EDITORIAL

From Medicalization to Empowerment: New Horizons in Transgender Care

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This issue of *Annals of Family Medicine* features 2 articles on the care of transgender (trans) individuals. In an age of disinformation and political persecution of trans people, providing empathetic and evidence-based care to trans patients has never been more important. Throughout this piece the term trans is used inclusively to represent all who identify with a gender different than their sex assigned at birth.

Porat and colleagues conducted a fixed cohort study to investigate the incidence of erythrocytosis secondary to testosterone hormone therapy in trans individuals.[1] Overall, the cumulative incidence of erythrocytosis among their participants was low (12.6% for hematocrit >50.4%; 1.0% for hematocrit >52%; 0.6% for hematocrit >54%).[1] Their results add to growing literature suggesting that though testosterone use is associated with erythrocytosis, severe erythrocytosis (hematocrit >54%) is uncommon, and clinical significance of this level in a healthy individual is unclear.[2,3]

Current Endocrine Society guidelines suggest laboratory monitoring every 3 months in the first year of therapy to monitor for side effects such as erythrocytosis.[4,5] In the context of evolving care delivery and efforts to mitigate barriers to care and overmedicalization of transness, the team aimed to evaluate the necessity of quarterly laboratory draws. Their study is timely as the most recent World Professional Association for Transgender Health Standards of Care were published in Fall 2022.[6] The guidelines support the monitoring of hematocrit (or hemoglobin levels), but their comment on frequency parallels the hesitancy explored by Porat; they "suggest rather than recommend testing to be carried out every 3 months in the first year to allow some flexibility on the timing of these tests as there is no strong evidence or evidence from published studies supporting specific testing intervals."

Guidelines for testosterone-induced erythrocytosis in trans individuals are largely based on studies of cisgender men who are hypogonadal.[3,5] The authors argue that drawing a hemoglobin/hematocrit laboratory quarterly in the first year for all patients may be unnecessary. Instead, they recommend using shared decision making that considers individual preferences, care accessibility, and any clotting risk factors (eg, tobacco use, body mass index [BMI]) that may favor more frequent laboratory draws. Taking their conclusions one step further, this transition should also spur a shift away from the gender binary that currently drives principles of hormone dosing (including standardized laboratory draw frequencies and "goal" laboratory values). Symptom- and response-based titration is more consistent with the spectrum of gender identities and embodiment goals seen in trans individuals and as such should be the primary guiding principles of dosing.

In collaboration with community members, reevaluation of care models with an accessibility lens is imperative because trans individuals face significant barriers to health care access.[7] One barrier is the anticipation of discrimination, which may dissuade individuals from presenting to treatment or disclosing information about their identities.[8] With this in mind, Alpert and colleagues utilized a community-based participatory research model and qualitative data approach to explore the experience of trans individuals during clinical encounters.[9] They interviewed 30 participants, and their results yield insight for clinicians into the experiences of trans individuals when their gender identities are known, and the reasons they may modify or withhold information.

To understand the experiences of trans individuals in a physician's office, though, clinicians must also recognize what occurs outside the examination room. Trans individuals navigate systems of interpersonal and structural discrimination, both from inside and outside of medicine, that hinder access to care. The gender minority stress model is central to understanding the health inequities faced by trans individuals and the steps needed to advance quality of and access to care.[10-12]

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The model describes both distal (eg, experiences of prejudice, discrimination) and proximal stressors (eg, the anticipation of mistreatment, concealment of one's identity, internalization of stigma) and the impact that these factors have on both health and health care access.

Gender minority stress affects trans people's ability to access care both before and during interactions with health care clinicians as highlighted by Alpert et al's study. A theme that emerged from their interviews is that trans individuals are frequently faced with the decision of what information to disclose during a visit, balancing stigma risk with the possibility of receiving suboptimal care.[9] The gender minority stress model provides important context for conceptualizing the results of Alpert et al's study and how stressors are compounded upon in trans individuals' journey to receiving quality health care. These factors are further intensified in those with intersecting minoritized identities, and particularly enhanced by the pervasive racism that trans individuals of color face.[13]

Two other thematic findings from the Alpert et al paper are the patients' perceptions of clinicians' questions as voyeuristic, stigmatizing, or self-protective; and the feeling of being pathologized when clinicians learn about patients' trans identity.[9] Supporting these findings, other studies have found that clinicians often misattribute care concerns to trans patients' gender identity or transition, or ask questions about patients' gender identity that are invasive or unnecessary to the visit.[14] Both reflect the pathologizing of trans gender identity and are a form of discrimination colloquially termed "trans broken arm syndrome." A recent article by Wall et al referred to it as "gender-related medical misattribution and invasive questioning" (GRMMIQ).[14] As both Wall et al and Alpert et al posit in their discussions, an increased awareness of this phenomenon will hopefully advance recognition of the biases clinicians bring, either consciously or unconsciously, to their care of trans patients.

Historically, our medical system has done more to harm than heal members of the trans community. Both articles consider how the over-medicalization of trans patients has negatively influenced not only patient care interactions but also medical care guidelines. Family medicine physicians have the unique role of building close, longitudinal relationships with patients over their lifespan. As the primary point of care, this position must be used to think critically about how the medical field can be an unsafe space for trans individuals, and then use that awareness to instead create a safe and affirming medical home.

Read or post commentaries in response to this article.

Key words: barriers to care; gender-affirming hormone therapy; health disparities; primary care; testosterone erythrocytosis; transgender health

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