COMMENTARY

Training in Gender Affirming Care is Medically Necessary

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In July 2023, Senate Bill 150 (SB150) became law in Kentucky, the home of these authors as well as the American Board of Family Medicine. SB150 bars medical providers from prescribing puberty-blockers, gender affirming hormone therapy, or surgery to minors.[1] The wave of antitransgender legislation that swept the country that year[2] greatly impacted our practice, and most importantly the health of our most vulnerable pediatric patients. In this commentary in response to Barr et al, "Family Medicine Residents' Intentions to Provide Gender Affirming Care,"[3] we briefly review the medical rationale and our personal reasons for providing gender affirming care (GAC), discuss the impact of training on access to care, and call for research to increase this important provider workforce.

Transform Health was founded by the first author (KFB) in 2016, as a multi-disciplinary team dedicated to providing LGBTQ+ health care, training, research, and community outreach. The Transform Health clinic was set up as a way for KFB to provide a safe space (designated visit slots/times) within the Family and Community Medicine department at our academic medical center. She began seeing new LGBTQ+ patients 1 half-day a month. Transform quickly had a 6 month waitlist (with relatively more follow up visits), which necessitated a gradual increase to weekly sessions. By 2018, KFB had to move 100 non-LGBTQ+ patients to other providers to open panel space for continued demand. Author STM joined Transform Health in 2019 and, likewise, quickly filled her panel. Even with the addition of other providers for short periods of time, our wait list was never shorter than 4 months. Most recently, author MA joined our GAC providers. Still, it is not enough. Presumably due to the very few providers of GAC in our state, we struggle to provide timely care to all the patients who need it, a very common dilemma, especially in more rural and conservative areas.[4]

Over this time, the Transform Health clinic's proportion of transgender spectrum patients to LGBTQ+ patients grew to around 80%. To some extent, this shift was due to a positive change in our clinic: the other physicians and advanced practice providers had become more comfortable taking sexual histories, providing comprehensive testing for sexually transmitted infections (STI's) and prescribing HIV pre-exposure prophylaxis (PrEP). Training our colleagues to provide gender-affirming hormone therapy, however, has never evolved in the same way, likely due to multiple factors, including additional liability surrounding SB150. Nevertheless, we will continue to work on faculty development, resident continuity and other measures to ease our colleagues into a larger scope of practice for their transgender patients.

We undertake this work consistent with the literature demonstrating multiple benefits and safety of GA. Both hormonal and surgical therapy are, by expert consensus and the majority of the literature, the standard of care because they so clearly improve dysphoria.[5–7] Ideal placebo-controlled trials are unfortunately impractical for GAHT. It would be

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See Related Article on Page XXX.

unethical to randomize subjects to no treatment; and impossible to blind, given their overt effect on body structure. In addition, the transgender community is a relatively small population of subjects with low access to health care and great distrust in the medical system,[8] making recruitment and statistical comparison difficult. Nonetheless, the numerous decent cohort studies conducted over the last 3 decades continue to point strongly to reductions in suicidality and improvements in quality of life, especially for people receiving care as children and teens.[9–11] We see these results in real life more than could ever be conveyed on article. We have seen patients come from rural and remote areas where they have felt isolated and afraid, only to reintegrate into their communities once they begin treatment. We've seen adolescents hiding in the dark of telehealth screens who grow into young adults feeling at home in their bodies and engaging actively in their care. We see admissions for suicide attempts and ideation go down. Many patients now serve on our speakers' bureaus to educate current and future health care providers. While hormones or surgeries do not solve every problem, our experiences leave us no doubt that GAC is life-saving care. We need more people to do it. Education and training are part of the mission of Transform Health, and an important area of research.

A number of investigators have studied LGBQ+ or transgender education in medical school and some residency programs.[12,13] They found that the vast majority of gender affirming health education is done in brief, one-time sessions with a multi-modal approach and without practical skills outcomes.[12,13] Anecdotally, there has been a large push to include gender diversity training into medical school and residency, though to what degree and within what scope remains unclear. Barret al extend this research, demonstrating that the intention of graduating residents to provide GAC remains far lower than the need, and that states with restrictive laws, unsurprisingly, have less interest from residents.[3] While broadly generalizing, we assume that states with restrictions on gender affirming care, many of which have largely rural populations and conservative cultures, had the least access to care at baseline, as well as people more at-risk for poor mental health and suicidality. We would argue these states desperately need more providers of GAC, not fewer. Yet, we find it difficult to train our own trainees and colleagues adequately for the task. Even at times when LGBTQ+ and transgender rights and visibility were expanding, learning the principles, medications, and laboratory surveillance of GAHT was a hard sell for busy, overwhelmed clinicians with more care gaps to close and electronic health record boxes to click.

The global pandemic's blessing in disguise was telehealth expansion, but that did not reduce clinical work by any means. Now antitransgender legislation has introduced a new fear of liability based on political definitions of health rather than science-based risks and benefits. Providers must now consider a high potential for increased scrutiny.

How do we increase the number of family physicians doing gender affirming care in this most crucial time of vulnerability for our patients? We can cite the ethics of our profession, the position of the AAFP, curriculum development across the educational spectrum including professional development, and so on. Practically we need high quality research on experiments and models of curriculum content and style, dissemination of practice through immersion and normalization, and integration of standardized patients and OSCE's to name a few. We also need clear definitions of gender affirming care. Barret al, in fact, posed the question of whether residents planned on incorporating GAC into their clinical practice, without actually defining it.[3] Even the definition they include in their article, while appropriately broad, leaves itself open to resident interpretation. Did residents decide that using gender—inclusive intake forms, or providing a referral to another clinic would constitute a "yes" response to intention to provide gender affirming care? Did most of them generally only count puberty blocking or hormone therapy as GAC? We would argue that inclusive forms and accessible referrals constitute the bare minimum care and respect that should be practiced by every provider, so what we really need to know is which specific services current and future physicians (and other providers) have enough training to do, intend to do, and actually do. One of the training mechanisms of our Transform Health initiative is Transtrack, a residency emphasis within our department. Residents in this track spend more time in the attendings' Transform Health clinic, attend 5 to 6 didactic sessions each year, and have opportunities to do scholarly work, teaching, or community engagement. Author MA, who is a graduate of our Transtrack, found that her understanding of hormones and related therapy for both transgender and

cisgender patients improved tremendously. She also noticed that having transgender care as a focus in our outpatient clinic has resulted in all the residents (as well as other attendings and staff) being more confident seeing transgender patients across all health center settings and transitions of care. Qualitative research on trainees and providers would bring out similarly nuanced benefits and drawbacks of GAC that is integrated in Family Medicine, and augment our understanding of why physicians and other providers do or do not include GAC in their practices.

We each made the choice to provide hormone therapy based on patient and community need for a life-saving treatment that we were capable of learning. What we have gained from doing the care is more than self-development or a sense of acting ethically. We see patients' quality of life improve in real time. We help restore the trust of individuals and communities in doctors and health care. There is no better antidote to provider burnout than finding meaning and joy in your work, and yet, Barr et al. Found that under 30% of Family Medicine residents overall, and barely over 20% in politically restrictive states, intend to pursue this type of meaningful patient care.[3] Even in our restrictive state of practice, we are dedicated to providing evidence-based treatment and training, because we do not want anyone to miss out on the benefits to patients and providers. The study by Barr et al. serves as background data, while this commentary serves as a call for expansion of both training and research until GAC is an integrated, normalized part of Family Medicine practice that benefits patients, Family Physicians, and the community.

To see this article online, please go to: http://jabfm.org/content/00/00/000.full.

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