

Ensuring Gender-Affirming Care in Nephrology

Improving Care for Transgender and Gender-Expansive Individuals

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Introduction

Transgender and gender-expansive (TGE) people face unique sociopolitical and health-related challenges, including access to high-quality health care (1,2). TGE people have a gender identity that differs from the sex assigned to them at birth (usually female or male) (3). Sex is often assigned to a person at birth on the basis of reproductive organs. Gender, however, is a distinctly different self-designated social construction with multiple influences (*e.g.*, family and culture) that encompasses (1) gender expression (the way that someone presents their gender *via* physical appearance and behaviors) and (2) gender identity (the way that someone conceptualizes their gender) (4). Although legal and administrative documents (*e.g.*, insurance cards) often denote sex, they should strive to denote gender to affirm TGE individuals.

With an estimated 0.6% of the United States population identifying as transgender (3), approximately 180,000 people with CKD, approximately 4400 people on dialysis, and approximately 700 people on the kidney transplant waitlist may identify as transgender. These figures underestimate gender minority populations because gender identity assessment is limited in United States health surveys (4), and available answer choices may not include all TGE identities. Kidney professionals have a responsibility to partner with TGE stakeholders, primary care providers, and other multidisciplinary colleagues to provide high-quality, gender-affirming care to TGE people.

Language Review

TGE identities have spanned time and geography with recognition of three or more genders in other parts of the world, including Nepal and New Zealand (2). The landmark Institute of Medicine report on lesbian, gay, bisexual, and transgender health used the term “gender minority” to encompass individuals who are transgender or have other gender identities (*i.e.*, not cisgender) (4). The term “cisgender” describes individuals whose gender identity aligns with sex assigned to them at birth. “Transgender,” “gender nonconforming,” “gender nonbinary,” “gender fluid,” “gender incongruent,” and “genderqueer” are among many terms used to describe individuals for whom gender varies from the sex assigned to them at birth. Although some TGE individuals identify with the “transgender” label, others

do not; a transgender woman may identify as a “woman” but not as a “transgender woman.” TGE individuals may use gender-based pronouns, like he/him/his and she/her/hers, or neutral pronouns, like they/them/theirs and ze/zir/zirs. Notably, gender minority individuals have diverse romantic attractions, gender expressions, behaviors, and sexual orientations that are independent of their gender identities (4).

TGE people vary in how they align their gender identity with gender expression. Some TGE individuals may socially transition (change name, pronouns, clothing, or mannerisms), medically transition (use gender-affirming hormone therapy), surgically transition (have facial, tracheal, chest, or genital procedures), and/or express their gender outside of traditional conceptualizations of femininity or masculinity (3). Affirming care involves avoiding assumptions, asking questions in a culturally humble way, and accurately using names and pronouns.

Putting Effective Language into Practice

The collection of standardized sexual orientation and gender identity data in electronic health records (EHRs) is vital to delivering high-quality, person-centered care. The absence of these data has exacerbated the invisibility, stigmatization, and health disparities affecting TGE people (4). In accordance with recommendations from the Joint Commission and others, we suggest a standardized process to gather sexual orientation and gender identity data from all patients in a culturally sensitive manner with an assurance of equality and respect (5,6).

Proper collection of gender identity requires a two-step process in which current gender identity is collected prior to sex assigned at birth (6,7). This order emphasizes one’s current identity rather than sex assigned at birth, which may be dysphoria inducing. Asking both questions signals that the difference between gender identity and sex assigned at birth is recognized and appreciated. It also correctly identifies gender minority people who may not identify with a gender minority label (*e.g.*, someone assigned female sex at birth who identifies as a “man,” not as a “transgender man”). Questions assessing gender identity can depend on context (*e.g.*, clinical versus research), and they can change over time as society and terms evolve (5,7). We recommend assessing

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gender identity with the question “what is your current gender identity? (check all that apply)” and the answer choices agender, genderqueer, man, woman, nonbinary, transgender man, transgender woman, two spirit, another gender identity: (free text box), and choose not to disclose. To assess sex assigned at birth, we recommend asking “what was the sex assigned to you at birth, for example on your original birth certificate? (check one)” and the answer choices female, intersex, male, another sex: (free text box), and choose not to disclose. To respectfully inquire about pronouns, we recommend asking “which pronouns do you use? (check all that apply)” and the answer choices: he/him, she/her, they/them, another pronoun set: (free text box), and please use my name instead of pronouns. Finally, all patients should be offered to provide the name that they use as a free text box. The last two questions can respectfully determine a patient’s pronouns and name to enhance effective, inclusive communication. In addition, EHRs should record surgical procedures (including gender-affirming procedures), hormonal and other medical therapies, and an organ inventory. Because therapies, procedures, and organs change, updating records is critical to ensure delivery of appropriate preventive and therapeutic care (3).

Clinical Pearls for the Nephrologist

Lack of evidence-based guidelines complicate the interpretation of laboratory values used to estimate kidney function for TGE people (8). When transgender women receiving estrogen had serum creatinine values compared with cisgender women and men, values were similar between transgender women and cisgender men. Imperfect estimations have downstream effects; a transplant-eligible transgender man receiving testosterone therapy experienced delays in being waitlisted for transplantation and challenges determining dialysis adequacy because of sex-specific eGFR cutoffs (8). An individualized, multidisciplinary approach to interpreting results is needed. “Male” reference ranges may be appropriate to interpret a serum creatinine from a transfeminine person using feminizing hormone therapy. As muscle mass decreases, “female” ranges may become more appropriate.

Hemoglobin and hematocrit (H&H) may be altered in individuals receiving androgenic therapy through stimulated erythropoiesis (8). H&H for transgender men can depend on testosterone dose and menstrual blood loss. “Male” reference ranges may be most appropriate to interpret H&H in an amenorrheic transgender man. Among transgender women, H&H should be interpreted in the context of an organ inventory (*i.e.*, male ranges may be appropriate because of pulsatile androgen activity from testes).

Spirolactone (in doses from 50 to 200 mg twice a day) is the most common gender-affirming, antiandrogenic agent used by transfeminine individuals to promote breast development. In individuals with CKD, serum potassium and BP must be carefully monitored, and continued gender-affirming use of spironolactone should be discussed with a multidisciplinary team if/when kidney function declines.

There is insufficient evidence to guide testing for osteoporosis among TGE people; however, individuals with higher risk for osteoporosis (*e.g.*, those with suboptimal

hormone replacement after gonadectomy) benefit from nuanced attention to mineral metabolism parameters (9).

If individuals have a particular organ and meet criteria for screening on the basis of age, risk factors, or symptoms, screening should proceed regardless of hormone use or sex assigned to them at birth (3). Evidence-based kidney transplantation guidelines do not exist. A thoughtful approach to the side effects (*e.g.*, hair loss or hirsutism) and risks (*e.g.*, venous thromboembolism) posed by immunosuppression in conjunction with gender-affirming hormone therapies and surgeries should be discussed with patients and within a multidisciplinary team to ensure best practices and shared informed decision making (10). The World Professional Association for Transgender Health (11), the Endocrine Society (9), and other institutions (*e.g.*, the University of California, San Francisco) provide excellent primary and gender-affirming care guidelines for TGE people.

Why Affirming Care Matters

TGE people face stark injustices, including disproportionate exposure to violence and innumerable legal, social, economic, and health care–related challenges (1). The US Supreme Court is debating whether Title VII of the Civil Rights Act of 1964 ensures nondiscrimination on the basis of gender identity and gender expression. The ramifications will have a profound effect; over 30% of TGE people report a prior adverse job outcome because of their gender identity, and 77% hid their gender transition/gender from their employer (1).

Over 50% of transgender people delay medical care because of insufficient provider knowledge about TGE health and identity, prior negative experiences, fear/mistrust of the health care system, and payment and insurance barriers (4). These barriers—coupled with stress and other inequalities (*e.g.*, education and housing)—have contributed to dramatic differences in suicide, substance use, depression, anxiety, and other comorbidities, especially among those with other marginalized identities (*i.e.*, people of color) (1,4). TGE issues should not be reduced to politics—the lives and wellbeing of TGE people are at stake.

A Call to Action

Culturally humble and affirming care for TGE people matters because unique implications for kidney and systemic health may stem from or be exacerbated by inadequate or uninformed care. These may range from avoidance of screenings (for diabetes and hypertension) to transplantation-related disparities, including living donation, *etc.* We recommend that the nephrology workforce implement the following actions to enhance TGE care:

- Promote tools to improve TGE care spanning across clinical environments (*e.g.*, dialysis units and transplant centers) from intake with accurate data collection in the EHR to gender-affirming communication and medical care (3),
- Improve inclusive engagement of TGE individuals in research and in the workforce, and
- Advocate for and implement nondiscrimination policies that explicitly include gender identity, sex, and sexual orientation to protect all patients (4).

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