               |
| 15         | Woman  | Social worker                                   | Some                             |
| 16         | Man     | Pediatric health care provider                  | Some                             |
| 17         | Woman  | Occupational therapist                         | No                               |
| 18         | Woman  | Physician                                       | Yes                              |
| 19         | Woman  | Physician                                       | Some                             |
| 20         | Transgender man | Pediatric health care provider | Some                             |
| 21         | Man     | Pediatric health care provider                  | No                               |
| 22         | Woman  | Physiotherapist                                 | No                               |
| 23         | Man     | Pediatric health care provider                  | Some                             |

*Note. Anonymized to protect participant confidentiality.*
Data collection

We conducted the interviews from August to November 2019, which were audio recorded. The first two authors and a research assistant, all who were trained in qualitative research and gender-sensitive care, conducted the interviews using a semi-structured guide (see Supplementary Material). Our interview guide was informed by a systematic review on gender-sensitive care among health care providers [27] and was also pilot tested with a pediatric clinician prior to conducting the interviews. The interviews lasted an average length of 26 min to fit within clinicians’ busy schedules. Within our interview guide we asked participants to describe their current role and types of patients they work with, the importance of gender within their practice, any gender-related training and the strategies for providing gender-sensitive care (see Supplemental Material).

Data analysis

The interviews were professionally transcribed, verbatim, then checked for accuracy by the first author and a research assistant. We used a narrative, thematic analysis to gain an understanding of participants’ experiences of gender-sensitive care [69]. This approach focused on first-person accounts of experiences and events that have occurred and are linked into current discussions as examples [70]. We first familiarized ourselves with the data, generated initial codes, revising and defining the themes [70]. We used a two-stage, inductive, thematic approach using an open coding, constant comparative method to assess all possible codes in the data. Both authors independently read the transcripts while using the objectives to guide our analysis. The authors have experience and training in pediatric rehabilitation, sociology and gender-sensitive care (i.e., modules from the Canadian Institutes of Health Research (CIHR) on integrating sex and gender in health) [71]. The first author also is also a sex and gender champion with the CIHR’s Institute of Gender and Health. We each developed a list of preliminary codes while noting patterns between them and then met to compare and contrast the preliminary codes. In this discussion, we relabelled, split or merged codes, while re-visited transcripts. We then established the meaning of all of the codes within our coding tree.

Team discussions helped to resolve any discrepancies in the organization of the themes. The first author applied the coding scheme to all of the transcripts. A second researcher reviewed a sample of the coding to ensure accuracy. We then extracted relevant quotes that represented each theme and sub-theme while checking for accuracy by the first author and a research assistant. We then extracted relevant quotes that represented each theme and sub-theme while using the objectives to guide our analysis. We included excerpts from the interviews that reflected the participants’ experiences to illustrate the themes [69,73]. We also considered how our background training and experience may have influenced the development of the themes, while noting this in our audit trail.

Results

We identified four themes regarding clinicians’ strategies for providing a gender-sensitive care approach: (1) awareness of gender biases and not making assumptions; (2) recognizing gender-based vulnerabilities; (3) respecting patient preferences and needs; and (4) advocacy. We recognize that although these themes inherently overlap, they are discussed sequentially. It is also salient to note that several participants within our study sometimes confused the terms sex and gender and there are some instances where they did not use inclusive language. We feel it is essential to report their original perspectives and verbatim quotes.

Awareness of gender biases and not making assumptions

The first theme regarding strategies for providing gender-sensitive care involved clinicians being aware of their own biases, including the influence of their own gender and not making assumptions. Most clinicians explained how critical it was to not judge someone’s gender identity. For example, a pediatric health provider said: “Issues of gender come up…I want to make sure that nobody feels like I’m judging them or treating them a certain way because of their gender or sexuality. So, I might be a bit more mindful about what I’m saying” (#23). Another health care provider similarly mentioned the importance of being aware of gender-related biases. To illustrate, they revealed,

Talking about routine practices that you’re doing and the effects of what that would mean to different genders…That makes you look at your own assumptions and think, should I be doing this differently? …When it comes to gender in practice being mindful and careful with the language and being open to having your assumptions changed and open to how well you’re good intentions may have been perceived….We’re all in the same big culture society bubble and wonder how much of that permeates into health care settings….It’s a matter of being able to ask that comfortably. (#16, pediatric provider)

Another health care provider explained why it was critical to be aware of their own biases. They said, “Not assuming gender norms might be a helpful thing. So, not assuming that all boys are going to like cars and physical activity; All those things that we tend to deem more masculine …Until I get buy-in and trust and have that established relationship, I’m not as effective as a clinician” (#7, Occupational Therapist). This particular clinician told us that she used to have gender-based preconceptions but then she realized “my preconceived ideas went out the window and I realized that kids are kids, and teens are teens. So, just being open to what they’re interested in and trying to put aside what I thought. As soon as I put those things aside, you’re better able to form that therapeutic alliance” (#7, Occupational Therapist).

Meanwhile, an assistive technology consultant who works with children who are non-verbal and use augmentative and alternative communication devices explained that she used to make assumptions but now asks the children about their preferences. She said, “When I first started, I made the assumption that they might want a boy voice for both voices, but now I’m realizing you really have to ask the client what their preference is and go through all the options, instead of just either the boy or the girl voices” (#11, assistive technology consultant). Other clinicians explained why it was important to be flexible to avoid bias:

I’d like to be able to describe myself as someone who wasn’t following these gender stereotypes and was open-minded to the kind of fluidity of all that, but when it comes down to it; there is some ingrained norms that I have grown-up with and become used to that might influence the way I interact with my male clients versus my female clients. (#10, Therapeutic Recreation Specialist)
Additionally, being aware of people’s needs often helped some clinicians to avoid gender-biases. To illustrate, a physiotherapist expressed:

Being mindful of your language and we want to empower young people to be who they want to be and I really try to make an effort to avoid very gendered language, especially with young girls and trying to avoid commenting on their appearance, but rather giving them compliments on their abilities…If a child chooses something that’s non-gender conforming, you have to be sensitive to that, and not make a big deal of it because that would be inappropriate…It’s important to be aware of our gender biases. (#8)

A part of not making gender-based assumptions involved clinicians’ recognizing the role of their own gender and being reflexive. For example,

It goes back to that reflexive practice and trying to open up your thinking to move away from that binary mode which stretches beyond just gender alone, but stop seeing things in terms of disability and able-bodied or success or unsuccessful…Trying to understand the filters through which you understand and provide advice and remembering what your mandate is. For me, under the umbrella of services that I provide, explicit discussions on sexuality and gender are completely on the table and I need to be comfortable with that. (#17, Occupational Therapist)

Another important part of avoiding gender-based assumptions involved active listening and rapport building. For example, a social worker explained:

It's ultimately about really listening with an open, nonjudgmental approach and really helping people to find their true authenticity and not having assumptions… I felt prepared to deal with someone who was a teen who was questioning their identity. So, I took it from a perspective of this pre-teen and really listening to that client and using my counselling skills to really hear what they were saying and trusting that I knew enough about the resources that were out there to say, let's help you through this. (#15)

Some clinicians shared with us that asking questions upfront helped them to avoid making assumptions about sexuality or gender and facilitated the creation of a safe space for patients to discuss it further if they wanted.

Recognizing gender-based vulnerabilities

A second theme involved an awareness of gender-based vulnerabilities, which was salient for many clinicians when providing a gender-sensitive care approach. Most of them noticed such patterns, either through their clinical experience over the course of their careers or through gender-specific training and research. Several clinicians described observing gender-specific vulnerabilities (whether perceived or actual) and included: boys with disabilities at risk of social isolation; girls expressing pain differently; and LGBTQ+ and gender diverse patients at risk of bullying and mental health issues.

Clinicians underscored the importance of being prepared for patients with gender-based vulnerabilities so that they could provide them with the most appropriate supports. For example, several clinicians reported that their male patients often displayed more instances of social isolation. Health care providers felt it was critical to address such concerns because being isolated could put youth at further risk of bullying or mental health issues. To illustrate, an occupational therapist shared, “I met with him and it turned out there were tons of issues that came up around bullying and then we got into conversations on peer relations. From there, it came out that this teenager was just starting to really understand the depth of his diagnosis” (#1). Clinicians who worked with LGBTQ+ and gender diverse patients expressed similar concerns. For instance, a health care provider clarified, “there can be a lot of mental health issues that come up too. I think knowing what I know, sometimes the LGBTQ+ community can also have a lot of mental health issues that come along with it” (#4, Occupational Therapist). Other clinicians concurred: “There was some mental health concerns and questions around identity and they were really struggling and even some concerns about risk and self-harm…They grew up with feeling different and isolated” (#15, Social Worker).

Other clinicians, particularly occupational therapists, physiotherapists, and nurses mentioned that there were gender differences in perceptions of pain amongst their patients. For example, an occupational therapist shared, “I think chronic pain disproportionately affects girls more than boys…The expression of pain I think that’s probably different. There’s probably a lot of deep-rooted social norms that kids strongly abide” (#7). In sum, several clinicians reported that being aware of the research on gender-based incidences and related vulnerabilities was helpful for them in their practice.

Respecting patient preferences and needs

A third theme involved clinicians showing respect for patients’ gender-based preferences and needs, which included affirming their name and pronoun. Clinicians reported how critical it was to respect patient’s preferences, especially when addressing gender identity. For example, a nurse explained, “I’m starting to be a lot more attentive to how the child identifies themselves and where they come from and those sorts of things, and that’s a new thing for me…You’re just reminded to be respectful of how the person wishes to be identified” (#2, Nurse). Another health care provider shared, “Gender is important…I want to make sure that we’re looking at their needs, their goals, what we need to work on, addressing their concerns, and I want to be sensitive and understanding in any way I can” (#14, Speech Language Pathologist). Others described how it was critical to listen and understand a person’s gender identity and what they valued. For example, an occupational therapist explained:

Being respectful of what people consider themselves to be, what they want to be identified as…Being more mindful of that now, as part of your day-to-day clinical interaction with people is really important…It requires more of an understanding from them and more of a partnership between the clinician and the individual…Trying to understand from them what their needs are and having that open dialogue that goes both ways. So, people are able to express what their needs are, what their concerns are. (#13)

Documentation and pronouns

Most of the focus within this theme of respecting and affirming their name and pronoun to appropriately document gender identity. Clinicians commented that the use of gendered pronouns helped them to show respect for patients. For instance, an occupational therapist shared, “I really made a conscious effort to use the correct pronouns, even in the client’s absence, because it’s more respectful and then you’re actually honoring that person’s identity” (#7). Other health care providers reported that asking patients upfront about how they would like to be identified was particularly critical. A physician shared their experience: “It’s become part of my practice just to ask how would you like to be addressed? Do you have a pronoun of preference? …If someone brought something up we’d explore the issue further” (#18).

Similar strategies to document a patient’s pronouns were used as a way of showing respect. In particular, a clinician mentioned an instance of working with a transgender patient and how it was
essential to affirm their pronoun during their interactions with them. Additionally, they explained handling a situation when the medical documentation only allowed for a binary (i.e., male/female) choice and how they worked to create a respectful environment. They revealed:

Knowing this was someone who identified as transgender and being aware of how our medical system wasn’t really ready for that person and adjusting my approach to be able to make them feel more comfortable … I really didn’t want that person to feel uncomfortable because I was thinking of them going into all of these different appointments and every time having to re-say a name that they’ve moved away from … Preferred pronouns normalizes and respects what somebody wants (#10, Therapeutic Recreation Specialist).

Other methods of showing respect involved taking time to carefully review their chart before meeting with them to avoid potential misgendering. To illustrate, a physiotherapist explained,

I’ve seen people where I’m not sure but it’s not necessarily that they’re identifying as the opposite gender to what their sex is. It’s just because they’re ambiguous looking and that happens … I would double check because I wouldn’t want to offend that person. It’s important to collect that information because there are different interventions that are used; So, you at least need to know the anatomy piece. It’s nice to also have them identify from a gender perspective because you’re not starting off on the wrong foot. (#22)

Some health care providers mentioned that appropriately documenting gender identity and pronoun helped them to create a safe environment for their patients. For example, some explained that it was imperative to ask about gender-related questions, particularly before deciding on a course of therapy or when assigning roommates for overnight life skills programs. A therapeutic recreation specialist mentioned, “We added it as a question, ‘do you have a preference on what gender your roommate would be?’ … It’s an interesting thing. It might not be a big deal or it might be something that would be really important for us to think about” (#10).

Creating a safe environment

Clinicians explained how providing a safe environment as essential and involved patients feeling comfortable to discuss their gender identity and pronouns, was essential. For instance, a clinician clarified how they developed rapport by listening to youth’s needs and asked them questions to provide an opportunity for them to share more about their gender identity. Developing rapport with patients was an essential aspect of effective communication. A physiotherapist explained her approach:

It’s important for therapy sessions to develop rapport; keep them interested or distracted if pain is a big issue. Having a conversation about something that they’re really interested in will often help with that … Regardless of how they identify I’m going to try and bond with and for some people it will be easier than others but as long as I’m adhering to their preferences and supportive of that. (#22, Physiotherapist)

Inter-professional communication

Another aspect of providing a safe environment involved effective inter-professional communication. Specifically, it was imperative to communicate effectively about gender identity and related preferences with other team members. A clinician revealed:

In our particular clinic the way that we hand-off to one another, we make sure that we’re handing over information so that patients are not having to repeat themselves … In this situation it’s great because to be able to pass along things like gender and pronouns … In the conversations that I had with other professionals, it’s trying to make sure that people are appropriately aware. (#14, Speech Language Pathologist)

Others mentioned how inter-professional communication and collaboration played a role in providing gender-sensitive care. For example, an occupational therapist reported:

I helped out a colleague with something when another OT was away and this client was in the process of transitioning, so they just let me know their name. We talk amongst ourselves about our caseload. We’re supportive of each other that way and I feel more comfortable with the heads-up going to see them. So, that I was prepared and knew what their name … It’s more how to address them. That’s the most important for me. (#6)

Another clinician, a physiotherapist, shared a similar experience: “I am fortunate to work on a team that’s very collaborative. So, whether it’s looking at something that’s gender-sensitive or some other psychosocial issue, it’s sort of ingrained that we’re inherently communicating with all of the people who are involved in that individual’s care … If there are issues, we’re communicating with each other that way” (#12, Physiotherapist).

Patient advocacy

A fourth key theme for providing gender-sensitive care involved patient advocacy. Clinicians identified that a critical component in providing a gender-sensitive care approach involved advocating for patients’ gender-based needs and the importance of respecting diverse identities. One clinician explained,

Even though I do respect queer people and allies and advocates who are not polite and civil in educating people, I do try to take that role and I’m not always super friendly when people are doing things that are disrespectful and unkind to me … but I do try to say, you may not have been aware the you’re using is actually harmful. Can I have a conversation about why that is and then we can talk about how to do it properly? (#20)

Meanwhile, a physiotherapist (#22) similarly reported having to intervene with other health care providers who were not as supportive or understanding of nonbinary patients and advocating for them. Additionally, others explained that it was imperative to advocate for their patients in helping to address their gender-specific needs. For example, they shared, “If I feel that a patient is interested in a gender non-conforming activity, then reaching out to my colleagues to make it happen to help them participate in that activity” (#8, physiotherapist). In summary, advocacy was a key theme in providing gender-sensitive care.

Discussion

This study explored clinicians’ strategies for providing a gender-sensitive care approach within pediatric rehabilitation. Developing a better understanding of gender-sensitive care is critical for optimizing patient health outcomes and could help to address health inequities resulting from gender relations, perceptions, and norms that may cause challenges with recognizing symptoms and seeking timely health services [64,74]. Research demonstrates that having knowledge about gender is associated with more positive attitudes and enhanced patient care [25,75,76].

Our findings highlighted the following strategies that clinicians had in providing gender-sensitive care: (1) awareness of gender biases and not making assumptions; (2) recognizing gender-based vulnerabilities; (3) respecting patient values, preferences and needs; and (4) patient advocacy. In regards to being aware of gender biases and not making assumptions, acting in such a way is imperative because stereotypes and gendered attitudes could
influence health care decisions [77]. For example, research shows that lacking knowledge in gender-sensitive approaches and having biases is linked with health inequities and discrimination that could adversely affect health outcomes [78–80]. Further, some research emphasizes that it is critical for health care providers to be self-aware as a gendered person and particularly how one’s own gender contributes to the treatment of patients [80]. Indeed, self-awareness and personal reflection concerning the influences of one’s own communication, judgments, responses and behaviour can affect the delivery of gender-sensitive care [30].

Surprisingly few participants in our sample described how biases within the health system may have influenced their practice of gender-sensitive care and therefore, is an area deserving further exploration. Some research emphasizes that gender relations are often shaped by the structures in which they occur [81]. Indeed, there are often different social role expectations for men, women and nonbinary individuals that could affect rehabilitation outcomes [77]. Additionally, attitudes about femininity and masculinity might differ within rehabilitation organizations [77] and could interact with the gender composition of the health care workforce [82,83]. It is particularly crucial to consider gendered biases within pediatric rehabilitation, given the disproportionate number of clinicians who are women, and patients who are boys/young men.

A second key strategy that our study highlighted in providing gender-sensitive care involved recognizing gender-based vulnerabilities. These findings align with other research underscoring the importance of considering gender differences in the incidence and clinical presentation of disease so that treatments can be tailored for optimum health outcomes [30]. Additionally, it is essential for health care providers to acknowledge that gender norms and expectations start early in life and can shape individual health behaviours, having critical consequences for how children cope with their condition throughout the life course [42,45,84,85]. Understanding gender differences and gender-based health vulnerabilities (e.g., pain perception, depression, suicide risk) could help to enhance gender-specific and gender-sensitive care, which are core components of patient-centered medicine [3].

Other strategies that clinicians mentioned in providing gender-sensitive care involved respecting patient values, preferences and needs along with patient advocacy. These results align with the patient-centered care [31] and culturally sensitive care models that outline the importance of being aware of one’s own values, biases and power differences with patients while understanding their values and priorities [86–88]. Recognizing the gendered socialization of roles and identities is salient because some research shows that male and female patients are treated differently despite other factors being equal—suggesting that some health care providers could be making decisions based on stereotypes [56,57]. Future research should explore this in further depth, especially parental influence and preference for gendered expectations and roles.

Respecting patient values, preferences and needs parallels with the principles of patient-centered care, which requires clinicians to be open to information from patients about their needs, expectations and preferences, while also listening and respecting them [31]. Research indicates that communication plays a critical role in therapeutic sessions, ongoing patient-clinician relationships and patient satisfaction [31,89]. Communicating effectively allows clinicians to understand patients’ needs and priorities, which can enable them to tailor their recommendations [31,90]. Further, studies highlight that working collaboratively, building trust and rapport, active listening, providing education combined with a flexible approach can help with effective communication and engagement [31,91]. In our study, we found that clinicians recognized the role of effective communication in gender-sensitive care, both with patients and inter-professionally with other clinicians. This emphasis on effective communication with patients, is aligned with culturally competent care, family centered care and interprofessional collaborative care (e.g., openness, respect, inclusion and shared understanding of roles), all of which are linked to increased positive health outcomes and patient satisfaction [92,93]. Our findings also align with Kattari et al.’s study that highlighted the importance of creating inclusive and respectful environments [94]. They found that transgender and nonbinary individuals who had a health care provider who was ‘transgender inclusive’ were significantly less likely than those whose providers were not inclusive to have had suicidal ideations and depression [94].

Our findings also underscored the importance of clinicians advocating for patients, particularly those from sex and gender minority groups. Advocacy is a way of helping to improve health equity [95]. Other research similarly shows that clinicians should advocate for evidence-based, anti-bullying policies on the basis of sexual orientation and gender identity [96]. Collaboration between health care providers is also needed to make a lasting change in addressing gender-sensitive care within pediatrics [96]. Research indicates that effective advocacy should include persistent efforts to raise awareness and understanding of the critical role of the social determinants of health (including gender) [95]. Education on the role of gender in health care, with particular attention to those who are socially excluded and minority groups who are vulnerable to poor health, could be embedded as part of health care training [27,95].

Strategies for providing gender-sensitive care and implications for rehabilitation

Our findings highlight several potential implications for gender-sensitive care strategies that could be useful within the context of pediatric rehabilitation. First, more education and training in gender-sensitive care is needed. Although there was a strong interest in this topic, most clinicians within our sample had limited training in gender-sensitive care (see [63] for further details on recommended formats and content of training). Clinicians should consider engaging in relevant training (e.g., gender-sensitive or equity, diversity and inclusion) to help avoid bias and stereotypes while aiming to create safe, inclusive, and respectful environments, particularly for patients who identify as nonbinary or transgender [97]. Having sufficient knowledge and training in gender-sensitive care could help increase clinicians’ confidence in working with gender-diverse clients and their awareness of the risks for minority groups (e.g., higher risk of depression and suicide) [98]. As part of an education and training plan, health care organizations could consider having a gender champion or mentor that others could seek support from when they need advice related to gender-sensitive care. Additionally, some evidence suggests that it could be worthwhile to embed gender-sensitive care within person-centered care [32] or within existing health education programs [27]. Having a standard training program could help health care providers to have a shared understanding of terminology and the common gender-based vulnerabilities for the particular patient groups they are working with.

A second potential strategy for enhancing gender-sensitive care involves affirming names and pronouns at beginning of each visit, in handoffs and in the electronic health record. Other
research indicates that failing to identify the correct name and pronoun within a medical setting can impact quality of care and patient satisfaction [99]. Therefore, having a medical documentation system that captures gender-diversity (i.e., name, pronoun, gender identity) could help to avoid potentially misgendering a patient, and consequent stress or stigma [4]. Applying such a strategy also aligns with the World Professional Association for Transgender health [100]. It is noteworthy that affirming name and pronoun may require extra care within a pediatric setting where parents are often present in an appointment and may not yet be aware of their child’s gender identity [101].

Limitations and future directions
The limitations of our study include that the research was conducted at only one site and it was not the intention of this exploratory research to be representative of other locations. Further, most of the participants were female. Even though this is reflective of the gendered nature of the pediatric rehabilitation profession [40], future studies should consider purposively recruiting more males and nonbinary participants. It is also important to recognize that some participants confused the terms sex and gender; however, we felt it was essential to report their verbatim quotes. Further research should unpack sex and gender-sensitive care in further depth. Some qualitative researchers might consider our average interview length to be relatively short; however, our interviewers were highly trained and experienced not only with qualitative research but also with the topic. Future studies should consider the impact of gender-sensitive care on health outcomes and patient satisfaction. More research is needed to better understand the role of parents and family in practicing gender-sensitive care. Additionally, future research could compare and contrast what gender issues are unique to the rehabilitation context compared to general pediatrics and differential exposures, vulnerabilities to disability, gender-differences in rehabilitation services. Finally, it would be worthwhile to better understand the role of the intersection of culture and gender-sensitive care.

Conclusion
Improving our understanding of the strategies that health care providers use to offer a gender-sensitive care approach is important for helping to address health disparities and improve patient outcomes. Our findings revealed that the following themes were important strategies in providing gender-sensitive care: (1) awareness of gender biases and not making assumptions; (2) recognizing gender-based vulnerabilities; (3) respecting patient values, preferences and needs; and (4) advocacy.

Acknowledgement
We would like to thank the participants involved in the study and the TRAIL lab staff for their support in this project.

Disclosure statement
No potential conflict of interest was reported by the author(s).

Funding
Funding for this study was provided, in part, by the Canadian Institutes of Health Research and Social Sciences and Humanities Research Council (CIHR-SSHRC) Partnership grant and the Kimel Family Fund through the Holland Bloorview Kids Rehabilitation Hospital.

ORCID
Sally Lindsay http://orcid.org/0000-0002-5903-290X
Kendall Kolne http://orcid.org/0000-0002-4125-1362

References
[1] Heidari S, Babor T, Castro P, et al. Sex and gender equity in research: rationale for the SAGER guidelines and recommended use. Res Integr Peer Rev. 2016;1:2–9.
[2] Phillips S. Defining and measuring gender: a social determinant of health whose time has come. Int J Equity Health. 2005;4:11.
[3] Tannenbaum C, Greaves L, Graham I. Why sex and gender matter in implementation research. BMC Med Res Methodol. 2016;16(1):145.
[4] Coen S, Banister E. What a difference sex and gender make: a gender, sex and health research casebook. Ottawa: CIHR; 2012.
[5] Liszewski W, Peebles K, Yeung H, et al. Persons of nonbinary gender - awareness, visibility, and health disparities. N Engl J Med. 2018;379(25):2391–2393.
[6] Bauer G, Braimoh J, Scheim A, et al. Transgender-inclusive measures of sex/gender for population surveys: Mixed-methods evaluation and recommendations. Plos One. 2017;12(5):e0178043
[7] Bauer G. Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity. Soc Sci Med. 2014;110:10–17.
[8] van der Meulen F, Fluit C, Albers M, et al. Successfully sustaining sex and gender issues in undergraduate medical education: a case study. Adv Health Sci Educ Theory Pract. 2017;22(5):1057–1070.
[9] Baggio G, Corsini A, Floreani A, et al. Gender medicine: a task for the third millennium. Clin Chem Lab Med. 2013;51(4):713–727.
[10] Dielissen P, Bottema B, Verdonk P, et al. Attention to gender in communication skills assessment instruments in medical education: a review. Med Educ. 2011;45(3):239–248.
[11] Janssen S, Lagro-Janssen A. Physician’s gender, communication style, patient preferences and patient satisfaction in gynecology and obstetrics: a systematic review. Patient Educ Couns. 2012;89(2):221–226.
[12] Hariz G, Hariz M. Gender distribution in surgery for Parkinson’s disease. Parkinsonism Relat Disord. 2000;6(3):155–157.
[13] Karim F, Islam A, Chowdhury A, et al. Gender differences in delays in diagnosis and treatment of tuberculosis. Health Policy Plan. 2007;22(5):329–334.
[14] Arber S, McKinlay J, Adams A, et al. Patient characteristics and inequalities in doctors’ diagnostic and management strategies relating to CHD: a video-simulation experiment. Soc Sci Med. 2006;62(1):103–115.
[15] World Health Organization. World Health Organization gender responsive assessment scale: criteria for assessing programs and policies. WHO Gender mainstreaming manual for health managers: A practical approach. Geneva:
2010. http://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf

[16] Briones-Vozmediano E, Vives-Cases C, Peiró-Pérez R. Gender sensitivity in national health plans in Latin America and the European Union. Health Policy. 2012; 106(1):88–96.

[17] World Health Organization. Integrating gender perspectives in the work of WHO. Geneva: World Health Organization; 2002.

[18] Tannenbaum C, Clow B, Haworth-Brockman M, et al. Sex and gender considerations in Canadian clinician practice guidelines: a systematic review. Can Med Assoc J Open. 2017;5(1):E66–E73.

[19] Coen S, Banister E. What a difference sex and gender make: a gender, sex and health research casebook. Ottawa (Canada): Canadian Institutes of Health Research. 2012.

[20] Commission. E. Promoting gender equality in research and innovation. 2014. https://ec.europa.eu/programmes/horizon2020/en/h-section/promoting-gender-equality-research-and-innovation

[21] Lindsay S, Cagliostro E, Albarico M, et al. Gender matters in the transition to employment for young adults with physical disabilities. Disabil Rehabil. 2019;41(3):319–332.

[22] Lindsay S, Cagliostro E, Albarico M, et al. A systematic review of the role of gender in securing and maintaining employment among youth and young adults with disabilities. J Occup Rehabil. 2018;28(2):232–251.

[23] Lindsay S, Proulx M, Maxwell J, et al. Gender and transition from pediatric to adult health care among youth with acquired brain injury: experiences in a transition model. Arch Phys Med Rehabil. 2016;97(2 Suppl):S33–S39.

[24] Regitz-Zagrosek V. Sex and gender differences in health. EMBO Rep. 2012;13(7):596–603.

[25] Celik H, Lagro-Janssen TALM, Widdershoven GGAM, et al. Bringing gender sensitivity into healthcare practice: a systematic review. Patient Educ Couns. 2011;84(2):143–149.

[26] Verdonk P, Benschop Y, De Haes H, et al. Medical students’ gender awareness. Sex Roles. 2008;58(3–4):222–234.

[27] Lindsay S, Rezai M, Kolne K, et al. Exploring outcomes of gender-sensitivity educational interventions for healthcare providers: a systematic review. Heal Educ J. 2019;78(8):958–976.

[28] deKleijn M, Lagro-Janssen ALM, Canelo I, et al. Creating a roadmap for delivering gender-sensitive comprehensive care for women Veterans: results of a national expert panel. Med Care. 2015;53(4 Suppl 1):S156–S164.

[29] Kristoffersson E, Andersson J, Bensg C, et al. Experiences of the gender climate in clinical training - a focus group study among Swedish medical students. BMC Med Educ. 2016;16(1):283–294.

[30] Miers M. Developing an understanding of gender sensitive care: exploring concepts and knowledge. J Adv Nurs. 2002;40(1):69–77.

[31] King G, Desmarais C, Lindsay S, et al. The roles of effective communication and client engagement in delivering culturally sensitive care to immigrant parents of children with disabilities. Disabil Rehabil. 2015;37:1362–1371.

[32] Macke K, Hasler G. Why should person-centred facilitating be gender-sensitive? Person-Centered Experiential Psychother. 2019;18(4):360–366.

[33] O’Dwyer C, Tarzia L, Fernbacher S, et al. Health professionals’ perceptions of how gender sensitive care is enacted across acute psychiatric inpatient units for women who are survivors of sexual violence. BMC Health Serv Res. 2019;19(1):990–1001.

[34] Hendricks M, Testa R. A conceptual framework for clinical work with transgender and gender nonconforming clients: an adaptation of the minority stress model. Prof Psychol Res Prof. 2012;43(5):460–467.

[35] Hendriks B, Vandenberghe AM-JA, Peeters L, et al. Towards a more integrated and gender-sensitive care delivery for victims of sexual assault: key findings and recommendations from the Belgian sexual assault care centre feasibility study. Int J Equity Health. 2018;17(1):152–162.

[36] Brunner J, Cain C, Yano E, et al. Local leaders’ perspectives on women veterans’ health care: What would ideal look like? Womens Health Issues. 2019;29(1):64–71.

[37] Hanafy S, Amodio V, Haaf H, et al. Is it prime time for sex and gender considerations in traumatic brain injury? Perspectives of rehabilitation care providers. Disabil Rehabil. 2020;23:1–9.

[38] Rahmanian F, Nazarpour S, Simbar M, et al. Needs assessment for gender sensitive reproductive health services for adolescents. Int J Adolesc Med Heal. 2020. DOI:10.1515/ijamh-2017-0201

[39] Bloorview H. Dear everybody: your impact matters–2017–2018 impact report. Toronto (Canada): Holland Bloorview Kids Rehabilitation Hospital; 2018.

[40] Information ClifH. Canada’s health care providers: provincial profiles, 2008–2017. Ottawa (Canada): Canadian Institute for Health Information; 2019.

[41] Statistics Canada. Canadian Survey on Disability, 2017. Ottawa: Statistics Canada; 2018.

[42] McMillan I. Gender-sensitive services vital for women with mental health problems. Learn Disabil Pract. 2008;11(6):7–9.

[43] Milligan M, Neufeldt A. The myth of asexuality: a survey of social and empirical evidence. Sexual Disabil. 2001; 19(2):91–109.

[44] Shah S. Disabled people are sexual citizens too: supporting sexual identity, well-being and safety for disabled young people. Front Educ. 2017;2(46):1–5.

[45] Toft A, Franklin A, Langley E. Young disabled and LGBTþ: negotiating identity. J LGBT Youth. 2019;16(2):157–172.

[46] Abbott D, Carpenter J, Gibson B, et al. Disabled men with muscular dystrophy negotiate gender. Disabil Soc. 2019; 34(5):683–703.

[47] Powers K, Hogansen S, Reilly C, et al. Gender matters in transition to adulthood: a survey study of adolescents with disabilities and their families. Psychol Schs. 2008; 45(4):349–364.

[48] Bult MK, Verschure O, Jongmans MJ, et al. What influences participation in leisure activities of children and youth with physical disabilities? A systematic review. Res Dev Disabil. 2011;32(5):1521–1529.

[49] Imms C, Reilly S, Carlin J, et al. Characteristics influencing participation of Australian children with cerebral palsy. Disabil Rehabil. 2009;31(26):2204–2215.

[50] Law M, King G, King S, et al. Patterns of participation in recreational and leisure activities among children with complex physical disabilities. Dev Med Child Neurol. 2006; 48(5):337–342.
[89] Pelzang R. Time to learn: understanding patient-centred care. Br J Nurs. 2010;19(14):912–917.
[90] King G, Baxter D, Rosenbaum P, et al. Belief systems of families of children with autism spectrum disorder or Down syndrome. Focus Autism Other Dev Disabl. 2009; 24(1):50–64.
[91] Lequerica A, Donnell C, Tate D. Patient engagement in rehabilitation therapy: physical and occupational therapist impressions. Disabil Rehabil. 2009;31(9):753–760.
[92] Rosenbaum P, King S, Law M, et al. Family-centred service: a conceptual framework and research review. Phys Occupat Ther Pediatr. 1998;18(1):1–20.
[93] Fellin M, Desmarais C, Lindsay S. An examination of clinicians’ experiences of collaborative culturally competent service delivery to immigrant families raising a child with a disability. Disabil Rehabil. 2015;37(21): 1946–1954.
[94] Kattari S, Walls N, Speer S, et al. Exploring the relationship between transgender-inclusive providers and mental health outcomes among transgender/gender variant people. Soc Work Health Care. 2016;55(8):635–650.
[95] Farrer L, Marinetti C, Cavaco Y, et al. Advocacy for health equity: a synthesis review. Milbank Q. 2015;93(2):392–437.
[96] Earnshaw V, Reisner S, Juvonen J, et al. LGBTQ bullying: TRanslating research to action in pediatrics. Pediatrics. 2017;140(4):e20170432.
[97] Lombardi E. Enhancing transgender health care. Am J Public Health. 2001;91(6):869–872.
[98] Veale J, Watson R, Peter T, et al. Mental health disparities among Canadian transgender youth. J Adolesc Health. 2017;60(1):44–49.
[99] Mizock L, Lewis T. Trauma in transgender populations: risk, resilience, and clinical care. J Emotional Abuse. 2008; 8(3):335–354.
[100] Deutsch M, Green J, Keatley J, et al. Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR working group. J Am Med Inform Assoc. 2013;20(4):700–703.
[101] Lindsay S, Kolne K, Rezai M. Challenges with providing gender-sensitive care: exploring experiences within a pediatric rehabilitation hospital. Disabil Rehabil. 2020. DOI:10.1080/09638288.2020.1781939