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Reports and Recommendations

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# Endocrine Nurses Society Position Statement on Transgender and Gender Diverse Care

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## Abstract

The Endocrine Nurses Society (ENS) is committed to clinical excellence in the art and science of endocrine nursing throughout the world. ENS recognizes that transgender and gender diverse (TGD) individuals face challenges and inequities that place them in the realm of health disparities. Further, TGD individuals often face substantial barriers to care and have difficulty finding healthcare providers who are knowledgeable about the unique health needs of this patient population. ENS recognizes that endocrine nurses care for young adult and adult TGD individuals. This position statement outlines recommendations for healthcare providers and organizations seeking to embrace a gender-affirming approach to care and increase access to high-quality, comprehensive care for TGD individuals. This Position Statement was accepted by ENS on September 8, 2020 and has been endorsed by the European Society of Endocrinology Nurse Committee, European Society of Paediatric Endocrinology Nurses, Pediatric Endocrine Nursing Society, Endocrine Nurses' Society of Australasia, and the Federation of International Nurses in Endocrinology.

**Key Words:** culturally competent care, gender-affirming care, gender dysphoria, healthcare disparities, nursing, transgender

Transgender is a term used to describe individuals whose gender identity is not congruent with the sex recorded/assigned at birth. Gender diverse is a term used to describe identities that are neither exclusively masculine nor feminine (ie, nonbinary) (Box 1). Sociocultural awareness and acceptance of transgender and gender diverse (TGD) individuals has evolved over the past several years. In parallel with increased acceptance, a growing number of publications have described challenges faced by TGD people and their unique health [1-3]. Approximately 1.4 million adults identify as transgender in the United States [4].

Importantly, transgender individuals often face significant barriers to healthcare access [1]. Indeed, a 2016 web-based survey of more than 6000 TGD individuals found that 30% of respondents had avoided seeking healthcare for fear of discrimination, and 25% had been denied

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medical services [5]. The challenges and barriers create significant health disparities for TGD individuals [6]. In addition, individuals are often stigmatized and experience discrimination (eg, transphobia), harassment, and victimization (eg, physical and sexual violence) [1]. The lack of access to care and mistreatment of transgender individuals contribute to poor reproductive and sexual health outcomes (ie, increased rates of sexually transmitted infections including HIV) and significant mental health morbidity including increased rates of depression, anxiety, and somatization as well as substance abuse and suicide [1]. In addition, transgender individuals who have been exposed to reparative (conversion) therapy have adverse mental health outcomes and are 4 times more likely to attempt suicide in their lifetime [7]. A recent 2021 national community survey of nearly 1000 Australian TGD people found 43% had attempted suicide [8]. Similarly, a 2020 study examining an Amsterdam cohort (1972-2017) found transgender individuals had a 3- to 4-fold higher risk of suicide compared to the general population of the Netherlands [9]. In terms of annual risk, a recent study of transgender individuals in the United States found 48.5% reported having suicidal ideation in the past year [10]. Moreover, 10.7% of transgender individuals report having attempted suicide in the past year [11].

While many TGD individuals are aware of their gender incongruence in childhood, most individuals present in late adolescence or early adulthood having lived with incongruence (gender dysphoria) for years [12]. Healthcare for TGD persons falls into 2 broad categories. First, care relates to the sex at birth (and intact organs) that follows established primary care guidelines for health maintenance and promotion of physical, psychological, and sexual health as well as prevention practices (ie, screening for prostate, breast, and genitourinary cancers) [13]. The other aspect of care relates to gender-affirming care, an approach that validates and aligns with the individual's gender identity and expression [12-15]. Gender-affirming care includes sensitive communication and may include nonmedical interventions (eg, binding to compress the breasts of a trans male) and may also include medical interventions.

Gender-affirming interventions may include halting pubertal development with gonadotropin-releasing hormone analogs after Tanner II development in adolescents to alleviate gender dysphoria that increases with pubertal progression [16]. Gender-affirming hormone therapy for transgender women (male to female) includes feminizing estrogen treatment (ie, 17-β estradiol tablets, patches, or injections) while transgender men (female to male) use testosterone to induce virilization (ie, testosterone gels or injections of long-acting testosterone esters) [15]. Some transgender individuals may also pursue surgical intervention including "top surgery" (ie, masculinizing mastectomy/chest reconstruction and feminizing breast augmentation) and/or "bottom surgery" (ie, hysterectomy, oophorectomy, vaginectomy, phalloplasty, metoidioplasty, scrotoplasty) [2]. Long-term regret for undergoing gender confirming surgery is quite low (1%-2%) [2]. Importantly, evidence supports that gender-affirming hormone and gender-confirming surgery are correlated with improved mental health and quality of life [2,14].

Evaluating psychological outcomes to gender-affirming surgery are challenging given the variability in outcome measures between studies—highlighting the need for more harmonized, systematic evaluation [17]. Despite methodologic differences between studies and the variety of measures employed, a 2019 systematic review concluded that surgical intervention can lead to multiple, significant improvements in psychological functioning. Importantly, the strength of the evidence is limited by the lack of validated measures that are specific to gender-affirming surgeries [18]. A 2021 systematic review examining the psychological effects of gender-affirming hormone therapy identified 20 reports that employed a range of study designs (ie, randomized controlled trial, before-after trial, prospective/retrospective cohort, and cross-sectional studies) [19]. While the strength of the evidence is limited by methodologic differences across studies, authors concluded that gender-affirming hormone therapy may be associated with improvements in quality-of-life measures and decreased depression and anxiety symptoms. Consistent with these conclusions, a 2020 publication reporting longitudinal data on 50 transgender individuals found significantly decreased depressive symptoms following initiation of gender-affirming hormone therapy [20]. Concurrently, quality of life increased and suicidal ideation decreased (yet these measures did not reach statistical significance). Thus, the benefits of gender-affirming treatment may outweigh the risks.

Guidelines for gender-affirming care have been published by the World Professional Association for Transgender Health (WPATH) [21] and the Endocrine Society [14]. It is worthwhile to note that these guidelines are based on relatively low-quality evidence (ie, expert opinion), and there is a need for more robust studies to strengthen evidence-based approaches to care.

Transgender hormone therapy may reduce fertility, and surgery such as gonadectomy causes irreversible infertility. Accordingly, discussions of fertility preservation (ie, sperm or oocyte/embryo cryopreservation) are important [22]. Informed consent is a legal and ethical basis for most healthcare decisions [23], and the Fenway Institute has advocated for an informed consent model to respect patient autonomy and respect self-determination regarding

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gender-affirming hormonal treatment and surgery decisions [24,25]. However, evidence suggests the informed consent model is far from universal implementation [26]. Decisions surrounding care are individual and may be challenging when weighing social, financial, and health implications. Thus, mental health professionals as well as supportive family and peers can be useful in promoting a person-centered approach to care [24].

Given the unique health needs of TGD individuals, care should reflect local needs/culture and be individualized with interprofessional collaboration from a multidisciplinary team (ie, primary care providers, endocrinologists, nurses, pharmacists, surgeons, social workers, and mental health specialists) [2]. Notably, a recent review and synthesis of the literature notes the greatest barrier to healthcare for TGD individuals is the lack of access to providers who are knowledgeable in the health needs of this patient population [27]. Thus, there is a need to inform and train the current and next generation of healthcare professionals. Broadly, training falls into 2 categories. The first involves training clinical and ancillary staff on sensitive communication practices to foster trusting, respectful relationships and create a welcoming environment [28,29]. The second focuses on developing clinical competencies that are specific to TGD individuals (ie, gender-affirming hormone therapy) [28].

Reviews have highlighted the lack of knowledge and training among practicing healthcare providers as well as in curricular gaps in education for future providers [2,30,31]. Training programs have been shown to increase knowledge, confidence, and comfort in TGD care in students and practicing providers alike [32,33]. Endocrinology plays a key role in gender-affirming hormone therapy. As such, endocrine nurses play a central role in delivering comprehensive care that includes health maintenance, health promotion as well as disease prevention and advocacy for TGD patients. Moreover, endocrine nurses are frequently involved in the care of patients with differences in sex development (DSD) (Box 1), previously termed "intersex" [34].

Most patients with DSD do not experience gender dysphoria. Across the broad spectrum of diagnoses constituting DSD, 8.5% to 20% of patients experience gender dysphoria [35]. Notably, a 2018 report on 1040 participants in the dsd-LIFE study reported 5.1% experienced a change of gender in their lives [36]. Excluding individuals with Klinefelter syndrome/Turner syndrome, 3% of individuals reported a gender change after puberty. Investigators concluded that clinicians should be sensitive to gender dysphoria in patients with DSD and should consider counseling support when appropriate. Thus, patients with DSD may identify as TGD and merit consideration for gender-affirming care in the context of endocrine nursing practice.

The American Nurses Association [37], the National Association of Nurse Practitioners in Women's Health [38], National Association of Pediatric Nurse Practitioners [39], and the Pediatric Endocrinology Nursing Society [40] have developed position statements addressing the needs of transgender individuals. While the Endocrines Nurses Society (ENS) supports many of the positions of our fellow nursing societies, we feel there is a need to establish positions specific to endocrine nursing practice for young adult and adult TGD patients receiving endocrine care. We undertook an extensive literature review and engaged with community and interprofessional stakeholders to identify 9 position points and a list of resources (Box 2) for nurses seeking to increase their knowledge, comfort and confidence in delivering comprehensive, affirming care for TGD individuals.

## Position

We, the Endocrine Nurses Society

1. Endorse care for transgender and gender diverse (TGD) people that relies on best available evidence, such as the World Professional Association for Transgender Health (WPATH) Standards of Care [21] and the Endocrine Society Clinical Practice Guidelines [14], to inform individualized care.
2. Advocate that all TGD individuals have access to culturally sensitive, interprofessional care provided by qualified healthcare providers (ie, physicians, nurses, advanced practice nurses, physician assistants, pharmacists, mental health professionals and surgeons) that is personalized and includes
   - Appropriate screening based on age and sex assigned at birth (organs present);
   - Trauma-informed care (Box 1);
   - Substance use/abuse screening and counseling;
   - Sexually transmitted infection screening; and
   - Screening for suicidal ideation/attempts and self-harm.
3. Support an informed consent process prior to initiating hormonal therapy and gender-affirming surgeries that includes discussion of social and financial repercussions as well as the impact on fertility to promote shared decision-making and informed decisions that are aligned with patient values and preferences.

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**Box 1. Terminology and definitions**

*Sex*—a term relating to biological characteristics observed at birth (ie, sex chromosomes, gonads, external genitalia, hormone levels)

*Gender*—a societal construct related to perceptions of maleness or femaleness. Gender identity refers to one's internalized sense of being male, female, or variation along a male-female continuum.

*Cisgender*—gender identity consistent with the sex assigned at birth, derived from the Latin *cis* meaning "on the side of."

*Transgender*—a term used to describe individuals whose gender identity is not congruent with the sex assigned to them at birth.

*Gender diverse*—umbrella term for a wide range of gender identities that are neither exclusively masculine nor feminine (eg, nonbinary, genderqueer, gender fluid, X-gender).

*Gender dysphoria*—discomfort/distress resulting from incongruence between one's gender identity and sex at birth. Gender euphoria is the term used to describe a feeling of satisfaction and pleasure with one's gender.

*Gender expression*—how a person presents themselves to the world (ie, through dress, appearance, behavior, mannerisms, speech patterns etc.). Expression varies widely on a continuum and may not necessarily correspond with gender identity.

*Sexual orientation*—pattern of romantic and/or sexual attraction. Orientation may be toward persons of the opposite sex, same sex, both sexes, or more than one gender. Gender identity is not the same as sexual orientation.

*Social transition*—a term describing a process during which a transgender or gender-diverse person makes others aware of their gender identity. Social transition may include a change in gender expression (see previous definition), informing others about one's gender identity, and/or asking others to use a different name or pronouns in social interactions.

*Transition*—the process of changing gender expression, sex characteristics, and/or lifestyle to more closely align with one's gender identity. Transition may include one or more of the following: social transition (see previous definition), medical transition (eg, hormone therapy, surgery), legal transition (ie, legally changing gender status).

*Differences in sex development (DSD)*—a wide range of congenital conditions characterized by altered chromosomal, gonadal, or sex based on external genital development (eg, congenital adrenal hyperplasia, androgen insensitivity syndrome).

*Gender-affirming care*—an approach that aims to alleviate distress by validating an individual's gender identity and expression. Gender-affirming medical interventions may include hormone therapy and surgery to help align an individual's body with one's gender identity/expression.

*Trauma-informed care*—an approach to care that recognizes the impact of discrimination, violence, and trauma (ie, interpersonal, intimate partner, sexual, other) and emphasizes physical, psychological, and emotional safety for survivors.

4. Encourage assessment of gender dysphoria and appropriate support for patients with differences in sex development.
5. Advocate for professional and peer psychological support throughout the gender affirmation process, particularly in relation to medical decisions such as hormone therapy or surgery.
6. Promote continuing education of transgender topics for practicing nurses and nursing curricula at all levels of nursing education. Educational content should reflect the best available evidence-based policies, practices, and procedures to support provider competence and confidence in treating TGD patients, including gender inclusivity and awareness training.
7. Oppose reparative (conversion) therapy and policies that impede gender-inclusive environments.
8 Call for researchers to conduct well-designed studies to contribute to the evidence base for TGD care and document validated patient-reported outcomes.
9. Endorse policies and legislative/regulatory initiatives that seek to promote gender inclusivity and improve availability and access to affordable and appropriate healthcare coverage (including appropriate screening, preventative care, and mental health services).

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**Box 2. Resources**

**Clinical Resources**

Center of Excellence for Transgender Health (UCSF)
https://prevention.ucsf.edu/transhealth
Centers for Disease Control and Prevention
www.cdc.gov/lgbthealth/transgender.htm
Endocrine Society
https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence
GLMA: Health Professionals Advancing LGBT Equality
http://www.glma.org/index.cfm?fuseaction = Page.viewPage&pageId = 534
Hormone Health Network
https://www.hormone.org/your-health-and-hormones/transgender-health
National LGBTQIA + Health Education Center (Fenway Institute)
https://www.lgbtqiahealtheducation.org/
World Professional Association for Transgender Health (WPATH)
https://www.wpath.org/
Mayo Clinic
https://www.mayoclinic.org/medical-professionals/endocrinology/news/addressing-the-challenges-of-transgender-health-care/mac-20429315

**Legal Resources**

Human Rights Campaign
https://www.hrc.org/
National Center for Transgender Equality
https://transequality.org/

**Suicide Prevention Resources**

National Suicide Prevention Hotline
https://suicidepreventionlifeline.org/

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## Additional Information

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***Data Availability:*** Data sharing is not applicable to this article as no data sets were generated or analyzed during the current study.

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