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Editorial: Sex, Gender and Nursing

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The aim of this editorial is to raise awareness and provoke discussion about the issues of sex and gender in nursing. Here we provide a brief summary of a complex and challenging area. This topic has been the subject of significant heated debate on social media and has, more recently, come to the fore in more mainstream media and throughout sections of academia - prompting increasingly polarised discussion. It is now an issue where deeply held views are evident - some quite entrenched. We have begun to see some of this spilling over into the healthcare environment. It is an issue that nurses cannot ignore, and one that nurse clinicians, academics, researchers and policy makers urgently need to engage with.

Sex and gender as distinct concepts

For many, perhaps even most nurses, sex and gender are interesting, yet unproblematic concepts. Typically, sex is taken to refer to a biological reality which is observed at birth and distinguishes between male and female – normally on the basis of external genitalia, but which can also be determined at the biochemical and chromosomal level and on the basis of internal and external organs. A check of recent anatomy and physiology texts aimed at nurses, for example, Peate and Nair (2015) will quickly confirm this. Those with a knowledge of people who identify as

intersex will rightly point out that this picture does not account for that small groups whose sex organs do not conform to this picture – Dreger's (2017) work provides a helpful overview of this area and a compelling account of the injustices done to intersex people over time and by the medical establishment. While the existence of intersex people is evidence that the simple male/female binary does not account for all sex difference, it does not fundamentally alter the biological basis of sex.

In contrast to sex, gender is a relatively new concept which was adopted by feminism and women's studies in the 1970's and 1980's (Pluckrose and Lindsay 2020) to distinguish between biological sex and stereotypical behaviours and roles which were associated with male and female behaviour – the masculine and feminine. Before gender, these behaviours were generally considered to be innate to biological sex. Gender theorists reframed them as socially constructed ways of being, which were deeply embedded in society and which acted as a type of 'script' into which girl and boy children were socialised and women and men played out in their day-to-day lives. While there is evidence that some aspects of masculinity and femininity do have a biological basis (Halpern 2012), generally speaking, there is consensus that much of what we see as male or female behaviour are the outcome of socially expected norms and expectations.

Until recently these notions of sex and gender have been largely uncontested in healthcare, although the fact that the terms are sometimes used interchangeably (Stonewall 2021) has resulted in confusion. Despite this, the concept of biological sex remains the basis upon which much care is offered and informs the format for service design and delivery (including health services) across the world.

We assume that, while some readers will feel our account lacks detail and nuance, most will accept it as a broadly accurate picture which conforms to clinical reality, everyday practice and forms some of the foundational blocks of nurse education.

Problematising sex and gender

As noted above, there has always been some confusion around the difference between these related, but different concepts. More recently, however, there has been significant change in how the two are both viewed and used. Put simply it is now increasingly common, and, in some circles intellectually valid to argue that the reality of biological sex – once one of the most solid and indisputable of 'facts' in healthcare - is in actuality a social construction. Proponents of this view argue against the commonly understood position that sex is observed and recorded at birth – specifically by the observation of external genitalia - in favour of a position which states that sex is assigned at birth. The former view is rooted in a biological essentialism – having a vagina indicates a female baby, while the presence of a penis marks a male child. The latter argues that the new-born's sex is not observed but is *decided* upon by a doctor and / or midwife on the basis of 'invalid' criteria. Here genitalia, and by extension other biomarkers, are incidental to the sex identity of the baby. As such they do not determine it in any real sense, rather they are evidence of ideological custom and practice.

Drawing on the work of Butler (1990) and subsequent gender theorists, those against the notion of sex as biologically determined, argue that self-identified gender is a better marker of whether one is male or female. In effect, this position conflates

sex and gender. In self-identification, the individual – not external others - identifies their gender identity / sex. This self-identification is done on the basis of subjective experience in which the person determines their identity as a man or woman on the basis of how they feel and not how they appear to others. In other words, while a person may have the outward physical appearance, internal anatomical and physiological characteristics of a male, it is their internal sense of identity which defines if they are a man or woman. The terms transgender or 'trans' are commonly applied to and used by those whose natal sex differs from their gender identity. Given the conviction with which the concept of sex as a biologically and immutable reality has been held by so many for so long, this change represents a paradigm shift in its truest sense.

These changes have created major turbulence across a number of other academic disciplines (Brunskill- Evans 2020), but curiously, nursing has remained quiet in the face of this. Perhaps our discipline has seen the impact of the debates around gender and sex on social media and decided to step away. On one level this is understandable as, at times, debate has been vicious with threats of real harm - often directed toward women - who have sought to defend what they see as their sex-based rights, which they argue are under threat as a consequence of a retreat from biological sex. The cases of the Scottish MSP, Joanna Cherry (Hollyrood 2021) and the UK academic, Kathleen Stock (Grove 2020) are illustrative of what has become a deeply polarised area. For those in any doubt about the current level of emotion and even anger surrounding this topic, the recently launched GC Academia Network (N.D.) provides personal accounts of academics who do not support the emergence of what is perceived as being a new orthodoxy. We fully acknowledge

that this is deeply troubling, but we also believe that nursing has a professional and moral responsibility to engage in a discussion which has such significant implications for our discipline.

Implications for nursing

The implications of this change for nursing practice, education and research are profound. At the most basic level, if we take the view that sex is no longer biologically determined, but is interpreted on the basis of subjective experience, then one of our most widely used ways of differentiating between people in the practice setting -biological sex - is no longer workable. This will surely impact researchers who work with sex as a significant variable. As Suissa and Sullivan (2021) have noted, if we can no longer collect reliable data on sex related health experience and needs, it will be very difficult to determine future demand and ensure that services are fit for purpose.

At a very practical level, if sex is indeed secondary to gender, clinical colleagues e should, for example, expect to see increasing numbers of men on gynaecology wards and women being treated for testicular cancer. To uphold dignity, we will also need to consider the language we use when describing and caring for people who identify as men but who have ovaries, a womb and a vagina and who can therefore become pregnant and give birth, experience menstruation and menopause and how this is framed in written policy and patient documentation. Screening programmes aimed at people on the basis of biological sex will also have to be rethought.

Traditional ways of identifying, inviting and encouraging routine screening for those at risk of developing cancers which were previously associated with only men, or women will need to be revised (Dahlen 2020).The first steps toward this new reality are already taking place in health services, for example, in the UK the terms 'chestfeeding' and 'birthing partner' have been introduced in one English NHS Trust as inclusionary alternatives to breastfeeding and 'pregnant woman' (BBC 2021). It has been argued by some that this move to 'inclusive language' - other terms include 'vulva havers', 'menstruators' and 'cervix havers' - is problematic in that it reduces women to a list of their body parts (Vigo 2020). There is also concern that vulnerable groups, such as people with learning disabilities who already experience health inequality, may struggle to understand new terminology if it isn't clear and simple.

Language is not the only thing which may need to change in order to accommodate these developments. This will require sensitivity and skill on the part of both service planners and clinical staff. In order to prepare for these changes in practice, change will also have to occur in the classroom. Given what we already know about sex and gender normativity in nurse education programmes (MaCann & Brown 2018, McCann & Brown 2020), it seems likely that education and continuing professional development will be needed. It is also highly probable that development opportunities will also need to be provided for academic staff delivering this material.

Perhaps the most challenging issues arising from this reframing of sex and gender lie in the ethical problems it presents. To date, the response of many healthcare workers and organisations has been one of uncritical support for individuals who have declared a gender identity, which does not match their natal sex. This is

admirable, insofar as nurses should always be prepared to speak up in support of those they believe are marginalised. However, an uncritical approach to affirmation may neglect some of the legal and ethical practice implications that are likely to increasingly impact nursing care and treatment. These include criticisms of the use of puberty blockers for young people who express feelings of gender dysphoria (Pilgrim & Entwhistle 2020), and the associated issue of consent to potentially irreversible life changing treatment such as surgical removal of healthy tissue for those who seek physical transition. For those who do not share the view that gender self-identification is an acceptable alternative to biological sex, there is also concern about the impact on single sex, safe spaces for women and the option to request care by a female professional. Given what we understand of domestic abuse and sexual violence as predominantly male crimes, vulnerable female patients, will still require sensitive care and consideration in policy and decision making to ensure their preferences are upheld.

Nurses will also need to consider the fact that some of those who transition subsequently go on to detransition, (Butler & Hutchinson 2021, Entwhistle 2021) and that support for these people is currently very poor. It is essential therefore that our profession gives serious thought to developing the existing evidence base due to the ethical implications in this area of practice. At the very least we need to prepare nurses to be able to talk with, support and help guide those who are struggling to make sense of feelings of gender dysphoria so that they make fully informed choices on decisions, which in some cases will last a lifetime and will require ongoing medical treatment and intervention. These are likely to be some of the most difficult conversations.

It would be tempting to think that these conversations will be managed by someone else with a specialist knowledge. The reality, however, is that any nurse may be asked for support or help, with the practice, community or mental health nurse equally likely to encounter the dysphoric person. Preparation for these conversations needs to take place in our classrooms and skills labs if we are to meet the needs of patients and future nurses. We suggest that, beyond this, there is an urgent need to develop the evidence base for nursing practice in this area, in order to adequately inform nurses in providing the safest and highest quality advice, care and treatment to gender dysphoric, trans gender and non-binary people.

Conclusion

We are vehemently opposed to discrimination and marginalisation of any person based on sex, gender identity or any other characteristic. We believe that everyone should be able to access health and other services without fear of discriminatory practices or experiences. However, if this is to happen, nursing needs to engage in the conversation that has been taking place, and often raging, in other disciplines. It has profound implications for how we practice, teach and research. Unless we become active players, we will be at best observers and more likely confused followers in a debate around this most fundamental of health variables. This is a topic that will likely require significant discussion over the coming years, and we hope that this editorial may serve as an invitation to begin exploring the legal, ethical and practical implications of the paradigm shift in relation to sex and gender. We hope it will also highlight the urgency of this, as is the need for development of a robust evidence base.

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