Transgender Healthcare Saves Lives: Impacts of Access on Suicidality

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ABSTRACT

Transgender care amongst youth has received media and political attention in recent years, with broad impacts on transgender patients, especially in the field of pediatrics. Barriers to care contribute to poor outcomes, including increased suicidality, highlighting the need for equitable access to transgender healthcare. This article discusses strategies for healthcare providers to address these barriers and outlines important considerations for medical trainees and early-career physicians.

RÉSUMÉ

Les soins transgenres chez les jeunes ont retenu l'attention des médias et des politiques ces dernières années, ce qui a eu des vastes répercussions sur les patients transgenres, en particulier dans le domaine de la pédiatrie. Les obstacles au soins contribuent à de mauvais résultats, y compris l'augmentation de la suicidalité, soulignant la nécessité d'un accès équitable aux soins de santé pour les personnes transgenres. Cet article présente des stratégies permettant aux prestataires de soins de santé de surmonter ces obstacles et souligne les points importants à prendre en compte par les stagaires en médecine et les médecins en début de carrière.

Transgender youth face significant health disparities, particularly concerning mental health. I have met countless transgender youth hospitalized after suicide attempts, recalling their chosen names, injuries, and the systemic challenges they endure. These experiences highlight the critical need to address the disparities in transgender healthcare. For example, transgender individuals have higher rates of suicidality, depression, and anxiety

compared to cisgender peers (1). Notably, providing gender-affirming care is associated with a 60% lower risk of moderate or severe depression and 73% lower risk of suicidality compared to baseline, when measured by validated depression and anxiety scales (the Patient Health Questionnaire 9 (PHQ-9) and Generalized Anxiety Disorder 7-item (GAD-7)) at 3, 6, and 12 months of follow-up in an urban multi-disciplinary clinic (2).

Transgender youth face significant barriers to care with limited accessible providers, uncoordinated care, and gatekeeping and delayed access (3). Thus, transgender youth tend to avoid seeking healthcare because of fear of being challenged about their identity and 40-50% have unmet health needs, as evidenced by a cross-sectional study using nation-wide survey data of 2000+ youth across Canada in 2019 (4,5). This can be particularly distressing, when delayed treatment can lead to irreversible pubertal changes (6). Consequently, up to a quarter of patients obtain hormones from unregulated sources or attempt surgical procedures on themselves (7).

Within Canada, wait times range from 4-12 months (4) to diagnose gender dysphoria and discuss treatment options ranging from reversible (puberty blockers), partially reversible (cross-gender hormones), and irreversible (gender-affirming surgeries) options (6). Although medical therapy is not benign (altered bone density and vitamin D levels), this can provide time for identity exploration (8).

Despite life-saving implications, there is significant hesitancy to provide transgender care. Anecdotally, many cite concerns of patients regretting their decisions, which is not supported by the literature, with low rates of re-transitioning (<10% in North America) (9) and a majority of trans-identifying individuals reporting no decisional regrets (10). Other provider-specific barriers include stigma, knowledge gaps, and lack of exposure (11), which may stem from within medical education.

Unfortunately, medical students often lack exposure to 2SLGBTQ+ healthcare (12), despite trainees having some of the existing skills to participate in certain aspects of care. I would argue conversations about gender dysphoria are comparable to adolescent psychosocial history screening tools (HEADSS) (13), which ask about sexual practices, sexuality, and gender/sexual identity as part of a routine screening tool for all adolescents (14). Likewise, counselling on gender-affirming surgeries parallels consent for other irreversible surgeries (e.g., hysterectomy). Similarly, navigating mature minors and family/home conflicts are not unique to transgender youth. Although these examples highlight that medical students have some foundational skills required to engage in transgender healthcare, I believe that educational reform is required to increase comfort in applying existing skills to this patient population. Additional barriers to competence included limited curricular time, lack of topic-specific competency among faculty, and underwhelming institutional support (12). This is particularly important as transgender care has medicolegal implications under human rights legislations in Canada that recognizes gender identity as a prohibited ground of discrimination and encourages physicians to refer to specialists when care is outside their comfort or expertise (15).

Therefore, I encourage my colleagues to engage in the reform of medical education to address curriculum gaps to increase competence in providing transgender healthcare, which has lifesaving implications. There is evidence that simple interventions such as a 1 hour patient panel followed by a 1 hour small-group session with case studies dedicated to LGBTQ+ health topics in undergraduate medical education lead to an increased willingness to treat patients with gender identity issues and enhanced awareness that sexual identity and practices are clinically relevant (16). Specific to transgender healthcare, incorporating gender identity, treatment regiments, and monitoring requirements for medical management for transgender patients into the endocrinology unit of a second-year pathophysiology course was shown to significantly increase student willingness to care for transgender patients (17). Although these interventions have notable impacts, I argue that competence, which is fundamentally different than familiarity or willingness to provide care, requires more than a one-time session. In support of this notion, a recent scoping review identified 131 papers related to medical education and transgender health and found that transgender medical education is largely composed of “one-time attitude and awareness-based interventions” that do not provide competence to trainees (12). As such, further research and work is required to understand how to increase the competence of trainees in providing transgender healthcare.

In the meantime, something as simple as using chosen names can have tremendous effects, and lowers rates of depression, suicidal ideation and behavior (18). Likewise,

when transgender youth were asked what they want doctors to know, they wanted to feel as if "you are on [their] team", for special care during genital exams, to remember "names, pronouns, and gender markers are important" and that therapy "can save [their] life" (19). Trainees should also familiarize themselves and refer parents/youth to available resources that address such topics (20,21).

Ultimately, a lack of suitable care to transgender youth is harmful and we should facilitate these difficult conversations alongside patients, families, and caregivers through comprehensive assessments and shared decision making, with special consideration for family/caregiver dynamics, barriers to access, psychiatric comorbidities, and suicidality. Although it is a difficult process, transgender care can save lives, and should remain a priority.

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Conflicts of Interest Disclosure
There are no conflicts of interest to declare.