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## Brief Report

# Intrapartum care for transgender and gender-diverse individuals: an Obstetric Anaesthetists Association (OAA) members' perspective survey (2025)

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## A B S T R A C T

**Background:** Transgender and gender-diverse individuals are increasingly accessing obstetric services, yet evidence relating to their intrapartum care remains limited. This study surveyed obstetric anaesthetists practising in the United Kingdom (UK) to explore experience, training, departmental policies, and perspectives on language and care.

**Methods:** An anonymous thirteen-question online survey was distributed to members of the Obstetric Anaesthetists' Association (OAA) in June 2025. Quantitative responses were summarised descriptively, and free-text responses were reviewed by recurring topics.

**Results:** The response rate was low (13.7%) and a total of 262 responses were analysed. Most respondents were consultants, and nearly half had more than ten years' experience. Formal training was uncommon, and almost half reported never providing intrapartum care to a transgender patient. Few reported departmental policies, and comfort levels varied. Most believed inclusive language improved care.

**Conclusions:** This survey of UK-based OAA members demonstrated gaps in experience, and systems support for transgender and gender-diverse intrapartum care, and lack of training in transgender obstetric anaesthesia care, alongside the importance of respectful, patient-centred communication.

## Introduction

Trans and gender-diverse (TGD) individuals are increasingly accessing obstetric services. The 2021 England and Wales Census reported that 0.5% of people aged 16 years and older have a gender identity that differs from their sex registered at birth.<sup>1</sup> Although this currently represents a small minority, United Kingdom (UK) primary care data demonstrates a five-fold increase in recorded transgender identity between 2000 and 2018, with the highest prevalence observed in the 16–17 and 18–29 age groups.<sup>2</sup>

We devised this Obstetric Anaesthetists' Association (OAA) survey, to sit alongside recent UK guidance<sup>3</sup> and to examine clinicians' experience, training, policies, and attitudes toward language in TGD intrapartum care.

## Methods

We conducted an anonymous 13-question online survey of UK-based OAA members between 18 June and 30 July 2025. The survey questions were developed by the study authors, informed by existing literature and

clinical experience in obstetric anaesthesia and care for TGD individuals, without patient or public involvement. The survey was distributed to 1915 members by email using a combination of single-answer and free-text questions, with recipients receiving two reminder emails. The survey explored respondents' training and seniority, clinical experience with TGD patients, exposure to training and education, and the presence of departmental policies. We also explored their confidence, comfort, and attitudes toward inclusive language and patient identity.

Free-text responses were independently reviewed by two authors (WT, KB), with recurring themes and ideas discussed with a third author (NC) to develop a descriptive framework. The analysis was descriptive and exploratory and was not designed to achieve thematic saturation.

This survey (reproduced in [supplementary appendix 1](#)) is reported in accordance with the STROBE statement.

## Ethical approval

The project was undertaken as a service evaluation and followed the internal non-research governance process, including review by the Research Department, Information Governance team, and Caldicott

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0959-289X/© 2026 Elsevier Ltd. All rights are reserved, including those for text and data mining, AI training, and similar technologies.

Guardian. Confirmation was obtained from the Health Research Authority that formal HRA approval was not required, as participants were approached via the OAA membership list, participation occurred outside NHS clinical activity, and no NHS patients or resources were involved.

## Results

The survey response rate was 13.7% (262/1915). Respondents were predominantly senior clinicians, with demographic characteristics summarised in [Table 1](#).

### Experience, training, and support

Clinical experience with TGD individuals was limited, characterised by low levels of formal training, infrequent exposure, and poor awareness of departmental policies. In structured survey responses, around one quarter of respondents reported uncertainty or lack of awareness of local guidance, which was corroborated by qualitative comments from approximately 22 of 84 respondents. Full survey responses are shown in [Table 2](#). Among those providing written comments, approximately one third reported no prior experience of providing intrapartum care to transgender patients. The rarity of clinical encounters was frequently emphasised, with one respondent noting that “in 17 years as a consultant this has never come up.”

Respondents also identified practical barriers, including limitations of electronic health record systems and challenges accommodating patient needs within existing ward infrastructure.

### Attitudes to inclusive language and comfort in delivering care

Respondents reported varying levels of comfort in providing intrapartum care to TGD patients, and expressed differing views on inclusive language, from routine use of gender-neutral terminology to tailoring language to individual patients.

Qualitative comments expanded upon these perspectives. A small minority of respondents, approximately 5–10%, expressed concern that focusing on language during acute care could detract from clinical priorities, noting that “thinking more about the language than the anaesthetic care you are providing becomes distracting and potentially unsafe.” No respondents reported specific adverse events or compromised care related to language use.

Despite this, approximately two thirds of comments emphasised professionalism, respect, and a willingness to adapt language to individual preferences, highlighting the importance of asking patients directly and documenting choices clearly.

### Suggestions for improvement

Respondents' comments emphasised the importance of tailoring communication to individual patients, rather than mandating gender-

**Table 1**  
Respondent characteristics (n=262).

Characteristic	n (%)
Clinical grade (n = 262)	
Consultant	211 (80.8)
Resident doctor/trainee	36 (13.8)
Specialty doctor	7 (2.7)
Associate specialist	5 (1.9)
Clinical fellow	2 (0.8)
Years in current role (n = 260)	
>10 years	125 (48.1)
5–10 years	71 (27.3)
2–5 years	46 (17.7)
<2 years	18 (6.9)

**Table 2**

Survey responses on experience, training, policies, comfort, and attitudes.

Question	Response	n (%)
Relevance of knowing sexual orientation or gender identity	Yes	173 (66.8)
	No	41 (15.8)
	Unsure	41 (15.8)
	Prefer not to answer	4 (1.5)
Received formal training in transgender care	Yes	46 (17.7)
	No	214 (82.3)
Frequency of intrapartum care for transgender and gender-diverse patients	Never	122 (46.6)
	Rarely (1–2 times)	100 (38.2)
	Occasionally (3–5 times)	36 (13.7)
	Frequently (6 + times)	4 (1.5)
Departmental policy for transgender and gender-diverse care	Yes	14 (5.3)
	No	103 (39.3)
	Unsure	145 (55.3)
Comfort providing intrapartum care	Very comfortable	40 (15.3)
	Somewhat comfortable	79 (30.3)
	Neutral	100 (38.3)
	Somewhat uncomfortable	37 (14.2)
	Very uncomfortable	5 (1.9)
Use of inclusive language in practice	Always	29 (11.1)
	With exceptions	91 (34.7)
	Only for transgender and gender-diverse patients	71 (27.1)
	Unsure	64 (24.4)
	Not at all	7 (2.7)
Perceived impact of inclusive language on care	Greatly improves	64 (24.4)
	Somewhat improves	130 (49.6)
	Neutral	45 (17.2)
	Somewhat worsens	19 (7.3)
	Greatly worsens	4 (1.5)

neutral language for all encounters. One respondent noted that “each patient will have own particular circumstances and different needs, wishes and preferences,” and that care should be adjusted accordingly.

A small minority (approximately 5–8%) expressed strongly oppositional views, questioning the relevance or legitimacy of TGD care within obstetric anaesthesia. These comments were uncommon and contrasted with the majority of responses.

## Discussion

This 2025 survey of UK OAA members reveals limited clinical experience and training in TGD intrapartum care, alongside concerns

about guidance and systems support. These findings should be interpreted in the context of a low response rate (13.7%) and a predominantly senior respondent group. Participation was voluntary and interest-dependent, raising the possibility of responder bias and over-representation of clinicians with stronger pre-existing views. Nearly half of respondents reported more than 10 years in their current role, which may have influenced both reported experience and attitudes. Consequently, the views captured may not reflect contemporary training or experiences among more junior obstetric anaesthetists.

Clinical experience in obstetric anaesthesia care for TGD individuals was limited among respondents, and reported confidence, discomfort, and views on language should be interpreted cautiously. These findings nevertheless highlighted concerns and uncertainties that align with themes described in the existing literature, including psychological safety, engagement with maternity services, and wider perinatal inequities for TGD people.<sup>4</sup>

The 2024 guidance<sup>3</sup> consolidates earlier recommendations aimed at addressing gaps in knowledge, training, and systems of care for TGD individuals receiving obstetric anaesthesia care. This includes documentation practices, education and simulation, and departmental policy development as well as the universal adoption of gender-inclusive language.<sup>3</sup> Respondents, however, favoured an additive approach that retains familiar terminology while introducing inclusive options. Together, these perspectives highlight the need to understand how different implementation strategies work in practice and how they influence patient experience and clinical outcomes. Despite differing approaches, both aim to support respectful and safe care.

Prior work has highlighted challenges related to documenting gender identity, clinicians' confidence in communication, and the importance of clear and consistent recording practices to support safe care.<sup>5-9</sup> Ongoing debates about language in perinatal services reflect wider tensions: some authors caution that removing sex-specific language may reduce clinical clarity,<sup>10</sup> whereas others argue that inclusive terminology can remain precise when supported by explicit definitions and anatomical detail.<sup>11</sup> Qualitative studies describe practical and cognitive barriers to inclusive language use in clinical settings and suggest these may be mitigated through education and clearer documentation practices.<sup>9,12</sup>

Although some respondents expressed concerns about obscuring clinical facts, wider literature indicates that disengagement from maternity care among TGD individuals is more commonly associated with discrimination, misgendering, and inconsistent access to appropriate services.<sup>13</sup>

Although uncommon, openly hostile comments underscore the need for governance processes that ensure respectful, discrimination-free care. Looking ahead, demographic trends suggest that scepticism underestimates future need. National data shows younger cohorts are more likely to identify as transgender or non-binary, implying increasing encounters with TGD individuals as this cohort ages into parenthood.<sup>1,2</sup>

A prominent message was the need for structured education and nationally endorsed guidance, alongside practical tools to support documentation, handover, multidisciplinary training, and communication in clinical situations. The Royal College of Obstetricians and Gynaecologists has acknowledged the importance of inclusivity whilst affirming that established terms such as "women" will continue in guidelines to maintain clarity for the majority of service users.<sup>14</sup> This approach reflects respondents' preference for individualised language, rather than uniform changes applied to all encounters.

Several limitations should be considered when interpreting these findings. The response rate was low, at 13.7%, compared with a typical OAA survey response rate of approximately 30%, limiting generalisability. Participation was voluntary and interest-dependent, and respondents may therefore represent a self-selected subgroup with stronger views than the wider population of obstetric anaesthetists. The senior-heavy sample further limits generalisability and means that the perspectives of more junior clinicians, who may have received more

recent training in TGD health care, are underrepresented. As a result, the findings should not be interpreted as representative of all OAA members, nor of UK obstetric anaesthetic practice as a whole. One survey question conflated sexual orientation and gender identity, restricting interpretation of that item. All experience was self-reported, and true clinical exposure to TGD patients may therefore have been under- or over-estimated. In addition, as more than half of respondents reported no or minimal direct clinical experience with TGD individuals, some views expressed are likely to reflect anticipated challenges or opinions rather than experience-informed clinical practice. Finally, the survey format did not allow exploration of the reasons underlying negative attitudes, which limits their interpretation.

## Conclusions

This survey of UK-based OAA members demonstrates gaps in experience, structural support, and lack of training in TGD obstetric anaesthesia care, alongside the importance of respectful, patient-centred communication.

Improving care for TGD obstetric patients will require nationally endorsed guidance, supported by practical education and systems that enable clear documentation and communication of patient preferences.

## CRediT authorship contribution statement

**William Turner:** Writing – review & editing, Writing – original draft, Validation, Software, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Kat Butler:** Writing – review & editing, Methodology, Formal analysis, Data curation, Conceptualization. **Nuala Coyle:** Writing – review & editing, Methodology, Data curation, Conceptualization.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijoa.2026.104851>.

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