NCSA 2024 Himes Undergraduate Student Paper Award Winner: The Failure of the Veteran Affairs: Transgender Discrimination and Virtue Signaling

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Abstract
The Veteran Affairs (VA) created the directive now known as Directive 1341 in 2011 to establish policy and extend healthcare out to transgender and intersex veterans. Although the goal was to facilitate better access to care among this population, access was still lacking after the creation of the directive. Moreover, discrimination and lack of competent providers was a major issue within healthcare settings. This paper aimed at evaluating the effectiveness of the directive and the impact that it had on transgender veterans, suggesting that the directive could be a sign of virtue signaling. More studies are needed on this issue, as research is quite sparse on the topic. Although creating this directive may have suggested virtue signaling, the VA should address these gaps in healthcare, as well as discrimination within healthcare settings.

Keywords: Transgender; Veteran; Healthcare; Veteran Affairs; Gender-affirming care

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How much does the Veteran Affairs (VA) really care about their transgender veteran patients? Do they truly care for their patients? Or is it all a facade to gain a good reputation from society? First, I will be discussing the directive created by the VA and the policy established by it. Second, I will be discussing the experiences of patients who sought care from the VA. Third, I will be stating why care for transgender veterans is imperative due to the prevalence of suicide related events. Fourth, I will describe what virtue signaling is and why the VA could be participating in it. And finally, I will point out the present day state of VA care for transgender veterans.

In the 2000s, Massachusetts, Connecticut, Iowa, Vermont, Washington D.C., and New Hampshire legalized gay marriage in the United States. Then, in 2011, New York followed, along with many states who also followed until 2015. Throughout this time frame, the conversation on the rights of people in the LGBTQIA+ community was in full swing. and their rights were highly debated.

In June of 2011, the VA contrived a directive. The directive was put in place to establish policy for the delivery of healthcare to transgender and intersex veterans. The directive was described to provide care to patients "without discrimination in a manner consistent with care and management of all Veteran patients" (VHA Directive 1341 2018:5). Personal information of patients' transgender status was to be kept confidential. Also, it was stated that hormone treatments, mental healthcare, routine checkups, preoperative evaluation, post-operative care, and any other transition-related treatments that were medically necessary would be provided, except gender affirmation surgery.

Gender affirmation surgery is a broad term for these treatments: vaginoplasty and breast augmentation for patients who are transitioning from male to female (MTF), and mastectomy and phalloplasty for patients who are transitioning from female to male (FTM). Gender affirmation surgery can also include the revising of past gender affirmation surgeries for cosmetic purposes. Preoperative or postoperative evaluations or treatments are considered gender affirmation procedures, but they do not include surgical procedures. Although gender affirmation

surgeries could benefit transgender people, the VA still refrained from the surgeries themselves.

The key phrase here is "transgender people"; the only group of people under this directive who were not granted the right to have gender affirmation surgeries were transgender people. The other group of people under this directive were intersex people, and the VA made it very clear that they would allow surgery for intersex individuals (Blosnich et al. 2013). Why? The VA stated that this was the case because they wanted to "correct inborn conditions related to reproductive or sexual anatomy or to correct a functional defect" (VHA Directive 2011-024 2011:2). Through this, the VA was implying that there is a difference between transgender and intersex people, as well as implying that there's something wrong with intersex people at birth. This granted intersex people the right to gender affirming surgeries while transgender people were not.

To explain why this is an issue, I will discuss the difference between sex and gender, and also describe how intersex and transgender people are treated differently. Sex refers to the biological and physiological makeup that differentiates the sexes (hormones, reproductive organs, chromosomes, etc) (VHA Directive 1341 2018). Technically, there are 3 sexes present: male, female, and intersex. Intersex people are born with characteristics that don't tightly fit into the male and female sex boxes.

Gender is how an individual self identifies, which is separate from sex (VHA Directuce 1341 2018). Gender is not fixed at birth and can change many times throughout an individual's lifetime. Both transgender and intersex individuals are at risk in our society. One of the main issues is that transgender people usually cannot gain access to surgeries and treatments that could save their lives while intersex people (usually at birth, but can take place later in life) receive non-consensual surgery to "fix" them, or "correct" them, in the case of the VA. So, even though there is a definite difference between transgender and intersex people, there still should be equal opportunities for both of them; transgender people and intersex people should have access to gender affirming surgeries, and both groups should have the right to consent to those surgeries.

Since it is known that transgender individuals do not have access to gender affirmation surgery in the VA healthcare system, are they benefiting from the current care they do have access to? Even though some patients qualify for VA healthcare, they still do not have access to it to even benefit from it. Patients either are not aware of the care they have access to or they can't obtain care because healthcare providers are only reachable in long distances (Rosentel et al. 2016). If the patients do happen to be knowledgeable about the care they are provided, and they can access that care, they usually end up having long delays that can last for weeks or even several months. One transwoman said, "I said, I was seriously considering going full-time. I needed a referral, so my doctor at the VA put in a request. It took a few months to find someone there who was willing to work with me." (Transwoman, Air Force '70–'91)(Rosentel et al. 2016:111) All of these are known to be push factors when it comes to other veterans looking for care; most patients choose to look for care from other healthcare providers other than the VA, as a result. What also pushes patients away from the VA is the healthcare providers themselves. A trans woman Army veteran stated that she had to educate her own healthcare provider. She also claimed that her transgender status was not kept confidential in the way that the directive was put in place as policy. She said, "There's been some challenges [at the VA] as far as getting the right gender pronouns done, getting paperwork changed, getting the name change done, and that type of thing. It's been more of an administrative hassle than anything else." (Trans woman, Army '85–'05)(Rosentel et al. 2016:113).

Some healthcare providers in the VA were even reported to not be willing to work with transgender patients in the first place. In a 2017 study, sixteen trans women and five trans men were interviewed. It was found that, overall, transgender veterans were misunderstood by VA healthcare providers, which also prevented them from seeking care or continuing ongoing care (Dietert, et al. 2017). Another, very alarming issue is that patients were receiving harassment from their own healthcare providers. One trans woman even reported her care provider physically abusing her: "I went to see my primary care physician [at the VA]. It got actually physically abusive. She goes, ''How did you get these?'' and just reached out and flipped my boob. I said, 'If you ever touch me again inappropriately, there's going to be a huge problem here.' '' (Trans woman, Marine Corps, '76-'89)(Rosentel et al. 2016: 113).

Even under the directive, transgender veterans were not properly benefiting from VA healthcare as it was intended. Why is this important? In the transgender veteran population, suicide related events is a prevalent issue, and inadequate care could help these events spike. Between 2002 and 2011, Gender Identity Disorder (GID) doubled among VHA patients (Blosnich et al. 2013). A synonym of GID is Gender Dysphoria, which is when an individual feels some type of distress due to differences between their personal gender identity and gender assigned at birth (note that dysphoria is different from dysmorphia, which is when someone views that their body is abnormal in shape or size, and is not related to gender). 22.9 per 100,000 VHA veterans had GID, which was five times more than DSM-IV estimation for the

general U.S. population; 246 new diagnoses for GID were made each year. What was also higher than the general population metric in transgender veterans was suicide related events—it was estimated that 4,000 per 100,000 veterans to 5,000 per 100,000 veterans had suicide related events each year (Blosnich et al. 2013).

The fact that most transgender veterans could not even access healthcare or they received mistreatment in some way after the directive, means that it possibly did nothing to help veterans with GID, and, therefore, didn't prevent suicide related events. The fact that this was not considered soon after issues were discovered in the VA healthcare system shows that the VA possibly does not truly care for their transgender veteran patients; this could be a sign of virtue signaling on their part.

What is virtue signaling? "Virtue signaling is the act of engaging in public moral discourse in order to enhance or preserve one's moral reputation" (Westra 2021:156). Although this act can signal something positive, it isn't done in genuine good faith, but rather done to receive positive reputation and attention from others. (Westra 2021:1). Virtue signaling does more harm than good, in that it doesn't create legitimate changes or improvements in our moral system. It mostly amplified claims, expressions of outrage, and public shaming. How does this apply to the VA?

As discussed before, in the 2000s and 2010s, the rights of the LGBTQ+ community were highly debated (as well as debated today). As a result, the VA decided to come out with the 2011 directive, though the directive did no apparent good for their transgender population. Transgender people already facing harm and discrimination in the American society either could not access care, did not get care, or received mistreatments and harassment from the VA (Oblea et al. 2023; Rosentel et al. 2016). Many doctors did not even want to work with these individuals in the first place. To further explain why this could be virtue signaling, I will be describing the current state of the VA in transgender care today.

It is important to note that the VA eventually did allow gender affirmation surgeries for intersex people, as well as transgender veterans (VHA Directive 1341 2018). But according to information published in 2021, transgender veterans were still not gaining much access to these surgeries. Transgender veterans that were diagnosed with GID in the VA Northern California Healthcare System were evaluated (Agron, et al. 2021). The majority of patients (68.4% trans women, and 88.4% trans men) had not undergone surgery. On top of that, only 36.8% of trans women were seen in Dermatology clinics for gender specific needs, and only 62% had measurements of a prostate-specific antigen (PSA) (Agron, et al. 2021). There is another reason than just lack of improvement that has caused transgender veterans (along with many other members in the LGBTQ+ community) to receive poor quality healthcare or no healthcare at all.

The Don't Ask Don't Tell (DADT) policy was issued on December 21, 1993 by the Clinton Administration; it directed that military applicants would not be asked about their sexual orientation (Oblea et al. 2024). This not only caused the LGBTQ+ community in the military to be under-researched, but also caused a handful of military members to still have their identities and sexualities outed, and therefore, they were unfairly discharged. This policy was repealed in 2011 by the Obama Administration (Oblea et al. 2023). Military members discharged before the repeal of the DADT policy still did not receive the benefits they deserved. "However, the separated service members or veterans who were discharged before the repeal of DADT still must carry the burden of being identified as LGBTQ. For an entire decade following the repeal up until 2021, veterans who were discharged due to disclosure or being outed as LGBTQ were not able to access some of the essential benefits awarded to those who serve, such as GI Bill, education benefits, and access to VA healthcare." (Oblea, et al. 2022:3). This means that there were some transgender veterans out there who could not receive VA healthcare benefits in the first place, and the VA, along with our government, did nothing about it. If the VA truly cared, the 2011 directive would've raised attention to veterans who were not receiving benefits due to being wrongly outed. Therefore, with all of this in mind, it is apparent that the VA could've been simply virtue signaling during the time of the directive.

The inherent transphobia in society causes issues to transgender people, especially our veterans who don't get the treatment they deserve as people who have served our country. The field of healthcare needs people to further study this inherent issue of transphobia in our military and veteran communities to therefore fix the issues in the healthcare settings. If these issues are given publicity and further study, the large systemic issue of transphobia in U.S. healthcare in general could be combated.

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