BMJ Open

Perceptions of occupational physicians in supporting transgender and gender-diverse people (returning) at work — a focus group study: *The uncharted territory of gender-diverse occupational healthcare*

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To cite: Van de Cauter J, Motmans J, Van de Velde D, *et al*. Perceptions of occupational physicians in supporting transgender and gender-diverse people (returning) at work — a focus group study: *The uncharted territory of gender-diverse occupational healthcare*. *BMJ Open* 2025;**15**:e083604. doi:10.1136/bmjopen-2023-083604

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (https://doi.org/10.1136/bmjopen-2023-083604).

Received 22 December 2023
Accepted 10 February 2025

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ABSTRACT

Objectives This study aimed to explore the role of occupational physicians (OPs) in supporting transgender and gender-diverse (TGD) workers during gender transition and return to work (RTW) following gender-affirming (medical) interventions.

Design We conducted a qualitative study (ONZ-2023-0026) using focus groups.

Setting This study involved OPs in Belgium.

Participants Two semistructured focus group interviews were held with 19 OPs working in occupational health services in Belgium in May and November 2023. Purposeful sampling was used, which included OPs with at least 2 years of seniority and experience with TGD people or inclusive company culture. Participants were predominantly white and cisgender, with varying levels of seniority and sectoral coverage.

Methods Qualitative data was thematically analysed using Braun and Clarke to find patterned meaning.

Results The analysis created four themes: (1) 'What is the right professional attitude?: You never get a second chance to make a good first impression' discusses the aspects of professional attitude alongside ethical considerations; (2) 'Controlled open-mindedness' entails values and views of gender in light of medicine, the individual worker, organisations and society; (3) 'The balance game: "Fingerspitzengefühl" (intuitive flair or instinct) without treating' and (4) 'Being gender-bombarded: the need for OP-tailored training and best practices'. These themes highlighted the limited knowledge and experience of OPs regarding gender-affirming care (GAC) and their need for additional training. Participants struggled to find the best gender-inclusive professional approach to support TGD workers as well as employers and require 'best practices'. Implementing overarching legislative frameworks can help OPs and companies create an inclusive work environment considering the differences in occupational sectors and company culture. RTW policies should focus on abilities without medicalisation and stigmatisation and involve multiple stakeholders.

Conclusions Occupational medicine can be crucial in improving the health and well-being of TGD workers. However, with the ageing workforce, gender diversity poses new 'hidden' challenges for sick leave management, RTW and sensitive health surveillance. Multidisciplinary training with stakeholders and GAC professionals can enhance occupational practice and equip future OPs with the necessary competencies and confidence.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study, codesigned with the transgender and gender-diverse (TGD, healthcare) community, is the first to investigate occupational physicians' (OPs) perceptions of gender diversity in occupational health beyond binary perspectives. These insights will help develop a training and tool for OPs in supporting TGD people in (returning to) the workplace.

⇒ Qualitative data were collected through focus groups, which allows for the analysis of values and norms among individuals sharing similar (occupational) backgrounds and concerns for the health and well-being of workers.

⇒ Despite facing challenges in recruiting sufficient participants due to the limited number of practising OPs in Belgium, the study yielded valuable insights from 19 individuals.

⇒ Values and perceptions of participants may have been influenced by their gender identity and predominantly white backgrounds.

⇒ To ensure the study's rigour, the moderator received training in gender-affirming care practices, and measures were taken to minimise insider bias, through researcher triangulation with co-authors with multidisciplinary expertise and by including an independent observer during the interview process.

INTRODUCTION

Transgender and gender-diverse (TGD) people are becoming increasingly visible in

society and consequently also in the workplace. According to the World Professional Association for Transgender Health, the percentage of TGD adults ranges between 0.3% and 0.5% of the general adult population.[1] Unlike cisgender people, TGD people identify with and express their gender identity (GI) differently from their assigned sex at birth. TGD people experience more barriers to care (access) along with stigma and discrimination when navigating health systems.[2 3] Gender minority stress, as a stressor originating in being part of a minority group,[4] has additional detrimental health and physical effects,[1] resulting in overall lower health status of TGD people compared with cisgender people.[1 5] Gender transition has also been proven to be a burdensome journey,[6–8] necessitating short- and long-term work absences.[7 8] Moreover, access to quality care is limited, as indicated by T'Sjoen and Motmans.[9] In Belgium, it is primarily offered in specialised centres (n=2) (This was recently expanded to six specialised centres through an updated agreement with the National Institute for Sickness and Disability Insurance or Institut national d'assurance maladie-invalidité (INAMI).[10], resulting in long waiting lists and travel costs.[3 9] Additional mental health support (e.g., occupational mental health-related) beyond those related to diagnosis and treatment is not systematically provided.[11] Together, this can lead to significant experienced barriers to care, as described by the 'European Network for the Investigation of Gender Incongruence'.[3]

Although within healthcare, there is more attention towards gender-affirming care (GAC) and gender-inclusive practice,[1 9] there is still a significant need for additional training. The study by Burgwal et al.[12] surveyed different healthcare professionals (HCPs) ranging from nurses and general practitioners to psychosocial care providers and other medical specialists in four European countries (n=810) and discusses the importance of training in GAC for healthcare providers to improve the quality of care for TGD individuals. It highlights that many HCPs lack knowledge about referral networks and support groups, and existing professional guidelines are often outdated. The study reveals that 52.7% of HCPs had received training, but this was often done on a voluntary basis or at conferences, with those trained showing significantly higher confidence in working with TGD clients compared with those without training. Differences in confidence levels were noted based on factors such as country, profession and sexual orientation. General practitioners had the lowest confidence levels. HCPs expressed a preference for mandatory training provided by specialised organisations, with experiential learning being favoured over didactic methods. The need for such training to be integrated into mandatory educational curricula is emphasised, as no widely accepted curriculum for transgender health currently exists in Europe. The aspect of occupational health providers was, however, not touched on. There is thus still much to learn about how sick leave and return to work (RTW) affect TGD workers, as well as the role of occupational medicine (OM),[7] and the training level of occupational health professionals.

However, according to Belgian legislation,[13] every employer must be affiliated with an occupational health service (OHS); every salaried worker has free access to an occupational physician (OP); but the visibility and use of OHS generally remain low.[14 15] As seen in our previous study,[8] TGD people are often not aware of the existence of an OHS or the possibility of consulting an OP; although when acknowledged, these healthcare providers were considered valuable allies. However, the multidisciplinary action on occupational health and focus on prevention could be valuable in supporting vulnerable populations such as TGD workers. TGD people have lower work outcomes due to lower well-being (sense of belonging, health outcomes), job satisfaction, perceived support and concealment of their GI.[16] This is even higher in older TGD workers or when belonging to sexual identity, ethnic and racial minorities.[17] Positive work experiences, such as empowerment, high support and identity integration, have also been reported among TGD workers.[7 13 15] These experiences, occurring in a supportive and inclusive work climate, are associated with higher levels of job performance, satisfaction and general well-being.[7]

Although literature[16 18 19] advocates the need for more inclusive organisational support, there is no mention of the possible role of OHS or OPs. Competency requirements for OPs have been studied by the WHO, the European Association of Schools of Occupational Medicine and the Occupational Medicine Section of the European Union of Medical Specialists.[20–24] In 2016, Lalloo *et al.*[25] conducted an international Delphi study to establish core competencies (n=12) for OPs and determine their ranking. The study identified good clinical care as the most valued competency, followed by general principles of assessment, assessment of disability, communication skills, ethical issues, teamwork, environmental issues, health promotion, clinical governance, management skills, and teaching and research methods, which ranked the lowest. Even though OPs' perspectives on these core competencies stratified by field of practice (general, management, academic) have a general agreement,[26] there is a notable absence of focus on diversity, equity, inclusion (DEI) and gender in these competencies. Likewise, the official OM training curriculum in Belgium does not include a specific focus on DEI or GAC.[27]

As there is a paucity of studies examining TGD people's occupational health beyond a binary view of gender,[7 28] we aimed to explore the views and experiences of OPs regarding their role in supporting TGD people (returning) at work.

METHODS

Study design and recruitment

A qualitative study was conducted from a pragmatic perspective, focusing on practical research questions and analysis of sociocultural issues.[29 30] This study is part of the

research initiative 'Return to Work of Transgender and Gender Diverse People', conducted by Ghent University and supported by the Belgian National Institute of Health and Disability Insurance. Developed in collaboration with the TGD healthcare community, including the Transgender Info Point at Ghent University Hospital and Belgian Rainbow Houses, this project also received input from TGD members for our website and social media.

In Belgium, it is mandatory for every employer to be affiliated with an OHS, which is usually (90%) an external provider (external OHS vs an internal OHS).[31] Every salaried worker has free access to an OP who works as a self-employed or employee of these OHS. Based on the 2023 statistics, Flanders—the northern and largest of Belgium's three regions—has 796 fully trained OPs out of 1228 nationwide.[32]

Recruitment was based on multiple purposeful sampling strategies, for example, criteria-based and snowball sampling.[33] Gender, ethnicity, race, religion and sexual orientation were not criteria for inclusion or exclusion. Inclusion criteria entailed: (1) having at least 2 years of seniority as an OP; (2) having experiences with TGD people or overseeing workers in a company with an inclusive culture/policy/diversity charter. OPs were reached through their medical managers, who oversee 40 large internal and 10 certified external Belgian OHS, their professional organisations and digital recruiting on social media and networking. We applied no exclusion criteria, a decision made intentionally to foster an inclusive participant pool, particularly given the relatively small population of OPs in Belgium. By adopting this approach, we aimed to attract enthusiastic and motivated participants, including those involved in research and development at their OHS or holding academic positions, as their contributions were deemed valuable for a comprehensive exploration of the topic. We also welcomed participation from OPs in training, acknowledging their importance as the future OM workforce. This study was approved by the Ethical Committee of the Ghent University Hospital (ONZ-2023-0026) and adheres to the General Data Protection Regulation. Reporting was based on the 'Standards for Reporting Qualitative Research'[34] (see online supplemental information 3) and recommendations by Braun and Clarke (2021)[35] as well as Morgan's advice (2010)[36] regarding the use of individual quotes versus group interactions.

Data collection, participants and processing

We conducted two semistructured focus group interviews in May and November 2023. The interview guide was developed based on previous research by the research team[7 8] (see online supplemental material 1). Data were collected through an audio/video-recorded interview on-site (n=9) by the moderator and first author (JVdC), and notes (observer chart) were taken by the observer (LBe). A second focus group interview (n=10) was conducted online via the video conference software Microsoft Teams by the first author. The audio track was extracted; participants' voices were high-pitched for anonymity; and the video, adding depth and emotion to the transcriptions, was destroyed after analysis. Participants signed informed consent forms permitting pseudonymised data collection, analysis and publication of group results and receiving gift cards in appreciation.

Data analysis

Audio files were transcribed verbatim in Microsoft Office Professional Plus Word and analysed in Lumivero (2023) NVivo (V.14) by first author JVdC. A reflexive thematic analysis (RTA) [35] with an inductive approach was used. RTA includes deep familiarisation with data, a combination of coding approaches, creating initial themes and mapping, critically reviewing coding from a different perspective and thus themes followed by fine-tuning themes (appropriate all-encompassing naming) while keeping a continuous flow of writing and during all adhering to reflexivity (journalling, counsel). Through immersion, there was a deep familiarisation with the data. The first author (JVdC) used inductive coding while also memo-ing and making visual maps of the created codes, during which she repeatedly relistened to the audio tracks spread out over several weeks. Subsequently, the observer chart was coded inductively by the first author, and the coding of the interviews was then reviewed against the observer chart, discussed with the observer (LBe) and reassessed from a different perspective (holistic) based on earlier results.[7 8] Initial themes were then mapped out by JVdC, written down and mirrored to the data, after which they were fine-tuned and discussed with the multidisciplinary research team. Final themes were constructed thereafter, focusing on the gaps and needs in OM for supporting TGD workers, and a thematic map (see figure 1) was drawn up.

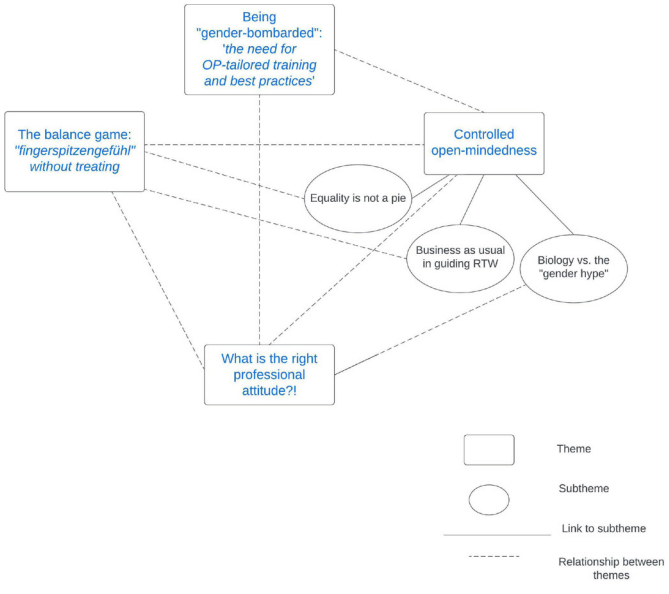

Figure 1 Thematic map of views and experiences of OPs supporting transgender and gender-diverse people. 'Fingerspitzengefühl', as in clinical intuition; OP, occupational physician; RTW, return to work.

Table 1 Characteristics of focus group participants (n=19)

Characteristics		Number—Descriptive statistics
Gender identity	Woman	12
	Man	7
	Transgender person	0
	Gender-diverse person	0
	Other/prefer not to say	0
Age	All	$\bar{x}$ = 44.17 (SD±12.4)
Seniority	All	Range 2–34 $\bar{x}$ = 17.1 years (SD±12.2)
	Group 1 (n=9)	$\bar{x}$ = 13.7 years (SD±12.4)
	Group 2 (n=10)	$\bar{x}$ = 20.1 years (SD±11.87)
Employment type	Salaried	15/19
	Self-employed	–
	Undisclosed	4/19
Workplace	External OHS	17/19
	Internal OHS	2/19
Duration of focus group interviews	Group 1	1h45min35s
	Group 2	1h46min24s

h, hours; min, minutes; OHS, occupational health services; s, seconds; X, mean.

Researcher reflexivity and validation

A high stance is placed on reflexivity[35] during analysis as the research team approached this study from the perspective of OM to maintain the occupational health of TGD individuals and as a partner in GAC bridging different levels of care with a client-centred goal. All authors are white and fall within gender and sexuality conformity, apart from two LGBTQIA members. We aimed for validation through triangulation, elaborate contextualisation and engaging in self-reflection.

RESULTS

Two exploratory focus groups were held in which 19 cisgender OPs with gender-conforming expressions participated (see table 1 for characteristics). All provinces in Flanders, Belgium, were covered by the participating OPs. The majority (14/19) did not follow additional training in diversity and inclusion, disability management or reintegration.

From the analysis, the following perceptions were captured, showing how OPs face challenges in providing gender-inclusive care in a predominant binary occupational health and safety culture while staying within the boundaries of their profession. It also highlighted their requirements for multidisciplinary training to navigate the right professional attitudes and support for all stakeholders. Four major themes (see figure 1) were thus constructed: (1) 'What is the right professional attitude?: You never get a second chance to make a good first impression' discusses the aspects of professional attitude alongside ethical considerations; (2) 'Controlled open-mindedness' entails values and views of gender in light of medicine, the individual worker, organisations and society; (3) 'The balance game: "Fingerspitzengefühl" (intuitive flair or instinct) without treating' discusses the conflicted, different stances of the role of the OP during gender transition at work while staying clear of curative medicine and finally (4) the theme 'Being gender-bombarded: the need for OP-tailored training and best practices' is driven by a desire for improvement and recognition of current limitations.

Data extracts are presented as snippets and quotes from individual participants or as interactions from the focus group when valuable for providing context[36] (see table 2). Full interactional quotes can be found in online supplemental material 2.

Theme 1: What is the right professional attitude?: You never get a second chance to make a good first impression

Participants felt uneasy and unsure on approaching a TGD worker for the first time and reflected on the challenging standpoint of the OP amidst the life of a (TGD) worker, the work environment and the health sector. They emphasised the evolution of their relationship with workers, strengthened by visits that established a culture of trust over the years. Nonetheless, they were mindful of how their behaviour affected clients' perceptions. Some have changed their approach, such as discontinuing formal titles. However, participants disagreed about how to address workers when calling them from the waiting room (last name and first name or simply 'next'). In contrast, others did not dwell on this, found it excessive and used a familiar approach (first name, nickname). Probing on possibilities of 'deadnaming' (using the non-affirmed birth name) or gender expression perceptions was met with silence or confusion.

Within this search for the 'right attitude', questions were raised regarding the limits of medical software in reflecting clients' GI versus their biological sex in medical records, which are linked to national registries. Furthermore, ethical considerations (consequentialism, deontology and virtue ethics), were explored, including reporting on GI antecedents regarding occupational risks, fitness for work as 'it can always have an impact on their workability' (P11) and occupational secrecy.

> …for me, it's mainly a question of occupational safety functions; some (TGD people) take a lot of medication; what is their impact (on their professional functioning)? But I find that confrontation (asking about medication use and gender) complicated. I don't know how to handle that. (P3)

Table 2 Results of a reflexive thematic analysis on occupational physicians' views and experiences, including definitions and quotes

Themes	Theme definitions and supporting examples
Theme 1: What is the right professional attitude?: You never get a second chance to make a good first impression	This theme reflects ruminations of OPs on first contact with TGD workers, ethics and mannerisms during the occupational visit, and how clients and other stakeholders perceive OPs. *I wonder, from the perspective of employer, colleague, employee, and occupational physician. What is the best attitude to adopt regarding TGD workers? (P8*) *I have learned not to shout 'sir or ma'am' in a waiting room. I've had a situation before. That person was visually a <hand gesturing> so I called out 'sir', but a lady rose. Then, I had to apologise; it was awkward for both the client and me. So now I call out the last name. (P9*)
Theme 2: Controlled open-mindedness	This theme is multifaceted, from OPs' values about sex versus gender to their reflections about 'gender hype' and demedicalisation, as well as how OPs work within a legislative framework and the need to reintegrate workers holistically without disregarding company culture.
Subtheme: Biology versus the gender hype	*Yes, I think gender is something expansive; I think it's just a kind of identity, a sense of something in which you feel at home <P7, P1 and P9 nodding> a bit like a nationality or a group. I think gender is complicated to reduce to something biological. (P8)* *So it is not because you are a man that 'prefers to pretend to be a woman' that he would automatically be sexually attracted to a man or a woman, so that is sometimes a question for me, or at least unclear; it is unambiguous, ehm, but maybe that's reality, I don't know. (P17) Would that always be clear to those people themselves?! <smiles>. (P10*)
Subtheme: Equality is not a pie	*There should be something legal, such as a 'Collective Labor Agreement' (CLB). We now have a CLB for older employees, but let's also do that for 'transgenders', with legal advice that is not binding; that is just advice. (P2)* *There are currently legal guidelines which necessitate us making (work) adjustments, while, if it is deleted or adjusted, it will become easier for us to make inclusion easier. (P3*) *Sometimes I wonder. Is all of this (adjusting guidelines) necessary? (P4)* *Abstractly, in a company with 100 people with only right hands, there is one with only a left hand. By investing a lot of time in resources so that the left hand can do its job, you marginalise or make it difficult for those people with only the right hand. (P5)*
Subtheme: Business as usual in guiding return to work	*You approach it as any intervention that has taken place. What impact does that have? It's not about the reasoning behind a medical intervention but what effect it has. I compare it to adding a droplet into a pond, and they have to mix well with each other and the psychology and everything else behind it. (P3)* *RTW during gender transition, for me that is reintegration, pure and simple, without anything more <laughs>. (P14*) *It's not the same as any RTW; this is something where you should involve coworkers and managers. It might be better to prepare this from a broad outline/framework. (P10*) *If you need a specific plan or approach for everything, I fear many employers will ask: 'What have we gotten ourselves into?!' (P15*) *Writing out a reintegration policy for every specific problem is going too far for me. While gender transition is a crucial process for some individuals, it is not a common occurrence. (P11)*
Theme 3: The balance game: 'Fingerspitzengefühl' without treating	This theme delves into the OP's role as a mediator between workers and stakeholders. It emphasises their proactive approach to managing time constraints and promoting workability while empowering employees without interfering with curative medicine. *I need to have my 'red flags' to refer them, which is especially important for us (OPs). There will be more of 'that audience' because people are becoming increasingly free and you have to understand it to give good advice. (P4)*
Theme 4: Being gender-bombarded: the need for OP-tailored training and best practices	This theme highlights gaps in practice and the challenges of medical training for OPs in an ever-changing world. *We are supposed to know all the sensitivities and more, but I don't even understand half the words, and not because I don't want to understand. (P1)* *There is a need for a ''Best Practice'' now and then, or something tailor-made for occupational physicians or written specifically for occupational physicians. <P15 and P19 nodding>That could be useful as a point of reference because we do that frequently in occupational medicine, having a 'standard for something like that, and we build on it. (P14)*

OPs, occupational physicians; P, participant; RTW, return to work; TGD, transgender and gender-diverse.

Although gender expression and identity were explored to the extent that OPs were conscious about their first impressions during the anamnesis, no questions were raised in either group about using gender-inclusive language during the visit and the physical examination. Either this was taken as a given or obvious. Moreover, they disregarded undisclosed TGD workers during their reflections.

During the interviews, an air of light-hearted embarrassment was covered with a humorous tone, especially when TGD people requested advice about coming out, to which none could respond appropriately. However, the overall attitude was to listen respectfully within the allotted consult time while acknowledging the vulnerability of TGD individuals.

However, there was cynicism towards how OPs were perceived, which impacted their attitude. The visibility of OPs for workers relied on 'effective' communication within organisations and healthcare. This, along with being an unfamiliar figure to other health professionals, limited multidisciplinary work and support.

> If your colleagues (physicians) don't even know what you do, how are you going to expect from people, who have never heard of an 'occupational doctor'<air quotes>, to know that you exist?! (P9)

Theme 2: Controlled open-mindedness

This theme is multifaceted, encompassing OPs' values regarding sex and gender, their reflections on 'gender hype' and demedicalisation, as well as how they operate within a legislative framework. Additionally, there is an emphasis on the need to reintegrate workers holistically while respecting company culture.

Subtheme: Biology versus the gender hype

This subtheme highlights the versatile values of the OPs. Discussions were more heated and chaotic when the aspects of biological sex, gender, GI and expression were explored. Some participants were uncertain about distinguishing between GI and sexual orientation, as well as the concept of heteronormative stereotypes, where two participants tried to clarify these concepts and promote diversity.

> Drawing a line can be challenging because individuals can identify as male, female, or somewhere in between. You can also be attracted to men, women, or people who fall somewhere in between. (P15)

> I agree with P15 that thé 'transgender (person)' does not exist (P14)

Apart from a difference in views and values, the analysis also indicated a diminished understanding of TGD people's experiences. There was a consensus that OPs and TGD workers should be respectful towards each other as frustrations arose from dealing with 'angry' (TGD) clients who strongly believed in gender as a spectrum. Some OPs experienced this as a personal attack and did not seem to question if 'asking for more explanations to understand' could be perceived as not gender-affirming, possibly resulting in clients feeling barriers to care and possible allies.

> But sometimes they (TGD people) try to convince you, which almost becomes a denial of something cellular. <heavy hand gestures> I don't understand that very well, and people become outraged. Then I think: 'I want to give you the freedom to do what you want and do, but thàt must be something unresolved somewhere, I don't know, but that much anger'…That's what I think, 'but where does that leave us (OPs)? (P4)

Some were open-minded in discussing only gender-related aspects that matter in the context of occupational risks. Others worried about physical work abilities and guidelines (eg, ergonomic) not adapted to gender diversity or medical transition. This highlights the 'uncharted territory of gender-inclusive' care in occupational health and well-being.

> After their medical transition, trans women may face challenges with tasks that other men can perform easily. (P18)

Subtheme: Equality is not a pie

Participants observed mixed reactions from company hierarchies regarding the gender issue in company culture. Some believed that they should only suggest gender-inclusive advice when they detect a 'group phenomenon' or acts of discrimination. In contrast, others saw themselves as the primary care equivalent in companies and the first point of contact. Awkwardness crept into the conversation when recalling requested advice from employers on sanitary facilities ('feeling unsafe as women in gender-neutral toilets'), and comparisons were made with special requirements for certain religious groups. Diversity and inclusion were deemed a working point and are still subject to societal acceptance issues and often resistance from employers. Participants emphasised the need for a comprehensive diversity charter with GI and sectoral agreements. Senior OPs preferred a respectful culture and promising inclusion and diversity practices over a generic company policy, which could lead to 'lip service'.

Conversations were balancing between society's view and inevitable 'trans panic' (an analogy with terminology from the literature regarding TGD people[37 38]), which led to ethical questioning if tailoring would not marginalise or stigmatise TGD people further. As they perceived TGD workers as a small group and considered the larger picture, participants indicated the limits of available resources. However, regarding OPs' practices, there was no consensus on the necessary level of support from legislation; some saw it as an incentive and some experienced restrictions. Some participants noted that OM is still in its early stages of gender inclusivity rather than following a

'passing trend of gender exploration' that is more prevalent among younger workers.

> I believe there is a current social fear that a disproportionate amount of attention is paid to approximately one percentage of society and also that attention is weakening towards being a cis man or cis woman, whereas that is still normal. (P8)

The emphasis was kept on being open-minded and mindful towards workers with other vulnerabilities or challenges that are underserved in supportive measures or even the whole worker population.

Subtheme: Business as usual in guiding RTW

Furthermore, this led to thoughts on sensitisation and RTW accommodations during gender transition. The majority initially perceived no need for special work accommodations, reasoning that postoperative care was uniform for all surgeries, including those in the genital area (groin, genitals, anal, etc, whether for cisgender or TGD people), as exemplified by P4's comment: 'No lifting for six weeks. So that's the same for everyone'. However, in light of GAC, participants would primarily follow work recommendations from attending physicians by listening to their clients and even sending them back for accurate advice or consulting their colleagues directly. This reflects feelings of insecurity as treating physicians often consider OPs in charge of proposing work accommodations, which participants also acknowledged. Some participants then cautiously suggested graduated RTW or ergonomic solutions (alternating standing–sitting) and other work clothes, while others immediately jumped to possible long-term work adaptations. None considered gender affirmation-related measures in cooperation with the employer or potential points of attention regarding specific surgical interventions or complications apart from the 'longer-term need for a toilet nearby' (P14). In contrast, two participants focused on the biopsychosocial aspects, and all agreed. Furthermore, participants stressed the importance of regular follow-up after RTW.

There were two main perspectives during discussions on RTW concerning diversity charters. The first view was that the role of OHS was to sensitise individuals to gender-inclusive practices and raise awareness through campaigns or on-demand. The second view was that 'every re-integration policy should proactively include gender-specific considerations' (P8). Some participants found having specific RTW frameworks for gender transition stigmatising, notwithstanding occupational physicians having familiarity with working with guidelines such as for other specific conditions that include an occupational health risk, for example, epilepsy and having an occupational safety function. However, considering the individual and sectorial differences and current socioeconomic imbalances, they found it imperative to establish a basic pre-emptive RTW policy that can be adapted to requirements focused on abilities and demedicalisation.

Theme 3: The balance game: 'Fingerspitzengefühl' without treating

Generally, participants found that OPs should focus on all factors that may hinder work performance, considering the employee's overall well-being. They often relied on their intuition to guide their next course of action, whether during a consultation, meetings with company HR or being privy to 'rumours' and evaluating the work climate during corporate committees or company visits. However, when facing TGD people or the gender issue, they felt abandoned by their 'gut feeling' and struggled to balance their course of the anamnesis. Their reflections and decision-making processes were based on their values and experiences, and they recognised that their role was limited in supporting social transition. This was attributed to their professional obligations and the need to maintain positive relationships with the company. However, it was remarkable that they could not think of strategies regarding the psychosocial challenges of social transition at work; this was quickly bridged to 'psychosocial counsellors'. Although they stressed that OPs should be involved when gender transition has occupational effects, no clear advice or suggestions were provided.

Moreover, there was discord on the amount of supporting psychosocial aspects, among other restraints, as 'we are not physicians treating patients; our focus is employability' (P7). However, others believed in being more proactive by providing contact points, consulting with the general physician or employer or suggesting informal visits. However, there were also medicalisation tendencies, with one participant stating, 'If we are considering the psychological aspect, then that is a matter for psychiatrists' (P5). This prompted a reflection on the expectations for OPs to have broad multidisciplinary expertise while maintaining empathy. It emphasised the significance of acknowledging their limitations and appropriately referring clients to other HCPs.

Furthermore, there was a noticeable difference in open-mindedness with seniority. Less experienced OPs held more idealistic views and had a more challenging time distancing themselves from support that could be considered curative medicine. On the contrary, more senior OPs performed their job to the best of their ability while staying within well-defined boundaries, such as displaying empathy but providing support only on request (see interaction in online supplemental file 1).

Participants emphasised the importance of clear communication of one's needs to ensure occupational health and awareness and smooth RTW, irrespective of GI, while respecting self-determination, avoiding medicalising the visit and thus recognising the importance of health literacy (HL) in empowerment and RTW (see interaction in online supplemental file 1).

Theme 4: Being gender-bombarded: the need for OP-tailored training and best practices

Remarks made during the interviews (eg, 'successful transformation', 'I would have never known you were

not a man', 'transgenders' and 'a man pretending to be a woman') revealed that there was a lack of understanding concerning GI, gender minority stress and not disclosing GI, and of using non-transphobic gender-inclusive language. However, participants provided critical feedback on their training and highlighted a significant gap in their knowledge regarding gender and sexology, which is a subject that is often considered taboo. There is a lack of understanding about (finding) established guidelines in GAC and other potential sources of information. Only two names of renowned Belgian specialists in GAC were mentioned, and one participant was aware of a gender team.

> Moderator: Does the 'Standards of Care for the Health of TGD People' sound familiar? Do you know anything about an international organisation for transgender healthcare?
>
> P4: Yeah, um, LGBTQ and all that other stuff.
>
> P5: Hm, that's a movement.

Although the groups used humour as a strategy, there was a sense of feeling powerless as 'there is a kind of jargon from within that gender world and I can't keep up anymore' <laughs> (P17). However, those feelings quickly changed into frustration and not measuring up to expectations.

Being conscious of their lack of knowledge, participants were open to further training and advocated OHS as organisers. Others saw this only as a booster option. The initial discussion focused on finding sources for a complex lexicon. Still, it soon turned to the need for a comprehensive training programme covering the reasons for gender transition, practical steps to take, everyday obstacles, potential gender-affirming interventions and how to contact the gender team. Participants stressed this training should be multidisciplinary, including social service providers, internal prevention services, HR representatives, counsellors, psychologists and the curative team. However, TGD community members, such as peer consultants, should not be included. On the contrary, some OPs saw the value in learning from TGD individuals and preferred practical, on-demand solutions that fit into their schedules and existing RTW frameworks that could be tailored to the individual.

> Actually, …first a 'triggering' needs to happen and create awareness and that 'good practices' (tool) before (multidisciplinary) GAC training). (P17)
>
> It could maybe be a case within a broader theme of reintegration (training). (P13)

DISCUSSION

To the best of our knowledge, this is the first qualitative study to explore the role of OM in the process of gender transition and RTW through focus groups with occupational physicians. The key findings are that OPs require elaborate training in gender-inclusive and affirmative care as they struggle to navigate the right professional attitudes and support without stepping beyond the boundaries of their profession. This training should be multidisciplinary and incorporate multiple aspects (terminology, background of gender minority stress, sociopolitical landscape of TGD people, gender-inclusive language and approach, steps in transition-related GAC) and be repeated in short form. Access to 'best practices' would be helpful during occupational health consultations. Moreover, emphasis was placed on an overarching legal framework for establishing an equity, diversity and inclusion (RTW) action plan in order not to marginalise and disempower vulnerable groups.

Due to limited research on the topic within OM, comparisons of our results remain challenging. However, our study aligns with the recent call to action by Q.V. Durand-Moreau towards more inclusion of TGD individuals in occupational health research[28] and the willingness or hesitation of general physicians to provide GAC but lacking competencies.[39] The OPs' limited experiences with TGD workers were seen as problematic due to a lack of gender-sensitive professional attitudes, little understanding of gender minority stress and varying perspectives on gender versus biological sex. Additionally, as mental health vulnerabilities of TGD in life and at work were acknowledged, they were not per se attributed to socially induced reasons (eg, stigma and discrimination) but to a psychological fragility or even psychopathology, indicating a lack of insight into work and societal influencers. This is not surprising as mental health and psychosocial aspects are already a complex subject in OM.[40] However, their rationale is likely due to a lack of knowledge in the field rather than fixed reasoning. Most participants in our study were willing to learn about these aspects, emphasising the importance of centralised worker experiences within the larger environment. Few focused on demedicalisation, consistent with a study by Bosma *et al*,[14] which reported that OPs highlighted the difficulty of balancing medicalised support for employees with chronic conditions within the work environment versus focusing on abilities and identifying and implementing workplace solutions. Our results are in line with a systematic review[41] that portrays discrimination faced by sexual and gender minorities from other healthcare providers due to beliefs and a lack of knowledge; such negative attitudes impact disclosure and access to care. Being self-conscious of their perceived attitude is thus essential for OPs,[1 42] as well as realising barriers to care[2 3] and considering the possibility of being in the first stage of GI disclosure[43] due to their proximity to the work environment. However, our participants also criticised medical records software and provided constructive feedback aligned with literature recommendations,[44] which suggests that their professional judgement is, to some extent, sensitive to gender-related factors. To support TGD workers, OPs must balance personal values with professional boundaries. To achieve this, our results suggest that an open-minded

approach, mutual respect and confidentiality are crucial. We identified the need to re-evaluate overarching facilitating legislation on company and societal levels, which aligns with studies on mental health and chronic conditions.[14 45] Similar to previous findings,[40] OPs in our study emphasised the importance of the organisational culture in supporting TGD workers and the flexibility they were granted. One potential solution is integrating GI into an existing diversity charter and safety culture while providing targeted sensitisation and reintegration guidelines as necessary.

OM could play an essential role in the health promotion and well-being of TGD workers, according to 'holistic' support systems advocated in GAC research.[46] This approach would align with Loisel's 'Work Disability Prevention Model'[47] and HL principles.[48] However, as seen in our study, there are problems with OPs' visibility in interdisciplinary (healthcare) collaboration, such as with GAC professionals, which are in agreement with literature on chronic conditions[14] and mental occupational healthcare.[15] As the 'Standards of Care for the Health of Transgender and Gender Diverse people, Version 8'[1] do not include work-focused accommodations or occupational health practice, we could assume that the use of OP is low and is, therefore, a cause for concern. Moreover, our study sample shows little knowledge of HL, which aligns with another European HL study,[49] and a reluctance to 'motivational interviewing'; empowering clients was deemed the responsibility of psychosocial counsellors and mental health professionals. Especially in workers with (concurrent) vulnerabilities, while respecting self-determination, lifting barriers to (access to) care is thus needed but left wanting. This could be attributed to OPs' evolving and challenging role in contemporary occupational health and well-being,[14 40 45 50] subject to sociopolitical factors.[51] To provide adequate prevention and support, the availability and accessibility of OHS and OPs should thus be promoted among employers, (TGD) employees and HCPs. Finally, OM should centralise itself alongside other health specialities during basic medical training and practice, fostering collaboration with other healthcare and GAC professionals. Requiring training in GAC is not exclusive to OPs as this also extends to other HCPs.[2 12 39] Such training in GAC was recently stressed as crucial in elevating competencies of HCPs,[41 52 53] which also falls in line with our thematic results (themes 1 and 4) regarding professional attitudes towards TGD people and training in gender-inclusive fundamentals. While possibly benefitting OPs' confidence in occupational risk evaluation and supporting occupational health practice, participants had mixed views on a mandatory course in their basic training, unlike the results of an earlier study[25] on HCPs' views of working with TGD people. This could be due to comprehensive OM coverage and a busy schedule with a 'role-playing game' between stakeholders aligning with implementation literature.[50] This may explain why incorporating a best practices guide/tool on GAC in OM and RTW is a valuable addition to a (repeated) training module along with a feasible multidisciplinary approach. As stated by John Harrison,[54] it is time for 'a new approach, a new deal' in the context of a new workforce versus a new generation of OPs.

Strengths and limitations

A significant strength of this study is the multidisciplinary collaboration between occupational health and the TGD (healthcare) community. Moreover, the study design allowed for an open and safe place for OPs to express different views and opinions, focusing on providing more inclusive occupational healthcare. The sample also had enough diversity (age, culture, geography and seniority) to offer different perspectives, including OPs with dual roles and those in training, which added value to our study. However, we recognise some limitations of this study, such as the prominent gender conformity of participants and the low experience with TGD clients or GAC. The current situation in Belgian OM poses a challenge in achieving a high response rate due to the limited number of practising OPs. The sampling strategy was limited to Flemish-speaking OPs in Belgium due to language considerations, potentially restricting the generalisability of our findings. In addition, the exact number of participants reached through our sampling strategy is unclear, which limits the sample's representativeness. However, this study has drawn careful findings and conclusions based on the results obtained from two focus group interviews. Additionally, it is essential to consider potential bias in the study due to the first author's prior GAC training, which may lead to more critical interpretations. However, this affinity also strengthened the study design and makeup of the interview guide. As insider research can also lead to further bias in result interpretations, this was countered by peer consultation with the co-authors and the inclusion of an independent observer during the interview.

Recommendations for good practices and future research

This study contributes to OM training and practice by addressing the needs of an increasingly visible group of workers with vulnerabilities as we aim to develop a support tool for OPs. However, further exploration through surveys and qualitative studies and mirroring these results is warranted, including larger samples and heterogeneity in the profession and GI. Additionally, future research should focus on implementing exemplary practices in OHS, and studies could prove fruitful in clarifying the role of OPs alongside OHS in gender-inclusive occupational healthcare. Moreover, multidisciplinary participatory studies involving the TGD community, GAC professionals and corporate stakeholders could assist in developing an action plan for electronic identification and explore tailored recommendations for sustained RTW.

CONCLUSIONS

OPs display low literacy on GAC, struggle to find the proper sources of information and have a high need for gender-inclusive training and best practices. The current sociopolitical landscape additionally hampers work inclusivity as OPs try to navigate the balance between all occupational actors and provide respectful and adequate support. OM still has much to learn about the challenges involved in gender transition, how it affects workers' well-being and workability, and the role OPs and OHSs can play.

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Acknowledgements We would like to thank the participants and all those involved. The first author would like to thank the Belgian Occupational Health Service 'Cohezio' for their support during the finalisation of this manuscript.

Contributors JVdC, LB, JM and DVdV contributed to the study's conception and design. Material preparation and data collection were performed by JVdC in part in collaboration with LBe. JVdC performed the data analysis in collaboration with LB, JM and DVdV. JVdC wrote the first draft. All authors commented critically on previous versions, read and approved the final manuscript written by JVdC. JVdC is also the guarantor for the overall content.

Funding This work was supported in part by the Belgian 'National Institute of Health and Disability Insurance' (Institut National d'assurance Maladie-Invalidité) as part of a larger project, 'Return to Work of Transgender and Gender Diverse People', with Ghent University (A19-TT-0901).

Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Consent obtained directly from patient(s)

Ethics approval This study involves human participants and was approved by the Ethical Committee of the Ghent University Hospital (ONZ-2023-0026). Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data to comprehend the study or relevant to the study results are included, additional data from the interviews are not available as they pertain to an ongoing elaborate research initiative "RTW of TGD people". The data generated and analysed during the present study are subject to the legal regulations of Ghent University in Belgium. Except for the pseudo-anonymised data included in the article and supplemental material, additional data are not available to the public due to the datasets being part of an ongoing research project.

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REFERENCES

1 Coleman E, Radix AE, Bouman WP, *et al*. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health* 2022;23:S1–259.
2 Burgwal A, Motmans J. Trans and gender diverse people's experiences and evaluations with general and trans-specific healthcare services: a cross-sectional survey. *Int J Impot Res* 2021;33:679–86.
3 Ross MB, van de Grift TC, Elaut E, *et al*. Experienced barriers of care within European treatment seeking transgender individuals: A multicenter ENIGI follow-up study. *Int J Transgend Health* 2023;24:26–37.
4 Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull* 2003;129:674–97.
5 Burgwal A, Gvianishvili N, Hård V, *et al*. Health disparities between binary and non binary trans people: A community-driven survey. *Int J Transgend* 2019;20:218–29.
6 Oorthuys AOJ, Ross M, Kreukels BPC, *et al*. Identifying Coping Strategies Used by Transgender Individuals in Response to Stressors during and after Gender-Affirming Treatments—An Explorative Study. *Healthcare (Basel)* 2022;11:89.
7 Van de Cauter J, Van Schoorisse H, Van de Velde D, *et al*. Return to work of transgender people: A systematic review through the blender of occupational health. *PLoS One* 2021;16:e0259206.
8 Van de Cauter J, Van de Velde D, Motmans J, *et al*. Exploring Work Absences and Return to Work During Social Transition and Following Gender-Affirming Care, a Mixed-Methods Approach: "Bridging Support Actors Through Literacy". *J Occup Rehabil* 2024;34:425–46.
9 T'Sjoen G, Motmans J. Integrating transgender care into mainstream medicine-an essay by Guy T'Sjoen and Joz Motmans. *BMJ* 2022;379:o1949.
10 Declercq E. Number of transgender (health)care centres expands from 2 to 6 (aantal centra voor transgenderzorg breidt uit van 2 naar 6, riziv). Available: https://www.riziv.fgov.be/nl/nieuws/aantal-centra-voor-transgenderzorg-breidt-uit-van-2-naar-6 [Accessed 30 Jan 2025].
11 Eyssel J, Koehler A, Dekker A, *et al*. Needs and concerns of transgender individuals regarding interdisciplinary transgender healthcare: A non-clinical online survey. *PLoS One* 2017;12:e0183014.
12 Burgwal A, Gvianishvili N, Hård V, *et al*. The Impact of Training in Transgender Care on Healthcare Providers Competence and Confidence: A Cross-Sectional Survey. *Healthcare (Basel)* 2021;9:967.
13 Federal Public Service Employment, Labour and Social Dialogue. Codex on well-being at work Book I.- General principles Title 4.- Measures related to health surveillance of workers (Codex over het welzijn op het werk Boek I.- Algemene beginselen Titel 4.– Maatregelen in verband met het gezondheidstoezicht op de werknemers). Brussels. 1996.
14 Bosma AR, Boot CRL, Snippen NC, *et al*. Supporting employees with chronic conditions to stay at work: perspectives of occupational health professionals and organizational representatives. *BMC Public Health* 2021;21:592.
15 Rothermund E, Michaelis M, Jarczok MN, *et al*. Prevention of Common Mental Disorders in Employees. Perspectives on Collaboration from Three Health Care Professions. *Int J Environ Res Public Health* 2018;15:278.
16 Eriksson A, Andersson S, Björk S, *et al*. *The organisational and social work environment of LGBTQ people*. Gävle, Sweden: The Swedish Agency for Work Environment Expertise, 2023.
17 Webster J, Thoroughgood C, Sawyer K. *Diversity issues for an aging workforce*. Routledge, 2018:34–58.
18 Beauregard TA, Booth JE, Whiley LA. Transgender employees: workplace impacts on health and well-being. In: Hassard J, Torres LD, eds. *Aligning perspectives in gender mainstreaming*. Cham: Springer International Publishing, 2021: 177–96.
19 Huffman AH, Mills MJ, Howes SS, *et al*. Workplace support and affirming behaviors: Moving toward a transgender, gender diverse, and non-binary friendly workplace. *Int J Transgend Health* 2021;22:225–42.

20 Delclos GL, Bright KA, Carson AI, *et al*. A global survey of occupational health competencies and curriculum. *Int J Occup Environ Health* 2005;11:185–98.
21 Gallagher F, Pilkington A, Wynn P, *et al*. Specialist competencies in occupational medicine: appraisal of the peer-reviewed literature. *Occup Med* 2007;57:342–8.
22 Macdonald EB, Ritchie KA, Murray KJ, *et al*. Requirements for occupational medicine training in Europe: a Delphi study. *Occup Environ Med* 2000;57:98–105.
23 WHO. Occupational medicine in Europe: scope and competencies, Available: https://www.who.int/publications/i/item/e68883
24 Occupational Medicine. Training – UEMS, Available: https://uems-occupationalmedicine.org/training/
25 Lalloo D, Demou E, Kiran S, *et al*. International perspective on common core competencies for occupational physicians: a modified Delphi study. *Occup Environ Med* 2016;73:452–8.
26 Demou E, Lalloo D, Macdonald EB. Differences in opinions of occupational physicians on the required competencies by field of practice: results of an international Delphi study. *BMC Med Educ* 2018;18:62.
27 Public-Health. Master-na-master in de arbeidsgeneeskunde. Public-Heal. Opleidingen Maatschappelijke Gezondheidszorg, 2024. Available: https://public-health.be/
28 Durand-Moreau QV. Towards more inclusive practices for gender-diverse people in occupational health research. *Occup Environ Med* 2023;80:526–7.
29 Morgan DL. Focus Groups. *Annu Rev Sociol* 1996;22:129–52.
30 Morgan DL. Pragmatism as a Paradigm for Social Research. *Qual Inq* 2014;20:1045–53.
31 Godderis L, Johannik K, Mylle G, *et al*. Epidemiological and performance indicators for occupational health services: a feasibility study in Belgium. *BMC Health Serv Res* 2014;14:410.
32 Federal Government of Public Health, Food Chain Safety, Environment. HWF STATAN 2023 (detailed statistics) (HWF STATAN 2023, detailstatistieken). HWF STATAN 2023 Detail. Stat, Available: https://overlegorganen.gezondheid.belgie.be/nl/documenten/hwf-statan-2023-detailstatistieken
33 Patton MQ. *Qualitative research & evaluation methods: integrating theory and practice, 4th edn*. Thousand Oakes, CA: SAGE Publications Inc, 2015.
34 O'Brien BC, Harris IB, Beckman TJ, *et al*. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med* 2014;89:1245–51.
35 Braun V, Clarke V. *Thematic analysis: a practical guide*. London: SAGE Publications Ltd, 2022.
36 Morgan DL. Reconsidering the Role of Interaction in Analyzing and Reporting Focus Groups. *Qual Health Res* 2010;20:718–22.
37 Rudin J, Billing TK, Farro A, *et al*. Penis panic in the workplace: Differential responses to MTF and FTM transgender employees. *AMPROC* 2016;2016:15105.
38 Westbrook L, Schilt K. Doing Gender, Determining Gender: Transgender People, Gender Panics, and the Maintenance of the Sex/Gender/Sexuality System. *Gend Soc* 2014;28:32–57.
39 Ulrich IP, Harless C, Seamon G, *et al*. Implementation of Transgender/Gender Nonbinary Care in a Family Medicine Teaching Practice. *J Am Board Fam Med* 2022;35:235–43.
40 Pößnecker T, Baxendale M, Braun S, *et al*. Occupational physicians dealing with mental health: between employee and company interests: a qualitative study. *BMC Psychol* 2022;10:306.
41 Ayhan CHB, Bilgin H, Uluman OT, *et al*. A Systematic Review of the Discrimination Against Sexual and Gender Minority in Health Care Settings. *Int J Health Serv* 2020;50:44–61.
42 Loos FK, Koehler A, Eyssel J, *et al*. Subjective Indicators of Treatment Success and Experiences of Discrimination in Interdisciplinary Trans* Healthcare. Qualitative Results from an Online Survey. *Z Sex* 2016;29:205.
43 Haimson OL, Veinot TC. Coming Out to Doctors, Coming Out to "Everyone": Understanding the Average Sequence of Transgender Identity Disclosures Using Social Media Data. *Transgend Health* 2020;5:158–65.
44 Deutsch MB, 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;20:700–3.
45 Lambrechts M-C, Ketterer F, Symons L, *et al*. The Approach Taken to Substance Abuse by Occupational Physicians. *J Occup Environ Med* 2015;57:1228–35.
46 Tebbe EA, Budge SL. Factors that drive mental health disparities and promote well-being in transgender and nonbinary people. *Nat Rev Psychol* 2022;1:694–707.
47 Loisel P, Côté P. The work disability paradigm and its public health implications. In: Loisel P, Anema JR, eds. *Handbook of work disability: prevention and management*. New York, NY: Springer, 2013: 59–67.
48 Jørgensen MB, Larsen AK. Occupational health literacy: healthy decisions at work. In: *International handbook of health literacy*. Policy Press, 2019: 347–58.
49 Güner MD, Ekmekci PE. A Survey Study Evaluating and Comparing the Health Literacy Knowledge and Communication Skills Used by Nurses and Physicians. *Inquiry* 2019;56:0046958019865831.
50 de Brouwer CPM, Verdonk P, van Amelsvoort LGPM, *et al*. Experiences of occupational physicians with the implementation of indicated prevention for long term sickness absence. *Work* 2017;57:157–72.
51 Iavicoli S, Valenti A, Gagliardi D, *et al*. Ethics and Occupational Health in the Contemporary World of Work. *IJERPH* 2018;15:1713.
52 de Vries E, Kathard H, Müller A. Debate: Why should gender-affirming health care be included in health science curricula? *BMC Med Educ* 2020;20:51.
53 Nowaskie DZ, Patel AU, Fang RC. A multicenter, multidisciplinary evaluation of 1701 healthcare professional students' LGBT cultural competency: Comparisons between dental, medical, occupational therapy, pharmacy, physical therapy, physician assistant, and social work students. *PLoS One* 2020;15:e0237670.
54 Harrison J. Training the next generation of occupational physicians. *Occup Med* 2021;71:322–4.