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Transgender-positive approach overdue in acute care

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Credit: University of California, San Francisco

Fears of insensitive questioning, withdrawal from hormone treatment and the use of a patient's legal name, rather than chosen name, may drive many transgender people away from acute care facilities, including emergency departments, urgent care and inpatient treatment, according to an analysis by UC San Francisco doctors in *JAMA Internal Medicine*.

In their review, publishing Aug. 27, 2018, the authors combed 80 studies to evaluate the medical needs of the estimated 1.4 million adults in the United States whose gender identity differs from their sex assigned at

birth.

In one cited study from 2015, one-third of more than 27,000 transgender people surveyed by the National Center for Transgender Equality reported at least one negative experience over the past year with their health care provider. This included refusal of treatment or verbal harassment. Additionally, close to one in four did not see a physician in the past year due to concerns about being mistreated. This distrust may lead transgender patients to avoid routine doctor visits and coming to acute care facilities when a disease is advanced, the authors noted.

"We believe that the majority of doctors and clinicians want to provide optimal care to all patients, but lack of training may mean that some fail to handle interactions with transgender patients in a culturally sensitive manner," said first author Nicole Rosendale, MD, assistant professor in the UCSF Department of Neurology and a neurohospitalist at Zuckerberg San Francisco General Hospital and Trauma Center.

Certain Questions Need to Be Nixed

Cultural sensitivity means rephrasing questions about the patient's "real" name, "sex change" surgeries or making references to their "biological" or "genetic" gender. Instead, health providers should ask about the name they are currently using, gender-affirming surgeries and the sex they were assigned at birth, said Rosendale, who is also affiliated with the UCSF Weill Institute for Neurosciences.

Clinicians can also reduce stress in transgender inpatients by allowing them to wear their own clothes, rather than a hospital gown, if that is an important component of their gender expression; and by placing them in a private room or shared room based on common gender identity.

"An acute hospitalization can be a scary, depersonalizing experience,"

said Lawrence Haber, MD, associate clinical professor in the UCSF School of Medicine and senior author of the review. "As providers, we want to do whatever we can to empower patients and make them feel comfortable in our care."

Rosendale and her colleagues, who are also hospitalists, propose that electronic health records retain consistent, dedicated space to capture chosen name and pronoun. This not only promotes better doctor-patient interactions in acute care settings, where they may be meeting for the first time, but may have important ramifications for the interpretation of laboratory values.

"The electronic health record may be misleading if potentially abnormal values are identified based on the patient's legal sex," Rosendale said. "In some instances, the record may even discount biomarkers that are thought to be sex specific, such as prostate-specific antigen in a transgender woman. Or it may prevent a clinician from ordering particular studies, such as a pregnancy test in a transgender man."

Cessation of Estrogen Therapy May be Unnecessary

Doctors' tendency to put estrogen therapy on pause in transgender women at higher risk for venous blood clots, stroke and heart attack, may be unwarranted and could result in masculinization after a few weeks of treatment cessation, according to the authors.

"There is a dearth of formal education in transgender health in undergraduate and graduate medical education," Rosendale said. "We have limited knowledge about medication risks – much is extrapolated from data in non-transgender populations receiving similar therapies, or based on smaller observational studies or case series of transgender patients."

While risks for venous blood clots in transgender women are the greatest concern, studies are conflicting. Those risks may be contingent on duration of hormone use, formulation of estrogen, type of drug delivery and additional risk factors. Discontinuing or changing the treatment should be considered after a discussion with the patient about the currently known risks and benefits.

"Our goal is to provide practical skills to help clinicians feel comfortable caring for transgender patients, as well as highlight specific steps that institutions can take towards more inclusive systems of care," Haber said.

Studies cited in the review indicate that 25 percent of respondents in the 2015 U.S. Transgender Survey reported undergoing transition-related surgery, while 49 percent received hormone therapy. Eighty out of 158 primary care providers (51 percent) in a 2017 study were willing to provide hormone therapy for transgender patients.

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