Competent ED Care of Gender-Diverse Patients

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Key Points

- There is not yet a formal, systematic recognition of the transgender and gender nonconforming (TGGNC) population living in the US. Like the US census, most healthcare research and electronic health records only collect binary sex or gender data so TGGNC people in the US are systematically made invisible.
- A simple, gender-affirming practice for emergency medicine (EM) clinicians is to universally ask patients their name (or how they would like to be addressed or called) and pronouns, and then use the correct names and pronouns. Gender affirmation supports patients' mental health and also protects their social safety.
- EM clinicians should be familiar with the social, medical, and/or surgical gender-affirming practices of TGGNC people and be able to competently address complications.
- TGGNC-relevant education and training of all EM staff, including nonclinical staff, will improve emergency healthcare of TGGNC patients.

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Foundations

Background

Transgender and gender nonconforming (TGGNC)[1] individuals have a gender identity that is different from that which was assumed or assigned, commonly based upon genitalia, at their birth. Transgender and gender nonconforming are separate gender identities, though they can overlap for the individuals who hold these identities. For example, some transgender individuals also identify as gender nonconforming. Gender identity is different from sexual orientation, though the two are often conflated or grouped together in the acronym "LGBT." TGGNC people, like cisgender people, can identify with any sexual orientation, including heterosexual, bisexual, pansexual, lesbian, or gay (Table 7.1).

Evidence Basis

TGGNC people have disproportionately high rates of negative and traumatizing life experiences that adversely impact their physical and psychological health, which often compounds their need for healthcare access. However, TGGNC individuals face significant barriers to receiving healthcare, beyond the inability to afford care [1]. Multiple studies across various medical specialties, including emergency medicine, have demonstrated that TGGNC patients experience negative interactions with healthcare practitioners and institutions [2–8]. Although most of the general ED population (92%) are satisfied with their care, TGGNC patients disproportionately report dissatisfaction with ED care [2–4, 9] and report misgendering, being mocked by ED clinicians and staff, being outed by staff, being asked inappropriate questions, and even being assaulted by care practitioners [2–4]. Some TGGNC individuals report not seeking care to avoid discriminatory interactions in yet another societal institution [2, 8].

Training about physical health, behavioral health, and social issues that affect TGGNC people is critical for clinicians yet has been traditionally left out of standard medical education curricula. The estimated number of TGGNC in the US is similar to the number of people living with HIV in the US: 1.2 million [10]. Basic information about HIV and its relevant medications and emergency complications is common knowledge among EM clinicians—it is a standard part of EM education and training. The same cannot be said of TGGNC-relevant healthcare. At the time of this writing, there is no systematic, formalized training about the care of TGGNC patients in health professional schools and residency training programs [11–14]. TGGNC patients find that their clinicians are not versed in the medical care that is relevant to gender-affirming practices, surgeries, and medications, so patients avoid or delay care, and/or have to teach their clinicians [1, 2].

[1] Not all "TGGNC" people have a "trans" identity. Some people whose life experience meets the definition for transgender identify exclusively with a particular gender. For example, a person who was female-assigned at birth might identify as a man (and *not* a transman). In this chapter, "TGGNC" includes people who identify as any gender that was not assigned to them at birth.

Table 7.1 Definition of terms

Term	Definition
Cisgender	Gender identity aligns with sex genitalia; gender identity matches gender assumed at birth
Intersex (or "disorders" or "differences of sex development"[a])	People whose gonadal, genital or other sex characteristic development varies from stereotypical female or male sex development; usually related to a congential difference in development
Transman (female-to-male (FTM))	Assigned female gender at birth, but gender identity is male
Gender-affirming	Behaviors or interventions that affirm a transgender person's gender identity (e.g. hormone use, choice of clothing)
Gender dysphoria	Distress that arises from incongruence between one's gender identity and one's assumed sex at birth (including physical traits and gender role)
Gender expression	Behavior, clothing, and/or personal traits that communicate gender (though expression and identity may not be the same)
Gender identity	Personal or subjective sense of self as belonging to a particular gender
Gender nonconforming/ gender nonbinary/ genderqueer	Terms for people who do not subscribe to binary "male" or "female" gender distinctions and may identify with both, neither, or a combination of male and female genders
Transwoman (male-to-female (MTF))	Assigned male gender at birth, but gender identity is female
Misgender	To incorrectly gender someone (in speech or in writing) by using the wrong name and/or pronouns.
Outing	Rather than "coming out," in which an individual purposefully tells about their gender identity (and/or sexual orientation), "outing" is when someone else tells or behaves in a way that discloses an individual's gender identity (and/or sexual orientation) without that person's express consent.
Queer	Umbrella term for people who do not identify as heterosexual and/or cisgender
Sex (Natal sex)	Genetic and physical traits associated with maleness or femaleness
Sex marker	The sex binary is used on formal identification and insurance cards, and the "F" or "M" identifies the holder as "female" or "male," respectively. "Sex marker" and "gender marker" are often used interchangeably, although sex and gender have different meanings.
Transgender	Actual gender identity does not align with gender assumed based upon genitalia at birth
Transitioning	Shifting one's gender expression to be more or less masculine/feminine
Transfeminine	Birth-assigned male individuals that identify as girls, women, or gender nonconforming
Transmasculine	Birth-assigned female individuals that identify as boys, men, or gender nonconforming
Transphobia	Prejudice against and dislike of transgender and genderqueer people
Transsexual	Historically used to refer to gender-affirming expressions of identity different than that which was assigned at birth
Two-Spirit	This term was coined in 1990, at the 3rd Annual Inter-tribal Native American, First Nations, Gay and Lesbian American Conference, and is used by some Indigenous people to communicate that they have a masculine and feminine spirit (this conceptualization includes diverse gender identities and same-gender attraction)[b].

Jalali and Sauer [47]

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[a]In 2006, the medical community stopped using the term "intersex" and started using "Disorders of Sexual Development." But this terminology is not uniformly, or even commonly, accepted among the people to whom it is meant to be applied, as it pathologizes many people with healthy bodies. Interested readers can start to learn more here: https://ihra.org.au/allies/

[b]"Two-Spirit Community." Re:Searching for LGBTQ2S+ Health. 2019. Available at: https://lgbtqhealth.ca/community/two-spirit.php. Accessed 28 April 2019.

The following sections aim to familiarize EM clinicians with the basics of TGGNC-specific emergency medicine needs using evidence-based information when available, and otherwise, best-practice guidelines. Because inclusive gender data has not been systematically collected, potential health outcomes are largely postulated based upon expert opinion and reasoned extrapolations from cisgender data. However, clinician and patient experiences, and available evidence, indicate that gender-affirming interventions (medical, surgical, and social) improve the mental health of TGGNC people, and that overall, when performed safely, gender-affirming interventions impart more benefit than risk [15–18].

Emergency Department and Beyond

Bedside

First and foremost, emergency clinicians can foster an environment of respect and safety that ensures TGGNC patients are treated with the same dignity as any ED patient. Unfortunately, TGGNC patients consistently report negative experiences in emergency departments including overt discrimination and mockery, as well as shaming or disgust from their treatment team [2–4]. To make emergency departments safe for TGGNC people, clinicians will need to combat their own explicit and implicit biases,[2] and constructively intervene when colleagues behave in ways that perpetuate stigma. Samuels et al. identified three specific areas for improving the ED experiences of TGGNC patients: communication, privacy, and competency [3].

Communication

Communication is of the utmost import to high-quality healthcare provision and yet, when caring for TGGNC patients, clinicians may find communication challenging on many fronts. One challenge is that the emergency clinician may not know when they are caring for a TGGNC patient. Often this information is not contained in or successfully communicated via the electronic health record (EHR). Some

[2] "Bias is the application of an attitude or preconceived notion (stereotype) to form a preference toward or against something or someone, which can manifest through behavior. Bias is explicit when the holder of the bias is conscious or aware that he or she has this preference or partiality. 'Implicit' or 'unconscious bias' is an unconscious attitude or partiality that 'is not readily apparent to the individual and can differ markedly from a person's explicit and expressed beliefs' (Sabin et al., 2009)" [Chisolm-Straker & Straker, 2015]. Implicit bias can affect clinical decisions and provider-patient interactions.

Sabin, J.A., Nosek, B.A., Greenwald, A.G. and Rivara, F.P. (2009), "Physicians' implicit and explicit attitudes about race by MD race, ethnicity, and gender," Journal of Health Care for the Poor and Underserved, Vol. 20 No. 3, pp. 896–913, doi: https://doi.org/10.1353/hpu.0.0185.

Chisolm-Straker M, Straker H. (2017) "Implicit bias in US medicine: complex findings and incomplete conclusions," International Journal of Human Rights in Healthcare, Vol. 10 Iss 1 pp. 43–55.

transgender patients, whose current name, sex marker, and gender expression socially conform to their gender identity, may be treated without a practitioner being aware that the patient had a different sex assumed at birth. For example, imagine Laverne Cox is an ED patient. Ms. Cox is an actress and transwoman well known for her role on *Orange is the New Black*. Given her feminine name and appearance, she is likely to be perceived as a cisgender female by a clinician. Some TGGNC patients readily disclose their identity to clinicians, others do not. Some do not share this information if they do not discern clinical relevance or if they fear it will provoke maltreatment [1, 2]. Others who have not legally transitioned may not feel empowered to ask clinicians to use their chosen name and gender identity. Astute clinicians may be clued in about a patient's TGGNC identity when they notice a "mismatch" between the patient's name, sex marker, and the patient's gender expression, or when they recognize gender-affirming medications/surgeries/practices during a patient encounter.

If not clearly stated in the EHR, a simple and best practice for clinicians is to ask what name and pronouns a patient uses. Using the correct name and pronouns for a TGGNC patient is a basic and *profoundly* gender-affirming practice. Asking allows the clinician to avoid misgendering, which is a distressing experience for TGGNC people. Many words traditionally used to greet patients are inherently gendered including "sir," "ma'am," "Mr.," and "Ms." For a transwoman to be misgendered and addressed as "Mr." is distressing and likely to negatively impact the entire encounter. Instead, clinicians can initially address patients by last name. "Hi, is your last name 'Hanley-Okua'?" And then follow up with: "What name would you like me to call you by? What pronouns do you use?" Or alternatively, "Hi I am Dr. Jansson and I use he and him pronouns; tell me what name you go by and what pronouns you use." At times, it can be helpful to specify pronoun options: she/hers, he/his, they/theirs. Occasionally, a patient may be upset by these questions or may need some additional explanation: "These are questions that all patients are now being asked to help clinicians, like me, avoid assumptions that can have a negative effect on patients' health and healthcare."

Even when a patient's gender identity is not directly relevant to the clinical presentation, a patient's experience and willingness to seek needed care in the future will be informed by how they were addressed and treated by the medical team. When a practitioner uses an incorrectly gendered term for a patient, it is best to simply acknowledge and correct the error. Unless the patient requests otherwise, the entire clinical care team should *always* use the patient's correct name and pronouns, regardless of whether the patient is present for the discussion. This information should be relayed to all team members, including technicians, phlebotomists, consultants, and transporters. This is particularly important when the electronic health record fails to communicate the correct name and pronouns to use.

Often the very ways clinicians have been taught to elicit histories rely on assumptions that are a barrier to communication with TGGNC people. For example, a question when assessing a patient's sexual health risks such as "Are you using condoms?" makes assumptions about body parts, sexual partners, and/or sexual practices.

Practitioners can instead use more open-ended questions (e.g. "How do protect yourself from sexually transmitted infections?"). Clinicians also need to practice respectful strategies for asking about gender-affirming therapies. As part of best practice with all ED patients, the clinical relevance of any sensitive exam should be explained to the patient and their express verbal consent should be ensured before proceeding. As is always the case, patients with capacity have the right to decline any aspect of care, including parts of the exam. Readers can review the case at the end of the chapter for more guidance on how to communicate about sensitive aspects of the history and exam.

Privacy

All patients deserve privacy for their history and examination and yet, in the reality of many emergency departments, true privacy can be hard to secure. When asking about names, pronouns, and medical/surgical history, it is useful to explicitly acknowledge the lack of privacy and use a lower volume. Sensitive physical exams (including exposure of the chest for EKG) should be performed in private. Routine practices such as fully exposing polytrauma patients to examine for clandestine injury can be distressing for TGGNC patients. Ensuring privacy during the sensitive parts of the history and exam will prevent the inadvertent "outing" of a TGGNC patient to other ED patients or staff members who are not participating in the patient's care. Practitioners should bear in mind that being "outed" in public spaces poses a safety threat for TGGNC patients.

Sensitive history and exams should only be performed if they are clinically relevant. Curiosity is an inappropriate reason to ask a patient about their gender-affirming practices or conduct exams that are not clinically relevant. For example, if a patient presents with a laceration to the arm, their gender-affirming practices are not relevant to the care they should receive. Inquiring into unnecessary history can be traumatizing for the patient and risks outing the patient to those who may overhear. Moreover, it is unacceptable to use a TGGNC patient for teaching purposes without their permission, especially when the "teaching" is simply about the presence of a TGGNC person in the ED. In one study of TGGNC patients that accessed ED care, a participant shared, "I have also had doctors/nurses call over other people on duty to come look at me for no reason. It made me feel like an animal in a zoo" [2].

Competency

Most practitioners have had little training on TGGNC health and health needs [19], and TGGNC people are often put in the position of having to educate their clinicians in order to receive appropriate care [1–3]. Basic knowledge of the gender-affirming social, medical, and surgical interventions TGGNC people use is critical and necessary for EM clinicians. Practitioners must understand why TGGNC people adopt these interventions and practices: to reduce gender dysphoria and/or have their gender expression convey their gender identity. Among a population where suicide is epidemic, these practices and interventions may be life-saving and should be framed as such.

Social (Nonmedical, Nonsurgical) Gender-Affirming Practices

Transition is the social process by which a TGGNC person shifts their gender expression to align with their internal sense of gender identity. TGGNC people may express their gender in the clothing, hairstyle, cosmetics, and accessories they choose, as well as through mannerisms. Other social practices TGGNC people may adopt to modify their gender expression include binding, packing, and tucking. As part of gender transition, some TGGNC people choose to change their legal name/sex. Legally changing one's name and sex marker are two separate processes and can be an onerous challenge. Although requirements can vary by state, changing one's legal name requires a court order and often entails paperwork, fees, and/or placing notices in the newspaper to announce the name change. Many people may not be able to navigate or afford this process. Requirements to change one's sex marker also vary by state and often require a physician's note verifying that a TGGNC person has "completed" a gender transition. This formally and systematically values medical and surgical gender affirmation over social gender-affirming practices. Medical and surgical interventions are not financially and/or medically feasible for all TGGNC people, nor are they uniformly desired [20]. If and once name/gender change has been achieved, a person must then comb through all aspects of their life to update their name and gender marker, including bank accounts, credit cards, loans, titles, utilities, professional degrees, licensures, and insurances.

The costs of transitioning are enormous. Insurance does not always cover gender-affirming medical or surgical interventions. In addition to time and fiscal inputs, the emotional costs include a process that requires innumerable episodes of coming out as TGGNC and also has the potential to exact crushing social loss. Many TGGNC people who transition experience loss of job, family, and/or friends as well as threats to safety. Thus, the decision to transition is quite complex and unique for each individual. For some TGGNC people, social gender-affirming practices are the only way they desire to or have the ability to modify their gender expression.

Binding

Definition

Binding describes the practice of tightly compressing the breasts against the chest wall to create a masculine contour of the chest. For transmasculine people, binding mitigates the gender dysphoria associated with having breasts. Binding can be accomplished using a variety of materials including doubled up sports bras, elastic wrap, and commercially made binders.

Possible Complications

Binding can result in chest pain, dyspnea, broken ribs, and skin avulsion and breakdown if people bind too tightly, for too long, or with unsafe material (e.g., plastic wrap, duct tape) [21].

Appropriate Clinical Interventions

Symptomatic binding should be addressed using harm reduction principles.[3] For the person who binds, this practice has mental health and safety purposes as it mitigates gender dysphoria and allows one to blend in when accessing masculine spaces (e.g., men's restrooms). Thus, simply directing a patient to stop binding is not a safe or feasible option, and doing so communicates a lack of caring about the patient's well-being and safety. Instead, clinicians should recommend safer binding practices such as using properly fitted (not too small) sports bras or commercial binders; limiting daily use to less than eight consecutive hours; recommending against nighttime wear; and suggesting occasional "off days," in which the breast tissue is unbound.

Packing

Packing is a practice some transmasculine people adopt to create a masculine contour to the groin. Packing devices, worn to simulate male genitalia, may be commercially- or home-made. Sometimes these devices may also be designed to allow a transman to urinate while standing ("stand-to-pee" device), which may be important to safely accessing men's restrooms. In the ED, packing devices are most likely to be incidentally discovered during the exposure of a multi-trauma or critically ill patient. In this case, the packing device should be discretely stored with the rest of the patient's personal items. The use of packing devices is not commonly associated with serious medical complications.

Tucking

Definition

Tucking is a practice some transfeminine people adopt to create a more feminine appearance to the groin. This is accomplished by pushing the testicles into the inguinal canals and/or wrapping the penis between the legs. Tape or tight-fitting underwear is used to hold the genitalia in place [22].

Possible Complications

The potential risks of tucking include reduced fertility (tucking renders the testicles unable to move closer to/farther from the body to regulate temperature), fungal infections (due to naturally moist conditions in this region), skin irritation (related to repeated use/removal of tape), urinary tract infections (related to urination avoidance because urination requires one to un-tuck), and chronic pain in the genitalia.

[3] Harm reduction refers to policies, programs, and practices that aim to reduce harms associated with a behavior or action, in people that are unable or unwilling to stop. The defining features are the focus on the prevention or mitigation of harm, rather than on prevention of the behavior itself. Harm reduction focuses on and prioritizes the person, not the behavior.

Appropriate Clinical Interventions

Dance belts (designed to support and conceal the shape of male genitals) or gaffs (designed solely to conceal male genitalia) may be used to accomplish feminization of the groin contour – although perhaps not as convincingly as tucking – and also avoid some of the risks associated with tucking. Patients who have symptoms related to tucking practices can also be counseled to try alternating between dance belt/gaff and tucking.

Gender-Affirming Medications

Gender-affirming medications, including hormones, are another method used to modify gender expression. There are few instances in which an EM clinician should stop or change a patient's gender-affirming medications. Additionally, for those TGGNC patients who are boarding in the emergency department (including psychiatric emergency patients), gender-affirming medications should be continued unless there is a specific contraindication. People who identify as gender nonconforming and desire medication-assisted transition may also be on low doses of virulizing or feminizing medications described below. Many TGGNC people do not have adequate health insurance and/or do not have access to qualified licensed medical practitioners. Still, their mental health is improved with the capacity to alleviate gender dysphoria and express their gender identity. Use of medications from unlicensed providers allows TGGNC people without other means to have more agency in gender expression, but puts them at increased risk of adverse side effects if they are exposed to inappropriate formulations or dosing. Hence it is prudent to inquire about who prescribes gender-affirming medications to a TGGNC patient. A brief summary about medications follows; for in-depth information on specific medical and surgical interventions, practitioners can access "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People" on the Center of Excellence for Transgender Health website [23]. Whether gender-affirming hormones expose TGGNC people to increased risk for mortality- and morbidity-related cardiovascular disease remains to be determined with certainty; the best studies to date are small and have considerable methodological limitations, consequently limiting the implications of their findings [18].

Transmasculine Gender-Affirming Medications

Bioidentical testosterone is used as a single virulizing agent. This is most often delivered as an injection (intramuscularly or subcutaneously), although topical preparations also exist. Testosterone therapy causes voice deepening, clitoral enlargement, male pattern of hair growth/loss, increased muscle mass, and cessation of menses. Polycythemia and derangements of lipid metabolism are common adverse effects.

Transfeminine Gender-Affirming Medications

The primary estrogen prescribed for feminizing therapy is 17-beta estradiol, which is the bioidentical hormone. This can be delivered via oral, topical, or injectable routes. Estrogen therapy causes breast enlargement, feminine adipose distribution,

decreased erections, and testicular atrophy with potential for irreversible infertility. The most common serious adverse side effect that EM providers need to be aware of is the risk of venous thromboembolism (VTE), and still, VTE is uncommon in this population. The risk of VTE is higher with other preparations such as ethinyl estradiol, which can be found in certain oral hormonal therapies prescribed to cisgender girls and women. The risk of VTE is higher with injectable estrogen compared to oral and transdermal preparations; risk is also higher if patients are getting estrogen "off the street" or overdosing (it can be tempting to take extra hormone in hopes of speeding up one's physical transition).

In addition to estrogen, transwomen who still have testicles may also use an antiandrogen agent such as high dose spironolactone (e.g. 200–400 mg daily) to lower testosterone to desired levels. As spironolactone is a potassium-sparing diuretic, hyperkalemia is a medication effect that EM clinicians may encounter.

Gender-Affirming Surgeries

Gender-affirming surgeries are less prevalent among TGGNC people than is medication use. These surgeries are often expensive and can require a long recovery period. Some TGGNC people simply have no desire for permanent physical alteration of their body. As with any surgery, these are often more prone to complications than medical interventions. While there are a variety of "minor" procedures, the major surgeries are often grouped into "top" or breast surgeries and "bottom" or genital surgeries.

Transmasculine Gender-Affirming Surgeries

Among transmasculine people, top surgery, or double mastectomy with chest reconstruction, is the most common surgery. Bottom surgeries include hysterectomy/oophorectomy, metoidioplasty (elongation of the clitoris with or without urethral lengthening), phalloplasty (creation of a phallus), and scrotoplasty (creation of a scrotum).

Transfeminine Gender-Affirming Surgeries

Among some transfeminine people, top surgery, or breast augmentation, may be desired if there is unsatisfactory breast growth after a 1–2 years of gender-affirming hormones. Bottom surgeries include penectomy (removal of penis), orchiectomy (removal of testicles), and vaginoplasty (creation of a neovagina). Some transfeminine people may have other procedures such as facial "feminization," "feminizing" vocal cord surgery, and/or body contouring. The concept of "feminizing" implies that certain ways of looking and sounding are for women, despite the obvious fact that women have a variety of body shapes and voice pitches. Still, transfeminine people with more "feminine" physiques and voices may more easily have their gender identity respected than transfeminine people that have more "masculine" bodies or voices.

- *Facial "Feminization"*

  Surgeries may include forehead and brow reshaping, jaw and chin contouring, rhinoplasty, hairline advancement, and tracheal shaving (reduction in the visibility of the "Adam's apple").

- *Voice "Feminization"*

  In this type of surgery, the vocal cords' length is shortened to produce a higher vocal pitch. Patients may have vocal coaching with a speech and language pathologist before such surgery, to "optimize" results.
- *Body Contouring*

  Body contouring is most commonly used by transwomen who seek a commonly recognized "feminine" shape. While this can be done with clothing modifications (e.g., corsets, shapewear), it can also be done surgically. For example, surgeons may shift abdominal fat to the gluteal and hip region to create the appearance of wider hips and a narrower waist.

  One unsafe body contouring practice used among some transfeminine people is free silicone injections. Nonmedical free silicone injections into the thighs, buttocks, and/or hips are a means of immediate relief of body dysphoria symptoms for transwomen. Free silicone injections may be particularly appealing for transwomen who are unable to access gender-affirming hormones and/or surgeries for medical or financial reasons. Free silicone can cause a serious local soft tissue inflammatory reaction and, if injected intravascularly, can result in embolic disease. The common practice of using nonmedical grade silicone for these injections, as well as having injections performed by nonmedical, inexperienced practitioners, increases the risk for devastating outcomes. Silicone pulmonary embolism, which clinically presents similarly to fat emboli syndrome, can lead to dyspnea, chest pain, hemoptysis, alveolar hemorrhage, acute respiratory distress syndrome, and devastating neurologic sequelae. Care is supportive and patients experiencing sequelae often require admission to a medical intensive care unit.

Insurance coverage for gender-affirming care – medications and surgeries – is company dependent. Some private insurers cover it and others do not. For people on Medicaid, coverage varies from state to state, with a handful of states explicitly excluding coverage for gender affirmation-related care [24]. Some TGGNC people, lacking coverage for needed care, may use unlicensed or unsafe medications and/or procedures, which can have negative health impacts. That said, gender-affirming care is increasingly considered a "medical necessity" and coverage expanded significantly with the passage of the Affordable Care Act [24].

Hospital/Healthcare System

Nondiscrimination Policy

Lambda Legal and the Human Rights Campaign coauthored a landmark publication to guide best practice in hospital policies called *Creating equal access to quality health care for transgender patients: Transgender-affirming hospital policies* [25]. The first best practice they recommend is to adopt and broadly announce a hospital-wide nondiscrimination policy that explicitly includes gender identity and gender expression.

Privacy

Gender identity information should be collected in a private setting. In multiple studies, TGGNC patients have described having their gender identity revealed to other patients as registration personnel asked them about their gender identity with other patients nearby. Not only is this a breach of privacy, but also it poses safety issues including threatening patients' ability to safely access gendered spaces like restrooms. TGGNC people may fear violent attacks if their identity is revealed [26, 27]. In one study, a participant shared, "I revealed my status, which no one knows usually until I tell them….when I tried to use the woman's restroom before I left, they threatened to call security on me. It was humiliating. I would die before I went back there again" [2]. Despite misconception, transgender and genderqueer people using the restroom are substantially more likely to be attacked by cisgender people than cisgender people are to be by TGGNC people [1, 26].

Electronic Health Record & Charting

Systematic, inclusive gender documentation in health records is an important step toward evidence-based care of this patient population. Inclusive gender information should be universally collected from patients and meaningfully displayed in the health record. This can get complicated when a patient has a name and/or gender identity that conflicts with their legal documents. Achieving this goal requires a capable electronic health record and staff properly trained to input the data. Even deciding who within the healthcare team should collect or have access to this information requires careful consideration. Literature indicates that, among literate populations, patients prefer when they can enter this data themselves [28].

For the clinician documenting an encounter with a patient, it is best practice to use the patient's pronouns throughout the document. Sex assumed at birth should be referenced only when it is medically relevant, or when the patient requests that it is documented so that other care team members are aware.

Rooming

Patients should be roomed according to their gender identity. This best practice policy is also supported by the Lambda report [25]. Complaints from other patients do not constitute grounds for an exception to best-practice room assignment, akin to nondiscrimination policies that protect against racial discrimination.

Billing

An ED visit can lead to serious fiscal consequences for an uninsured patient or for a patient whose insurance company refuses to pay for care it deems inappropriate based on the legally recognized gender of the patient. For example, insurance companies have refused to cover gynecologic care for legally recognized men who were assigned a female gender at birth. Awareness of this reality can help practitioners partner with patients to find the best and safest diagnostic and treatment options.

Although the visibility of gender diverse people is on the rise, the average emergency clinician cannot be expected to be an expert in TGGNC health. Beyond ensuring a respectful environment of care, a basic familiarity with the

gender-affirming social, medical, and surgical practices of TGGNC people can improve the safety, efficacy, and perception of emergency care in this patient population. Knowledge about best-practice and evidence-based care of TGGNC-patients is a core competency for all EM clinicians.

Societal Level

Lack of Systematic Recognition

There is not yet a formal, systematic recognition of the TGGNC population living in the US. Data collected about sex and/or gender are almost always binary, including only "female" and "male." The federal census only counts female and male *sexes*; in fact, the census is not concerned with *gender* at all. What do TGGNC people do? The options are to choose something that does not completely reflect their identity or experience. Not being counted perpetuates the untruth that such people do not exist. Like the US census, most healthcare research and electronic health records only collect binary sex or gender data. So, TGGNC people in the US are devalued by systematically being made invisible. This presents an ongoing barrier to an evidence-based understanding of the long-term health impact of gender-affirming interventions and how these interact with other facets of a person's health.

Systemic Discrimination, Trauma, and Poverty Negatively Impact Health

While TGGNC identities are not routinely collected in most national databases, there are an estimated 1–1.3 million TGGNC people in the US [29–31]. TGGNC people often experience discrimination in school settings, the criminal justice system, the workplace, and society at large, all of which can impact their health negatively [1, 32, 33]. TGGNC people are bullied in school, verbally harassed while using the restroom, and endure daily micro-aggressions.[4] In the 2015 US Transgender Survey, 52% of those perceived as transgender in primary school were not allowed to wear gender-affirming clothing; 12% experienced harassment when using a public restroom [1]. Violence is a common experience in this community. In a 2011 national survey of TGGNC people, 61% reported physical assault, and 64% sexual assault, at least once [32]. Law enforcement does not reliably offer supportive recourse. In fact, it is not uncommon for TGGNC people to experience trauma from law enforcement agents: 58% of 2011 national survey participants reported verbal harassment, misgendering, physical assault, or sexual assault by police officers [32]. A staggering 40% of TGGNC people report at least one suicide attempt compared to the national average of 4% [32, 34]. TGGNC people are more likely than cisgender people to use illicit substances or alcohol, and many describe their use as a way to cope with the disproportionately high rates of discrimination and trauma they experience [32].

[4] Microaggression: "a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group" (Merriam-Webster, 2019).

Despite achieving higher rates of advanced education, TGGNC people are disproportionately un- or underemployed in comparison to the general population: while 5% of the general population are unemployed, 15% of TGGNC people are unemployed [1]. Denied access to mainstream and legal employment opportunities, TGGNC people are more likely to live in extreme poverty compared to the general population. In a 2011 national survey, TGGNC study participants were four times more likely to have an annual household income of less than $10,000 in comparison to the general US population [30]. To survive, TGGNC individuals are more likely to turn to the "underground economy" (e.g., commercial sex work or selling drugs) to provide for themselves; hence they are more likely to be incarcerated [32].

TGGNC people of color disproportionately experience even higher rates of trauma and hardship than their White TGGNC peers. For example, in the 2015 US Transgender Survey, about 18% of participants lived in poverty, but nearly 42% of TGGNC people of color lived in poverty [1]. For some racial groups, the disparities are even more stark: While 1.4% of the survey's respondents were living with HIV (0.3% are living with HIV in the general US population), the rate among Black TGGNC people was 6.7%; for Black transwomen, the rate was 19% [1]. The rate of murder of TGGNC people—especially transwomen of color—is disproportionately higher than any other population [35]. Such disparities are not directly due to race or ethnicity, but result from the intersectionality of marginalized experiences. As evidenced above, systems of oppression, like racism[5] and transphobia, compound harm to individuals with membership in multiple oppressed groups.

In 2017 the National Institutes of Health (NIH) recognized gender "minorities," including transgender populations, as a health disparity population for the purposes of NIH research [36, 37]. But TGGNC people's status in the US is precarious and their rights change based upon the federal administration [38, 39]. Consequently, federal funds and practical capacity to study health issues that specifically affect this population are currently inadequate, limiting evidence-based advancements in TGGNC-healthcare.

The Old Is New Again

The presence of TGGNC people is not novel. People of all genders have been recognized for centuries [40–43]. For example, in some Indigenous nations on the North American continent, a third[6] gender exists to recognize those who do not identify solely as men or women. Such people were valued members of their communities, before European colonization and genocide. In the twentieth century, European Christian influences and impositions yielded a significant loss of community standing for (those who would today be called) Two-Spirit people [44].

[5] Racism can be observed "as a pattern of deeply entrenched and culturally sanctioned beliefs, practices, and policies which, regardless of intent, serve to provide or defend the advantages of Whites and disadvantages to groups assigned to other racial or ethnic categories" (van Ryn et al., 2011).

van Ryn, M. and Saha, S. (2011), "Exploring unconscious bias in disparities research and medical education", JAMA, Vol. 306 No. 9, pp. 995–6.

[6] Some Indigenous nations recognize more than three genders. Wilbur M, Keene A (hosts). All My Relations & Indigenous Feminism. All My Relations. Episode 1. 26 February 2019. https://www.buzzsprout.com/262196/973365-ep-1-all-my-relations-Indigenous-feminism

Marriages between Two-Spirit people and their spouses were no longer legally recognized and Two-Spirit people were forced into the gender binary. Many of those who did not conform lived in secret or killed themselves [44]. With the "gay rights"[7] and "Red Power"[8] movements that started in the 1960s, a reclaiming of culture and respect for gender diversity is reemerging.

It is largely communities of color that have documented TGGNC peoples throughout time, and TGGNC people of color are disproportionately represented among those with negative experiences and health outcomes. But, they are not representatively included in the limited health outcomes' research about TGGNC people [45]. This may be because many of these research endeavors rely on TGGNC individuals already connected to social service and healthcare organizations. Connection to services can out individuals or call attention to "otherness," which may be even more unsafe for TGGNC people of color in the US. Nonetheless, that TGGNC people have been documented throughout time lends credence to the conceptualizations of (1) gender as existing on a spectrum (not as a binary) and (2) diversity in gender identity and expression as a natural, expected phenomenon.

Recommendations for Emergency Medicine Practice

Basic

- The existence of gender diversity around the world has been documented for centuries and yet, until recently, the TGGNC population in the US has been largely invisible, including within the healthcare system, owing partly to the lack of systematic collection of data. *EM practitioners should be able to discuss how this serves to reinforce ongoing disparity and stigma, both in healthcare and at the societal level.*
- Best clinical practice is that EM clinicians universally ask patients their name (or how they would like to be addressed and called) and pronouns, and then *use the correct names and pronouns.*
- *EM clinicians need to be clinically competent in caring for TGGNC patients.* TGGNC people may use social, medical, and/or surgical gender-affirming interventions that sometimes result in health complications. EM residency curricula should include this content.
- *EM practitioners should respect the importance of gender-affirming practices and partner with patients to reduce harm, when it occurs.* Gender affirmation supports patients' good mental health, and may also protect their social safety, which impacts physical health.

[7] While the 1960s "gay rights" movement in the USA largely focused on white, cisgender gay men, its ethos theoretically included other queer people.

[8] A Native American social movement demanding self-determination of Indigenous people in the USA.

Intermediate

- *Develop written hospital policies that explicitly support TGGNC patients.* Formal hospital support normalizes clinicians' gender-inclusive and gender-affirming efforts, and facilitates TGGNC-patient safety and self-efficacy. Policy-makers can refer to the Lambda report for specific recommendations [25].
- *EHRs should capture and communicate the gender diversity of patients,* which is an important component of improving the evidence base for clinicians caring for TGGNC patients.
- *All EM staff, including nonclinical staff, should receive TGGNC-relevant education and training* to improve TGGNC-patient experiences, and ultimately make the ED a safer place for this marginalized population.

Advanced

- *EM clinician-researchers should include all genders in any research endeavors.* For example, when asking participants to share their demographics, the options might be "man," "woman," "transman," "transwoman," "nonbinary," and "other."
- *EM clinician-educators teaching medical professionals should purposefully point out false gender binaries whenever citing gender-noninclusive research.* By calling attention to the exclusion, education leaders make explicit their recognition of TGGNC people, the gaps in knowledge, and a willingness to accept gender nonbinary data.
- *EM clinicians should support state and federal legislation that improves TGGNC-patients' access to gender-affirming healthcare.* In this way, EM clinicians can improve patients' access to primary and preventative care, and may help decrease negative health impacts from the use of unlicensed practices and medications.

Teaching Case

Clinical Case

"James S."

A 34-year-old transman presents to the emergency department with a chief complaint of abdominal pain. Vital signs in the electronic medical record are a temperature of 37.9 °C, blood pressure of 127/72 mm Hg, heart rate of 87 beats per minute, respiratory rate of 18 breaths per minute, and a pulse oximeter of 97% on room air.

Practitioner — *Hi, I'm Dr. Martinique and I'll be taking care of you today. What name should I call you by?*

JS — *James is fine.*

JS reports one day of right lower quadrant pain with associated nausea and vomiting. He denies fever, chills, or a change in urinary/bowel habits.

Practitioner — *James, I need to ask you some questions about your sexual health and gender in order to figure out what might be causing this pain.*

	I see from the electronic record that you identify as a man and were assigned "female" at birth. Is this correct?
JS	*Yep.*
Practitioner	*I see that you are on testosterone. Who prescribes the testosterone and do you take it differently than prescribed?*
JS	*I normally go to a gender clinic and they give me the injection every two weeks – I missed my last couple injections because my insurance fell through.*
Practitioner	*Have you had any gender-affirming surgeries, like top or bottom surgery?*
JS	*Just top surgery.*
Practitioner	*Can you describe who you are having sex with and what parts of your body you use during sex?*
JS	*I only have one partner. I've been with him for the past two months. We only have oral sex.*
Practitioner	*Okay, just to make sure I understand: You're sexually active with one male partner. You have sexual contact in which he puts his mouth on your genitals and vice versa.*
JS	*Yes.*
Practitioner	*How do you protect yourself from STIs?*
JS	*We don't use anything. He told me he's clean.*
Practitioner	*Have you noticed any discharge, bleeding, or pain in the lower genital or anal region?*
JS.	*No.*

Given that the patient has his natal female anatomy, the initial differential diagnosis in this case is very broad and includes ovarian cyst, ovarian torsion, pelvic inflammatory disease, tubo-ovarian abscess, and ectopic pregnancy, in addition to appendicitis.

Practitioner	*James, there are many things that could be causing your symptoms today and it's important that we look for the most serious causes. To understand what is going on, I need to examine you carefully including a lower genital exam to see if your symptoms could be coming from there. Is that okay with you?*
JS	*Yes.*
Practitioner	*Sometimes people use different words when they talk about their genitals. I am happy to use whatever words will make you most comfortable. What words do you use for your genitals?*
JS	*You can just say "vagina."*
Practitioner	*Ok. Anytime I perform a genital exam, I have to have a chaperone. What gender of chaperone would you prefer? Is there a support person you would like to be here during the exam?*

The exam is notable for an obese abdomen with tenderness in right lower quadrant and right inguinal region without guarding. On pelvic exam, there is no cervical motion tenderness or adnexal tenderness. Lab work shows leukocytosis with left shift, normal urinalysis, and negative urine HCG. CT scan shows uncomplicated

appendicitis. The clinician orders antibiotics and consults general surgery. Ultimately, the patient goes to the operating room for appendectomy.

Practitioner	*Hello Dr. DeJesus, this is Dr. Martinique in the ED. I'm calling to let you know about a patient I have here with a CT-confirmed appy. Do you have a few moments to talk?*
Consultant	*Oh hi, sure, go ahead.*
Practitioner	*Great; the medical record number is A12345. Mr. JS is a 34 year old transman who came in with a day of nausea, vomiting, and right lower quad pain. Pretty classic story.*
Consultant	*I'm sorry, "transman" means what?*
Practitioner	*He was assigned a female sex at birth, but currently identifies as a man. You'll notice that the sex marker is female but he goes by "James" and uses "he/him" pronouns.*
Consultant	*Oh. Uh, are you sure this isn't her ovaries or something GYN then?*
Practitioner	***His** ovaries were assessed, and are healthy. The appendicitis is confirmed on CT; he already got antibiotics.*
Consultant	*Oh. Is there anything special we need to do for this? Do we need a GYN or medicine consult? Any chance this is an ectopic pregnancy?*
Practitioner	*The urine pregnancy test was negative. Seems to be a straightforward, uncomplicated appendicitis.*
Consultant	*I see. Ok. So…basically he has appendicitis and needs surgery; when there is a male bed available, he gets it.*
Practitioner	*Yep! He's in slot 13 in the ED. I told him to expect your team to come down to talk with him some more. I'll be here till seven. See you soon.*
Consultant	*Ok. I'll send the admitting PA. Thanks.*
Practitioner	*Take care.*

Teaching Points

1. Avoiding assumptions: How to ask about sex organs/genitalia, sexual partners, and sexual practices.

   The dialogue between the clinician and the patient demonstrates open-ended questioning to assess genital symptoms and sexual health. TGGNC patients may be uncomfortable talking about their natal anatomy using the standard medical terms (e.g., a transman may feel uncomfortable if a clinician asks about his vagina). Clinicians can use broad, unisex terms like "chest" or "lower area"/"lower genital area" to ask about symptoms in those regions. Alternatively, a practitioner can ask the patient what words they use for anatomical parts and then use those. If directly relevant to the chief complaint, the clinician should collect a surgical history to determine what anatomy the patient has.

   Often the way clinicians have been taught to elicit sexual health information is laced with assumptions about partners and behaviors. For example, asking a patient if they have sex with "men, women, or both" reinforces a binary concept of gender. The following questions recommended by the Fenway Institute can guide practitioners on how to ask sexual history questions without making assumptions [46]:

   - Are you having sex?
   - Who are you having sex with?

- What types of sex are you having? What parts of your body do you use for sex?
- How do you protect yourself from STIs?

2. How to approach a sensitive exam.

   Physical exams can be anxiety inducing for TGGNC patients. This is particularly true for chest (including electrocardiograms) and genital exams. Given that many TGGNC patients report having received unnecessary exams by practitioners, it is essential to explain the purpose of any invasive exam and ensure the patient expressly consents. Visual inspection and bimanual exam are all that is necessary for many gynecologic concerns. Practitioners should only use speculum exams with patient consent and when absolutely necessary to advance an emergency diagnosis or therapeutic intervention. These exams should take place in a private room (not in hallways). The clinician should allow a support person to stay in the exam room. If the patient is not accompanied by a support person, the clinician should ask the patient what gender chaperone they would prefer. Practitioners should use the patient's preferred terms for body parts and consider giving an anxiolytic for those with severe anxiety.

3. How to document the encounter.

   Use the patient's pronouns throughout the narrative sections of your chart.

   HPI

   34-year-old transgender man (on testosterone therapy, no history of gonad/genital surgery) presenting with right lower quadrant pain with associated nausea and vomiting, but no diarrhea, fevers, chills. Denies urinary symptoms, vaginal/anal discharge, pain, or bleeding. He has one male sexual partner and engages in unprotected oral sex.

   Assessment and Plan

   34-year-old transman with right lower quadrant pain and tenderness. My leading differential diagnostic consideration is appendicitis. Also consider GYN pathology like ruptured ovarian cyst/torsion, tubo-ovarian abscess, ectopic pregnancy, pelvic inflammatory disease but less likely given unremarkable pelvic exam. Pain control initiated. Lab work and cross-sectional imaging ordered.

Discussion Questions

1. Compare and contrast the sexual health questions used by the practitioner in this case with how you were trained to ask these questions. What hidden assumptions can you find in the ways you were trained to elicit this information?
2. Discuss how you might address a situation in which the patient's nurse seemed uncomfortable about the patient's transgender identity and consistently used female pronouns when talking about this patient.

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