Family Medicine and Community Health

Providing primary care to transgender patients

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Lara (not an actual patient), a 45-year-old transwoman, presents to your clinic for a yearly check-up. She has no significant medical history except for asthma. Her surgical history includes appendectomy and breast augmentation. Family history is significant for a mother who developed breast cancer at age 55 years and a brother with type 2 diabetes. In terms of her social history, she does not smoke, drinks 1–2 glasses of wine on the weekends and has been in a mutually monogamous relationship with a male partner for 2 years. Her medications include spironolactone, oestradiol and escitalopram.

Transgender people—people who identify as a gender other than the one assigned at birth—have existed throughout human history and in multiple cultures. Yet at no time have they received as much attention as they have in the last few years. The validity of their identities and their corresponding legal rights are a political battleground in the USA. Despite the increasing prevalence of people coming out as transgender or gender-expansive, and despite the trend towards greater societal acceptance of non-binary gender identities, transgender patients face significant barriers to accessing basic medical care. Medical schools and residencies have traditionally provided very little training on caring for transgender patients, a paradigm that is only now beginning to shift. Contrary to popular belief, patients identifying as transgender or gender-expansive span the entire age range, with paediatric to geriatric patients choosing interventions that include puberty-blocking medications, hormone therapy and/or surgical interventions. Primary care doctors find themselves learning, often from patients, how to provide sensitive, competent care to this underserved and marginalised population.

Several years ago, my panel of patients identifying as transgender consisted of four patients in their 50s–70s and one teenager. Even among the patients in their 50s–70s, it was remarkable how different their stories were. One transitioned at the age of 15 years. One was in her 50s and transitioning, having waited until her children were grown. One transman transitioned in his early 20s after getting married and becoming pregnant. He eventually married the love of his life, a woman who accepted him completely. His stepchildren and community have no idea about his former identity.

In 2010, the National Transgender Discrimination Survey interviewed 6450 transgender patients about their experiences in the healthcare setting. Fifty per cent of respondents said that they found themselves in the position of having to educate their doctors about transgender medical care (Grant JM, Mottet LA, Tanis J, *et al. National Transgender Discrimination Survey Report on health and health care*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, October 2010). I was one of those doctors.

Suddenly, aspects of my workflow that I had previously taken for granted were called into question. This patient needs hormonal therapy, but which endocrinologists were willing to prescribe it? Should I be doing screening mammograms on transwomen on oestrogen? What about transmen who had top surgery? When a prostate specific antigen (PSA) came back at a critically high value on a transwoman, was it because the electronic health record was using reference ranges for natal females?

These questions were time-consuming, but I was motivated to find the answers. I will be the first to admit that I sometimes sacrifice delving deeper in the name of getting things done. What motivated me to delve deeper here, though, was the utter, unexplainable grace these patients had with my fumbling. They voiced genuine appreciation of my time and interest in simply hearing their stories. Any primary care doctor knows that this, more than anything, is the reward of our jobs, and

why we show up every day to wade through piles of paperwork and stress our way through impossible schedules.

As it turns out, they had good reason to keep their expectations of me low. The same survey I mentioned earlier showed that 19% of transgender patients were outright refused medical care. The percentage was even higher among transgender patients of colour—28% were harassed in medical settings, and 2% were victims of violence in a doctor's office. Fifty per cent had to teach their provider how to care for them.

It isn't fair that patients who are already underserved and marginalised by society should carry the responsibility of teaching their providers. I wanted to provide a high standard of care that all of my patients deserve. Gradually, over time, I was able to learn more about caring for transgender patients. I went to a national conference, and to a community symposium. I found a network of transgender health providers for my state and got on their listserv. I read journal articles, and talked to endocrinologists. And what I learnt from all that was this: providing competent primary care to transgender patients is not that hard.

You may be sceptical at this point, but let me tell you: it's 10 times easier than remembering the new lipid management guidelines, or the slew of inhalers that none of my patients can actually afford. Basically, it comes down to this:

1. Show respect using your patient's preferred name and pronoun, and teaching your staff to do the same. When you make a mistake (not if, but when)—by misgendering someone, or using the wrong name, just apologise and move on.
2. Reflect the patient's language—about their identity, relationships and body parts. If someone refers to their husband, call them their husband. If someone refers to their bottom area instead of their vagina or penis, respect their preferences by using that term with them as well.
3. Take a good surgical history and 'screen what they have'. This means if the patient has breasts, a uterus or a colon, follow age-appropriate cancer screening guidelines for those organs. The one exception is breast cancer screening in someone who's been on oestrogen longer than 5 years, or has a first-degree relative with breast cancer, in which you might start earlier and screen more often.
4. Have a go-to resource for the fine details. My favourite is the review article 'Best practices in LGBT care: a guide for primary care physicians' (McNamara MC, Ng H. Best practices in LGBT care: a guide for primary care physicians. *Cleve Clin J Med* 2016;83(7):531–41). Table 4 succinctly summarises all the screening and immunisation recommendations based on gender identity and sexual practices. Another excellent resource is 'Care of the Transgender Patient' (Safer JD, Tangpricha V. Care of the Transgender Patient. *Ann Intern Med* 2019;171(1):ITC1–ITC16).
5. Start making a list of local specialists (in all fields of medicine, as well as therapy providers) who are trans-affirming for when you need to make referrals or consult.
6. Implement ways to make your clinic more accessible to lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) patients. This link, http://transhealth.ucsf.edu/trans?page=guidelines-clinic-environment, provides several helpful suggestions. Cultural humility is key.
7. For transgender children and adolescents, work with, or refer them to, an interdisciplinary programme where family dynamics and needs can be addressed.

Let's try this out with the case above. Lara is 45 years old, so lipid and A1c measurements may be warranted. She is a transwoman, which means that she was assigned male at birth and transitioned to female. Therefore, she does not have a uterus, so no cervical cancer screening is needed. Breast augmentation by itself is not an indication for mammography, but her family history of a first-degree relative with breast cancer is, as is oestrogen therapy for greater than 5 years. Her history of asthma means she needs a Pneumovax on top of the regular Tdap. It is great that she doesn't smoke, because if she did, that would compound her baseline elevated risk for venous thromboembolism on oestrogen. She is on spironolactone, so it would be prudent to check her blood pressure, potassium and creatinine, if they haven't been checked in the last year.

What about sexually transmitted disease (STD) screening and immunisations? Here, we go back to Table 4 of 'Best practices in LGBT care'. For transgender women, it recommends considering screening for STDs, such as HIV, gonorrhoea and chlamydia, every 6–12 months, based on the patient's history. Even if the patient is monogamous, it is important to ask if their partner is also monogamous. Also, consider testing for hepatitis A and B antibodies, and immunising them if they are not immune. The meningococcal vaccine may also be warranted if they have an additional medical, occupational or lifestyle risk factor. Read https://www.cdc.gov/std/treatment/sexualhistory.pdf for more information on taking a detailed sexual history using the five Ps (partners, practices, past STDs, protection from STDs and pregnancy prevention).

While this patient may not currently be high risk enough to qualify for pre-exposure prophylaxis (PrEP) against HIV, it would be good to let her know that if her relationship status changes in any way, that you can prescribe PrEP. An easy way to see if someone meets criteria is to visit www.ispreprightforme.com, where the patient can complete a short, confidential quiz. Warning: this quiz does not ask the question of whether their partner is monogamous.

Osteoporosis screening by dual x-ray absorptiometry (DEXA) scan would not be indicated in this patient until she turns 65 years old, unless she had her testicles removed and is not compliant with her oestrogen. The same recommendation would apply to a transman who had an oophorectomy and is not taking testosterone. Finally, screen for depression, anxiety, domestic violence

and substance use, all of which have a high prevalence in the lesbian, gay, bisexual, transgender (LGBT) population at large.

My message to primary care doctors treating transgender patients is this: do what you do best. Listen to your patients' amazing stories. Give them the sacred space to be vulnerable, physically and emotionally. Look up answers to questions when you don't know them, and enjoy learning something new that can help people. Let the grace wash over you. Repeat.

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