

of social acceptance.⁴⁶ This developmental approach to gender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").^{45,47} More robust and current research suggests that, rather than focusing on who a child will become, valuing them for who they are, even at a young age, fosters secure attachment and resilience, not only for the child but also for the whole family.^{5,45,48,49}

Medical Management

Pediatric primary care providers are in a unique position to routinely inquire about gender development in children and adolescents as part of recommended well-child visits⁵⁰ and to be a reliable source of validation, support, and reassurance. They are often the first provider to be aware that a child may not identify as cisgender or that there may be distress related to a gender-diverse identity. The best way to approach gender with patients is to inquire directly and nonjudgmentally about their experience and feelings before applying any labels.^{27,51}

Many medical interventions can be offered to youth who identify as TGD and their families. The decision of whether and when to initiate gender-affirmative treatment is personal and involves

careful consideration of risks, benefits, and other factors unique to each patient and family. Many protocols suggest that clinical assessment of youth who identify as TGD is ideally conducted on an ongoing basis in the setting of a collaborative, multidisciplinary approach, which, in addition to the patient and family, may include the pediatric provider, a mental health provider (preferably with expertise in caring for youth who identify as TGD), social and legal supports, and a pediatric endocrinologist or adolescent-medicine gender specialist, if available.^{6,28} There is no prescribed path, sequence, or end point. Providers can make every effort to be aware of the influence of their own biases. The medical options also vary depending on pubertal and developmental progression.

Clinical Setting

In the past year, 1 in 4 adults who identified as transgender avoided a necessary doctor's visit because of fear of being mistreated.³¹ All clinical office staff have a role in affirming a patient's gender identity. Making flyers available or displaying posters related to LGBTQ health issues, including information for children who identify as TGD and families, reveals inclusivity and awareness. Generally, patients who identify as TGD feel most comfortable when they have access to a gender-neutral restroom. Diversity training that encompasses sensitivity when caring for youth who identify as TGD and their families can be helpful in educating clinical and administrative staff. A patient-asserted name and pronouns are used by staff and are ideally reflected in the electronic medical record without creating duplicate charts.^{52,53} The US Centers for Medicare and Medicaid Services and the National Coordinator for Health Information Technology require all electronic health record systems certified under the Meaningful Use incentive program to have the capacity to confidentially collect information on gender identity.^{54,55} Explaining and maintaining confidentiality

procedures promotes openness and trust, particularly with youth who identify as LGBTQ.¹ Maintaining a safe clinical space can provide at least 1 consistent, protective refuge for patients and families, allowing authentic gender expression and exploration that builds resiliency.

Pubertal Suppression

Gonadotrophin-releasing hormones have been used to delay puberty since the 1980s for central precocious puberty.⁵⁶ These reversible treatments can also be used in adolescents who experience gender dysphoria to prevent development of secondary sex characteristics and provide time up until 16 years of age for the individual and the family to explore gender identity, access psychosocial supports, develop coping skills, and further define appropriate treatment goals. If pubertal suppression treatment is suspended, then endogenous puberty will resume.^{20,57,58}

Often, pubertal suppression creates an opportunity to reduce distress that may occur with the development of secondary sexual characteristics and allow for gender-affirming care, including mental health support for the adolescent and the family. It reduces the need for later surgery because physical changes that are otherwise irreversible (protrusion of the Adam's apple, male pattern baldness, voice change, breast growth, etc) are prevented. The available data reveal that pubertal suppression in children who identify as TGD generally leads to improved psychological functioning in adolescence and young adulthood.^{20,57-59}

Pubertal suppression is not without risks. Delaying puberty beyond one's peers can also be stressful and can lead to lower self-esteem and increased risk taking.⁶⁰ Some experts believe that genital underdevelopment may limit some potential reconstructive options.⁶¹ Research on long-term risks,

particularly in terms of bone metabolism⁵² and fertility,⁵³ is currently limited and provides varied results.^{57,64,65} Families often look to pediatric providers for help in considering whether pubertal suppression is indicated in the context of their child's overall well-being as gender diverse.

Gender Affirmation

As youth who identify as TGD reflect on and evaluate their gender identity, various interventions may be considered to better align their gender expression with their underlying identity. This process of reflection, acceptance, and, for some, intervention is known as "gender affirmation." It was formerly referred to as "transitioning," but many view the process as an affirmation and acceptance of who they have always been rather than a transition from 1 gender identity to another. Accordingly, some people who have gone through the process prefer to call themselves "affirmed females, males, etc" (or just "females, males, etc"), rather than using the prefix "trans-." Gender affirmation is also used to acknowledge that some individuals who identify as TGD may feel affirmed in their gender without pursuing medical or surgical interventions.^{7,66}

Supportive involvement of parents and family is associated with better mental and physical health outcomes.⁶⁷ Gender affirmation among adolescents with gender dysphoria often reduces the emphasis on gender in their lives, allowing them to attend to other developmental tasks, such as academic success, relationship building, and future-oriented planning.⁶⁴ Most protocols for gender-affirming interventions incorporate World Professional Association of Transgender Health³⁵ and Endocrine Society⁶⁸ recommendations and include ≥ 1 of the following elements ([Table 2](#)):

TABLE 2

The Process of Gender Affirmation May Include ≥ 1 of the Following Components

Component	Definition	General Age Range ^a	Reversibility ^a
Social affirmation	Adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms and other facilities	Any	Reversible
Puberty blockers	Gonadotropin-releasing hormone analogues, such as leuprolide and histrelin	During puberty (Tanner stage 2-5) ^b	Reversible ^c
Cross-sex hormone therapy	Testosterone (for those who were assigned female at birth and are masculinizing); estrogen plus androgen inhibitor (for those who were assigned male at birth and are feminizing)	Early adolescence onward	Partially reversible (skin texture, muscle mass, and fat deposition); irreversible once developed (testosterone: Adam's apple protrusion, voice changes, and male pattern baldness; estrogen: breast development); unknown reversibility (effect on fertility)

Gender-affirming surgeries	“Top” surgery (to create a male-typical chest shape or enhance breasts); “bottom” surgery (surgery on genitals or reproductive organs); facial feminization and other procedures	Typically adults (adolescents on case-by-case basis ^d)	Not reversible
Legal affirmation	Changing gender and name recorded on birth certificate, school records, and other documents	Any	Reversible

- a** Note that the provided age range and reversibility is based on the little data that are currently available.
- b** There is limited benefit to starting gonadotropin-releasing hormone after Tanner stage 5 for pubertal suppression. However, when cross-sex hormones are initiated with a gradually increasing schedule, the initial levels are often not high enough to suppress endogenous sex hormone secretion. Therefore, gonadotropin-releasing hormone may be continued in accordance with the Endocrine Society Guidelines.⁶⁸
- c** The effect of sustained puberty suppression on fertility is unknown. Pubertal suppression can be, and often is indicated to be, followed by cross-sex hormone treatment. However, when cross-sex hormones are initiated without endogenous hormones, then fertility may be decreased.⁶⁸
- d** Eligibility criteria for gender-affirmative surgical interventions among adolescents are not clearly defined between established protocols and practice. When applicable, eligibility is usually determined on a case-by-case basis with the adolescent and the family along with input from medical, mental health, and surgical providers.^{68,-71}

1. Social Affirmation: This is a reversible intervention in which children and adolescents express partially or completely in their asserted gender identity by adapting hairstyle, clothing, pronouns, name, etc. Children who identify as transgender and socially affirm and are supported in their asserted gender show no increase in depression and only minimal

(clinically insignificant) increases in anxiety compared with

age-matched averages.⁴⁸ Social affirmation can be complicated given the wide range of social interactions children have (eg, extended families, peers, school, community, etc). There is little guidance on the best approach (eg, all at once, gradual, creating new social networks, or affirming within existing networks, etc). Pediatric providers can best support families by anticipating and discussing such complexity proactively, either in their own practice or through enlisting a qualified mental health provider.

2. Legal Affirmation: Elements of a social affirmation, such as a name and gender marker, become official on legal documents, such as birth certificates, passports, identification cards, school documents, etc. The processes for making these changes depend on state laws and may require specific documentation from pediatric providers.
3. Medical Affirmation: This is the process of using cross-sex hormones to allow adolescents who have initiated puberty to develop secondary sex characteristics of the opposite biological sex. Some changes are partially reversible if hormones are stopped, but others become irreversible once they are fully developed ([Table 2](#)).
4. Surgical Affirmation: Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults,^{35,68} they are occasionally pursued during adolescence on a case-by-case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.⁶⁹⁻⁷¹

For some youth who identify as TGD whose natal gender is female, menstruation, breakthrough bleeding, and dysmenorrhea can lead to significant distress before or during gender affirmation. The American College of Obstetrics and Gynecology suggests that, although limited data are available to outline management, menstruation can be managed without exogenous estrogens by using a progesterone-only pill, a medroxyprogesterone acetate shot, or a progesterone-containing intrauterine or implantable device.⁷² If estrogen can be tolerated, oral contraceptives that contain both progesterone and estrogen are more effective at suppressing menses.⁷³ The Endocrine Society guidelines also suggest that gonadotrophin-releasing hormones can be used for menstrual suppression before the anticipated initiation of testosterone or in combination with testosterone for breakthrough bleeding (enables phenotypic masculinization at a lower dose than if testosterone is used alone).⁶⁸ Masculinizing hormones in natal female patients may lead to a cessation of menses, but unplanned pregnancies have been reported, which emphasizes the need for ongoing contraceptive counseling with youth who identify as TGD.⁷²

Health Disparities

In addition to societal challenges, youth who identify as TGD face several barriers within the health care system, especially regarding access to care. In 2015, a focus group of youth who identified as transgender in Seattle, Washington, revealed 4 problematic areas related to health care:

1. safety issues, including the lack of safe clinical environments and fear of discrimination by providers;
2. poor access to physical health services, including testing for sexually transmitted infections;

3. inadequate resources to address mental health concerns;
- and
4. lack of continuity with providers.⁷⁴

This study reveals the obstacles many youth who identify as TGD face in accessing essential services, including the limited supply of appropriately trained medical and psychological providers, fertility options, and insurance coverage denials for gender-related treatments.⁷⁴

Insurance denials for services related to the care of patients who identify as TGD are a significant barrier. Although the Office for Civil Rights of the US Department of Health and Human Services explicitly stated in 2012 that the nondiscrimination provision in the Patient Protection and Affordable Care Act includes people who identify as gender diverse,^{75,76} insurance claims for gender affirmation, particularly among youth who identify as TGD, are frequently denied.^{54,77} In 1 study, it was found that approximately 25% of individuals who identified as transgender were denied insurance coverage because of being transgender.³¹ The burden of covering medical expenses that are not covered by insurance can be financially devastating, and even when expenses are covered, families describe high levels of stress in navigating and submitting claims appropriately.⁷⁸ In 2012, a large gender center in Boston, Massachusetts, reported that most young patients who identified as transgender and were deemed appropriate candidates for recommended gender care were unable to obtain it because of such denials, which were based on the premise that gender dysphoria was a mental disorder, not a physical one, and that treatment was not medically or surgically necessary.²⁴ This practice not only contributes to stigma, prolonged gender dysphoria, and poor mental health outcomes,⁷⁷ but it may also lead patients to seek nonmedically supervised treatments that are potentially dangerous.²⁴ Furthermore, insurance denials can reinforce a socioeconomic

divide between those who can finance the high costs of uncovered care and those who cannot.^{24,77}

The transgender youth group in Seattle likely reflected the larger TGD population when they described how obstacles adversely affect self-esteem and contribute to the perception that they are undervalued by society and the health care system.^{74,77}

Professional medical associations, including the AAP, are increasingly calling for equity in health care provisions regardless of gender identity or expression.^{1,8,23,72} There is a critical need for investments in research on the prevalence, disparities, biological underpinnings, and standards of care relating to gender-diverse populations. Pediatric providers who work with state government and insurance officials can play an essential role in advocating for stronger nondiscrimination policies and improved coverage.

There is a lack of quality research on the experience of youth of color who identify as transgender. One theory suggests that the intersection of racism, transphobia, and sexism may result in the extreme marginalization that is experienced among many women of color who identify as transgender,⁷⁹ including rejection from their family and dropping out of school at younger ages (often in the setting of rigid religious beliefs regarding gender),⁸⁰ increased levels of violence and body objectification,⁸¹ 3 times the risk of poverty compared with the general population,³¹ and the highest prevalence of HIV compared with other risk groups (estimated as high as 56.3% in 1 meta-analysis).³⁰ One model suggests that pervasive stigma and oppression can be associated with psychological distress (anxiety, depression, and suicide) and adoption of risk behaviors by such youth to obtain a sense of validation toward their complex identities.⁷⁹

Family Acceptance

Research increasingly suggests that familial acceptance or rejection ultimately has little influence on the gender identity of youth; however, it may profoundly affect young people's ability to openly discuss or disclose concerns about their identity. Suppressing such concerns can affect mental health.⁸² Families often find it hard to understand and accept their child's gender-diverse traits because of personal beliefs, social pressure, and stigma.^{49,83} Legitimate fears may exist for their child's welfare, safety, and acceptance that pediatric providers need to appreciate and address. Families can be encouraged to communicate their concerns and questions. Unacknowledged concerns can contribute to shame and hesitation in regard to offering support and understanding,⁸⁴ which is essential for the child's self-esteem, social involvement, and overall health as TGD.^{48,85-87} Some caution has been expressed that unquestioning acceptance per se may not best serve questioning youth or their families. Instead, psychological evidence suggests that the most benefit comes when family members and youth are supported and encouraged to engage in reflective perspective taking and validate their own and the other's thoughts and feelings despite divergent views.^{49,82}

In this regard, suicide attempt rates among 433 adolescents in Ontario who identified as "trans" were 4% among those with strongly supportive parents and as high as 60% among those whose parents were not supportive.⁸⁵ Adolescents who identify as transgender and endorse at least 1 supportive person in their life report significantly less distress than those who only experience rejection. In communities with high levels of support, it was found that nonsupportive families tended to increase their support over time, leading to dramatic improvement in mental health outcomes among their children who identified as transgender.⁸⁸

Pediatric providers can create a safe environment for parents and families to better understand and listen to the needs of their children while receiving reassurance and education.⁸³ It is often appropriate to assist the child in understanding the parents' concerns as well. Despite expectations by some youth with transgender identity for immediate acceptance after "coming out," family members often proceed through a process of becoming more comfortable and understanding of the youth's gender identity, thoughts, and feelings. One model suggests that the process resembles grieving, wherein the family separates from their expectations for their child to embrace a new reality. This process may proceed through stages of shock, denial, anger, feelings of betrayal, fear, self-discovery, and pride.⁸⁹ The amount of time spent in any of these stages and the overall pace varies widely. Many family members also struggle as they are pushed to reflect on their own gender experience and assumptions throughout this process. In some situations, youth who identify as TGD may be at risk for internalizing the difficult emotions that family members may be experiencing. In these cases, individual and group therapy for the family members may be helpful.^{49,78}

Family dynamics can be complex, involving disagreement among legal guardians or between guardians and their children, which may affect the ability to obtain consent for any medical management or interventions. Even in states where minors may access care without parental consent for mental health services, contraception, and sexually transmitted infections, parental or guardian consent is required for hormonal and surgical care of patients who identify as TGD.^{72,90} Some families may take issue with providers who address gender concerns or offer gender-affirming care. In rare cases, a family may deny access to care that raises concerns about the youth's welfare and safety; in those cases, additional legal or ethical support may be useful to consider. In such rare situations, pediatric providers may want to

familiarize themselves with relevant local consent laws and maintain their primary responsibility for the welfare of the child.

Safe Schools and Communities

Youth who identify as TGD are becoming more visible because gender-diverse expression is increasingly admissible in the media, on social media, and in schools and communities. Regardless of whether a youth with a gender-diverse identity ultimately identifies as transgender, challenges exist in nearly every social context, from lack of understanding to outright rejection, isolation, discrimination, and victimization. In the US Transgender Survey of nearly 28 000 respondents, it was found that among those who were out as or perceived to be TGD between kindergarten and eighth grade, 54% were verbally harassed, 24% were physically assaulted, and 13% were sexually assaulted; 17% left school because of maltreatment.³¹ Education and advocacy from the medical community on the importance of safe schools for youth who identify as TGD can have a significant effect.

At the time of this writing,^{*} only 18 states and the District of Columbia had laws that prohibited discrimination based on gender expression when it comes to employment, housing, public accommodations, and insurance benefits. Over 200 US cities have such legislation. In addition to basic protections, many youth who identify as TGD also have to navigate legal obstacles when it comes to legally changing their name and/or gender marker.⁵⁴ In addition to advocating and working with policy makers to promote equal protections for youth who identify as TGD, pediatric providers can play an important role by developing a familiarity with local laws and organizations that provide social work and legal assistance to youth who identify as TGD and their families.

School environments play a significant role in the social and emotional development of children. Every child has a right to feel safe and respected at school, but for youth who identify as TGD, this can be challenging. Nearly every aspect of school life may present safety concerns and require negotiations regarding their gender expression, including name/pronoun use, use of bathrooms and locker rooms, sports teams, dances and activities, overnight activities, and even peer groups. Conflicts in any of these areas can quickly escalate beyond the school's control to larger debates among the community and even on a national stage.

The formerly known Gay, Lesbian, and Straight Education Network (GLSEN), an advocacy organization for youth who identify as LGBTQ, conducts an annual national survey to measure LGBTQ well-being in US schools. In 2015, students who identified as LGBTQ reported high rates of being discouraged from participation in extracurricular activities. One in 5 students who identified as LGBTQ reported being hindered from forming or participating in a club to support lesbian, gay, bisexual, or transgender students (eg, a gay straight alliance, now often referred to as a genders and sexualities alliance) despite such clubs at schools being associated with decreased reports of negative remarks about sexual orientation or gender expression, increased feelings of safety and connectedness at school, and lower levels of victimization. In addition, >20% of students who identified as LGBTQ reported being blocked from writing about LGBTQ issues in school yearbooks or school newspapers or being prevented or discouraged by coaches and school staff from participating in sports because of their sexual orientation or gender expression.⁹¹

One strategy to prevent conflict is to proactively support policies and protections that promote inclusion and safety of all students. However, such policies are far from consistent across

districts. In 2015, GLSEN found that 43% of children who identified as LGBTQ reported feeling unsafe at school because of their gender expression, but only 6% reported that their school had official policies to support youth who identified as TGD, and only 11% reported that their school's antibullying policies had specific protections for gender expression.⁹¹ Consequently, more than half of the students who identified as transgender in the study were prevented from using the bathroom, names, or pronouns that aligned with their asserted gender at school. A lack of explicit policies that protected youth who identified as TGD was associated with increased reported victimization, with more than half of students who identified as LGBTQ reporting verbal harassment because of their gender expression. Educators and school administrators play an essential role in advocating for and enforcing such policies. GLSEN found that when students recognized actions to reduce gender-based harassment, both students who identified as transgender and cisgender reported a greater connection to staff and feelings of safety.⁹¹ In another study, schools were open to education regarding gender diversity and were willing to implement policies when they were supported by external agencies, such as medical professionals.⁹²

Academic content plays an important role in building a safe school environment as well. The 2015 GLSEN survey revealed that when positive representations of people who identified as LGBTQ were included in the curriculum, students who identified as LGBTQ reported less hostile school environments, less victimization and greater feelings of safety, fewer school absences because of feeling unsafe, greater feelings of connectedness to their school community, and an increased interest in high school graduation and postsecondary education.⁹¹ At the time of this writing,^{*} 8 states had laws that explicitly forbade teachers from even discussing LGBTQ issues.⁵⁴

Medical Education

One of the most important ways to promote high-quality health care for youth who identify as TGD and their families is increasing the knowledge base and clinical experience of pediatric providers in providing culturally competent care to such populations, as recommended by the recently released guidelines by the Association of American Medical Colleges.⁹³ This begins with the medical school curriculum in areas such as human development, sexual health, endocrinology, pediatrics, and psychiatry. In a 2009–2010 survey of US medical schools, it was found that the median number of hours dedicated to LGBTQ health was 5, with one-third of US medical schools reporting no LGBTQ curriculum during the clinical years.⁹⁴

During residency training, there is potential for gender diversity to be emphasized in core rotations, especially in pediatrics, psychiatry, family medicine, and obstetrics and gynecology. Awareness could be promoted through the inclusion of topics relevant to caring for children who identify as TGD in the list of core competencies published by the American Board of Pediatrics, certifying examinations, and relevant study materials. Continuing education and maintenance of certification activities can include topics relevant to TGD populations as well.

Recommendations

The AAP works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social well-being. Any discrimination based on gender identity or expression, real or perceived, is damaging to the socioemotional health of children, families, and society. In particular, the AAP recommends the following:

1. that youth who identify as TGD have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space;
2. that family-based therapy and support be available to recognize and respond to the emotional and mental health needs of parents, caregivers, and siblings of youth who identify as TGD;
3. that electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of each patient while maintaining confidentiality and avoiding duplicate charts;
4. that insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions;
5. that provider education, including medical school, residency, and continuing education, integrate core competencies on the emotional and physical health needs and best practices for the care of youth who identify as TGD and their families;
6. that pediatricians have a role in advocating for, educating, and developing liaison relationships with school districts and other community organizations to promote acceptance and inclusion of all children without fear of harassment, exclusion, or bullying because of gender expression;
7. that pediatricians have a role in advocating for policies and laws that protect youth who identify as TGD from discrimination and violence;
8. that the health care workforce protects diversity by offering equal employment opportunities and workplace protections, regardless of gender identity or expression; and
9. that the medical field and federal government prioritize research that is dedicated to improving the quality of evidence-based care for youth who identify as TGD.

AAP American Academy of Pediatrics

GACM gender-affirmative care model

GLSEN Gay, Lesbian, and Straight Education Network

LGBTQ lesbian, gay, bisexual, transgender, or questioning

TGD transgender and gender diverse

Dr Rafferty conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, approved the final manuscript as submitted, and agrees to be accountable for all aspects of the work.

- * For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@aap.org.

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Comments

6 Comments

Sex isn't "assigned" , it's determined

December 22 2019 | John A. Weiss
The BOOM Youth Mentoring

Hi

Please change the word "assigned" to "determined".

The policy states:

"Sex," or "natal gender," is a label, generally "male" or "female," that is typically assigned at birth on the basis of genetic and anatomic characteristics, such as genital anatomy, chromosomes, and sex hormone levels.

This is unscientific and illogical. Sex is a REALITY. It's DETERMINED by observed biology. Not "assigned".

Your use of the word "assigned" demonstrates an anti-science position of denying biological reality.

A health and science professional group like AAP betrays it's professional and scientific credibility by replacing science with politics.

Regards,
John Weiss

Submitted on December 22 2019

RE: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

May 13 2019 | Steven Warns
United Way

A dangerous and emotionally motivated article based on no valid or verified scientific data. Appalling. Shame on AAP. Nuff said.

RE: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

November 14 2018 | Gregg Brown
Private Practice

Dr. Johnson and Dr. Sax make clear and compelling arguments against some over-reach and mischaracterizations found in this policy statement. I strongly recommend that the committee consider the arguments presented and update the policy statement accordingly.

In addition, I wish to point out the overly broad way in which this committee defined reparative therapy. Not only are physically aversive and shock therapies contained in this committee's definition of reparative therapy, but also non-aversive talk therapies all based around the nebulous idea that the therapist's intentions define the type of therapy.

What type of therapy is it if the child's intentions are to attempt to align her gender with her biological sex, while the therapist remains neutral?

Is any amount of challenging considered reparative therapy? If so has the therapist's role changed from being a therapist to being a facilitator?

Is there such a thing as therapy without a certain amount of challenging?

Clearly this definition of "reparative therapy" is overly broad, and cumbersome. This type of definition leads to a constraint of legitimate therapy due to the spectre that someone may perceive appropriate therapy to be

"reparative" because of the faulty way in which
"reparative" therapy is defined.

On a separate note, the citation about the inefficacy of "reparative therapy" for adult gay men has no place in a policy statement for TGD children and adolescents. As stated in the article, sexual orientation and gender are not the same. Likewise, adults are not the same as children or adolescents. When there is not evidence to support the idea put forth, let the idea stand on its own merits. Adding a citation that does not apply draws false parallels and is disingenous.

Thank you for this opportunity to comment on this policy statement. I strongly recommend the revisions mentioned.

Sincerely,
Dr. Brown

Submitted on November 14 2018

RE: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

November 10 2018 | Paul Johnson
Private Practice

Thank you for the opportunity to submit a comment on the article mentioned above. Upon reading what I submitted initially, I realize that one salient point was not included in my comments. I would like to submit my comments in their entirety as below:

The excellent points made by Dr. Sax (see comment from 23 Oct 2018 below) encompass many of my concerns about this AAP statement. His clear writing and references

clearly call for amendments to this policy statement. Two other important considerations regarding this policy statement are as follows:

1) This AAP statement clearly mischaracterizes watchful waiting as unsupportive and a way of pathologizing. This could not be further from the truth. A watchful waiting approach acknowledges that changes happen as the brain develops and humbly realizes that the ultimate outcome is unknown at an early age. It allows the child self-expression without strict adherence to a label that may not fit in the future. Watchful waiting is both compassionate and flexible; there is no reason to demonize this legitimate clinical approach. Please revise the statement to provide a more accurate description of watchful waiting.

2) The 4th bullet of gender-affirming care states "if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child". However, the policy statement reports that 20% of matched controls have experienced suicidality and 11% have attempted suicide which is not due to gender-related issues. We have no reason to believe that TGD children would be immune from non gender-related mental health conditions that are often intrinsic to other children and adults. This statement makes this dangerous and often repeated assertion that causes some of the mental health needs of TGD children to be overlooked and under treated. Please revise this bullet.

Sincerely, Paul Johnson MD

Submitted on November 10 2018

RE: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

November 10 2018 | Paul Johnson
Private Practice

This excellent points made by Dr. Sax (see comment from 23 Oct 2018 below) encompass many of my concerns about this AAP statement. His clear writing and references clearly call for amendments to this policy statement.

In addition, this AAP statement clearly mischaracterizes watchful waiting as unsupportive and a way of pathologizing. This could not be further from the truth. A watchful waiting approach acknowledges that changes happen as the brain develops and humbly realizes that the ultimate outcome is unknown at an early age. It allows the child self-expression without strict adherence to a label that may not fit in the future. Watchful waiting is both compassionate and flexible; there is no reason to demonize this legitimate clinical approach.

Please revise the statement to provide a more accurate description of watchful waiting.

Sincerely,

Paul Johnson MD

Submitted on November 10 2018

RE: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

October 23 2018 | Leonard Sax
Montgomery Center for Research in Child & Adolescent Development

What is best practice, when a 7-year-old boy announces that he is really a girl? We do have longitudinal cohort studies which provide useful evidence. Wallien and Cohen-Kettenis (2008) reported on 45 boys and 14 girls who presented with gender dysphoria with a mean age of 8.4 years. Ten years later, 28 of those boys, and 5 of the girls, were no longer gender dysphoric. In other words, of 45 boys followed over ten years, 28 boys, or 62%, did not persist in gender dysphoria. In another study (Singh 2012), 139 boys with gender dysphoria were enrolled at an average age of 7.5 years; at follow-up, averaging 13 years later, only 17 boys out of 139 (12.7%) were still gender-dysphoric. These studies, and others like them (see Zucker 2008 for review), suggest that the majority of boys who identify as gender-dysphoric prior to the onset of puberty will not persist in gender dysphoria after the onset of puberty.

Suppose parents consult a physician regarding their 7-year-old son who has said that he is really a girl. Suppose the physician, mindful of Wallien & Cohen-Kettenis (2008), Singh (2012), and Zucker et al. (2012), advises a cautious wait-and-see approach. The 7-year-old wants to study ballet? Excellent. But he will study ballet as a boy, not a girl, at least for the next year.

Rafferty & Committee (2018) savagely denounce such an approach as “outdated.” Even worse: that physician is trying “to prevent children and adolescents from identifying as transgender”. Such an approach they label “reparative therapy.” They then assert that reparative therapies have been shown to be unsuccessful. In support of that assertion they provide one citation, citation #38, a 1994 report of the lack of success of strategies intended to change the sexual orientation of homosexual men and women. Outdated, indeed. A report documenting the

failure of efforts to change the sexual orientation of adults is of doubtful relevance to the question of whether a 5-year-old boy who says that he is a girl should be encouraged to transition.

Rafferty & Committee assert that “more robust and current research” has proven that the old strategy of “watchful waiting” is harmful, and that gender-affirmative strategies should be deployed in prepubertal children. They set no lower age limit for the age at which a child can decide that the child should be reassigned to a different gender. They provide no longitudinal cohort study documenting any outcomes significantly different from those cited above. However, if a clinician were to conclude from studies such as Wallien & Cohen-Kettenis (2008) that watchful waiting is a reasonable approach, Rafferty & Committee harshly reject such an approach, without providing any more recent longitudinal cohort study documenting different outcomes.

Common sense suggests that a 3-year-old boy who says that he is a girl should be subject to some degree of watchful waiting before the boy is put in a dress and has his name legally changed. But such common sense is notably lacking from Rafferty & Committee.

Leonard Sax MD PhD

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Submitted on October 23 2018

ACP Journals

Position Papers | 21 July 2015



Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians

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Abstract

In this position paper, the American College of Physicians examines the health disparities experienced by the lesbian, gay, bisexual, and transgender (LGBT) community and makes a series of recommendations to achieve equity for LGBT individuals in the health care system. These recommendations include enhancing physician understanding of how to provide culturally and clinically competent care for LGBT individuals, addressing environmental and social factors that can affect their mental and physical well-being, and supporting further research into understanding their unique health needs.

PDF

Help

The lesbian, gay, bisexual, and transgender (LGBT) community is diverse, comprising persons from various races, ethnicities, and socioeconomic

backgrounds; however, LGBT persons face a common set of challenges within the health care system. These challenges range from access to health care coverage and culturally competent care to state and federal policies that reinforce social stigma, marginalization, or discrimination. Recent years have brought about reliable data collection, research, and a greater understanding of the health care needs of the LGBT community and the challenges they face in accessing care. Although great strides have been taken in reducing health disparities in the LGBT community, much more needs to be done to achieve equity for LGBT persons in the health care system.

Although members of the LGBT community face similar health concerns as the general population, certain disparities are reported at a higher rate among LGBT persons than the heterosexual population (1). These disparities experienced by LGBT persons may be compounded if they are also part of a racial or ethnic minority (1). Of note, LGBT persons are more likely to identify themselves as being in poor health than heterosexual individuals, and different segments of the LGBT population have individual health risks and needs. For example, gay and bisexual men are at increased risk for certain sexually transmitted infections and account for more than half of all persons living with HIV or AIDS in the United States (1); lesbian women are less likely to have mammography or Papanicolaou test screening for cancer (2); lesbian and bisexual women are more likely to be overweight or obese (3); and lesbian, gay, and bisexual persons are more likely to become disabled at a younger age than heterosexual individuals (4).

PDF

Help

Various state or federal laws may affect the quality of life of LGBT persons and can affect their physical and mental health. Same-sex marriage bans may cause psychological distress (5), prohibitive hospital visitation policies may prevent a same-sex parent from seeing a minor while the child is ill or participating in medical decision making for the child, and exclusions on transgender health care in private and public health plans may cause a transgender patient to seek treatment options through illegal channels (6). These laws and policies, along with others that reinforce marginalization, discrimination, social stigma, or rejection of LGBT persons by their families or communities or that simply keep LGBT persons from accessing health care, have been associated with increased rates of anxiety, suicide, and substance or alcohol abuse (7).

Addressing these disparities will require changes in the way LGBT persons and their families are regarded in society and by the health care system. Policies that are discriminatory toward the LGBT community, or are no longer supported by empirical research, continue to reinforce the environmental and social factors that can affect the mental and physical well-being of LGBT persons. The American College of Physicians (ACP) has a long-standing commitment to improving the health of all Americans and opposes any form of discrimination in the delivery of health care services. ACP is dedicated to eliminating disparities in the quality of or access to health care and is committed to working toward fully understanding the unique needs of the LGBT community and eliminating health disparities for LGBT persons.

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This Executive Summary provides a synopsis of the full position paper, which is available in [Appendix](#).

Methods

The ACP Health and Public Policy Committee, which is charged with addressing issues affecting the health care of the U.S. public and the practice of internal medicine and its subspecialties, developed these recommendations. The committee reviewed numerous studies, reports, and surveys on LGBT health care and related health policy. The committee also reviewed information on how state and federal policies may affect the physical and mental health of the LGBT population. Draft recommendations were reviewed by the ACP Board of Regents, Board of Governors, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The position paper and recommendations were reviewed by the ACP Board of Regents and approved on 27 April 2015.

ACP Position Statements and Recommendations

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The following statements represent the official policy positions and recommendations of the ACP. The rationale for each is provided in the full position paper ([Appendix](#)).

A glossary of LGBT terminology used throughout this paper can be found at <https://lgbt.ucsf.edu/glossary-terms>.

1. *The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.*
2. *The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.*
3. *The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.*
4. *The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.*
5. *The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on*

the physical and mental health of these persons and contribute to ongoing stigma and discrimination for LGBT persons and their families.

6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.

7. Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.

8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

9. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.

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Conclusion

The ACP recognizes that reducing health disparities in the LGBT population will take concerted efforts not only by those in the medical community but

also from society as a whole. Training future physicians to be culturally and clinically competent in LGBT health care, working with practicing physicians to increase their understanding of the LGBT population and their health needs, advocating for practical health policies supported by empirical research, and working to eliminate laws that discriminate against the LGBT community and their families are all important steps to reducing and ultimately eliminating the health disparities experienced by the LGBT community.

Appendix: Lesbian, Gay, Bisexual, and Transgender Health Disparities: A Policy Position Paper From The American College of Physicians

Understanding the LGBT Community

The LGBT community is a highly diverse and multifaceted group of persons encompassing all cultures, ethnicities, and walks of life. Under the LGBT umbrella, each individual group faces unique cultural and health-related needs but shares common challenges, such as social stigma, discrimination, and disparities in health care, that unite them.

Research into LGBT health has been expanding as the community has become more visible and outspoken about engaging the health care system in developing a knowledge base on the distinctive challenges and health disparities they face. However, gaps in the medical community's understanding of the overall makeup of the LGBT community and the environmental and social factors that may influence the needs of those

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persons present an obstacle to addressing challenges in a meaningful way. In 2011, the Institute of Medicine issued a report outlining a research agenda targeting several areas that could affect how the health care system approaches LGBT health, including demographics, social influences, disparities and inequalities, intervention that includes increasing access to care and addressing physical or mental conditions, and transgender-specific needs. The report also recommended the inclusion of the LGBT community in national health surveys and emphasized a need for scientific rigor and a respectful environment when gathering data (8).

One important obstacle to identifying health issues within the LGBT population is a lack of reliable data and the exclusion of sexual and gender minorities' identification on federal health surveys. Recent efforts have been made to gather population data on persons who identify as lesbian, gay, bisexual, or transgender and those who identify as being in a same-sex marriage or partnership. For the first time in 2010, the U.S. Census Bureau did not change the data reporting the number of same-sex couples that identified as being married. Before that, the 2000 U.S. Census changed the relationship status of same-sex partners identifying as being the spouse of the head of household to an "unmarried partner" because there were no states in which same-sex marriage was legal. In the 1990 U.S. Census, if a same-sex couple identified themselves as married, the sex of 1 of the respondents was automatically changed to the opposite sex and the couple was enumerated as an opposite-sex married couple (9). The Patient Protection and Affordable Care Act allows the Department of Health and Human Services (HHS) to collect "additional demographic data to further

improve our understanding of health disparities," and in 2013, the National Health Interview Survey—an annual study of health care access, use, and behaviors—included sexual orientation as part of its data collection system (10). Recent estimates put the number of persons who identify as lesbian, gay, bisexual, or transgender at more than 9 million or approximately 3.4% of the U.S. population, which some analysts believe may be an underestimate (1). Individuals who may have same-sex attractions or experiences but do not self-identify as LGBT may still fall into the category of sexual minorities and face health disparities associated with LGBT persons.

Access to Care in the LGBT Population

The LGBT community has often been overlooked when discussing health care disparities and continues to face barriers to equitable care. Barriers to care are multidimensional and include stigma and discrimination, poverty, lack of education, racial or ethnic minority status, and other psychological health determinants (11). Studies show that persons who identify as LGBT have greater economic disadvantages and are more vulnerable to poverty than those who do not. Using available information from national surveys, the Williams Institute reports higher overall poverty rates for persons identifying under the LGBT umbrella than heterosexual persons and higher rates of poverty in same-sex couples than heterosexual couples (7.6% vs. 5.7%) (12).

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Research shows that LGBT adults and their children are more likely to be uninsured by public or private insurance and that they and their family

members continue to face difficulties in gaining access to care and face a higher risk for health disparities than the general population (2). Most Americans gain health insurance coverage through their employer; data are limited but suggest LGBT persons face higher unemployment rates than non-LGBT persons. A 2009 survey in California found a 14% unemployment rate among LGBT adult workers compared with 10% among non-LGBT adults (13).

The Affordable Care Act sought to increase access to care for low-income Americans by expanding Medicaid programs to all persons at or below 133% of the federal poverty level, providing financial subsidies to help those making between 100% and 400% of the federal poverty level purchase insurance on the federal and state marketplace exchanges, and including nondiscrimination protections in health plans sold on the exchanges. Although estimates suggested that the number of uninsured LGBT persons would be reduced as a result of Medicaid expansion, only about half of states have chosen to expand their Medicaid programs, which greatly diminishes its effect. This increases the number of LGBT persons who may fall into what has been dubbed the "coverage gap," in which persons may earn too much to qualify for their state's Medicaid program but too little to qualify for subsidies (14).

Transgender individuals face additional challenges in gaining access to care. Not only are they more likely to be uninsured than the general population, they are more likely to be uninsured than lesbian, gay, or bisexual persons (1). They also face high out-of-pocket costs for transgender-specific medical

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care if they lack insurance or their insurance coverage does not cover transgender health care. According to the American Congress of Obstetricians and Gynecologists, transgender youth who receive inadequate treatment are at an increased risk for engaging in self-mutilation or using illicit venues to obtain certain treatments; research shows more than 50% of persons who identify as transgender have obtained injected hormones through illegal means or outside of the traditional medical setting (6).

Mental and Physical Health Disparities

Existing research into the health of the LGBT population has found some health disparities that disproportionately affect the LGBT population. In 2000, the first federally funded research study on the health of LGBT persons assessed 5 major areas of concern for lesbian, gay, and bisexual persons (the report noted that transgender health concerns warranted an independent evaluation): cancer, family planning, HIV and AIDS, immunization and infectious diseases, and mental health (15). Research has shown that lesbian women are less likely to get preventive cancer screenings; lesbian and bisexual women are more likely to be overweight or obese (16); gay men are at higher risk for HIV and other sexually transmitted infections; and LGBT populations have the highest rates of tobacco, alcohol, and other drug use (17). Lesbian, gay, and bisexual persons are approximately 2.5 times more likely to have a mental health disorder than heterosexual men and women (18).

Transgender persons are also at a higher lifetime risk for suicide attempt and show higher incidence of social stressors, such as violence, discrimination, or childhood abuse, than nontransgender persons (19). A 2011 survey of transgender or gender-nonconforming persons found that 41% reported having attempted suicide, with the highest rates among those who faced job loss, harassment, poverty, and physical or sexual assault (20).

Positions

1. The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.

Nondiscrimination policies are in place to prevent employment discrimination or harassment based on race, color, national or ethnic origin, age, religion, sex, disability, genetics, or other characteristics protected under federal, state, or local law (21). However, state law varies considerably on the inclusion of sexual orientation and gender identity in nondiscrimination policies and some policies based on sexual orientation alone may not include gender identity. Eighteen states have employment nondiscrimination or equal employment opportunity statutes that cover both gender identity and sexual orientation, and an additional 3 states have nondiscrimination statutes that cover sexual orientation only (22). The

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Human Rights Campaign, an LGBT rights organization, estimated that as a result of these assorted laws, 3 of 5 U.S. citizens live in an area that does not provide protection for gender identity or sexual orientation (23).

Sexual orientation and gender identity are inherently different and should be considered as such when assessing whether nondiscrimination or harassment policies provide protection to all members of the LGBT community. According to the Institute of Medicine, "sexual orientation" refers to a person's enduring pattern of or disposition to have sexual or romantic desires for, and relationships with, persons of the same sex or both sexes (8). "Gender identity" refers to a person's basic sense of being a man or boy, a woman or girl, or another gender. Gender identity may or may not correspond to a person's anatomical sex assigned at birth. The term "transgender" is now widely used to refer to a diverse group of persons who depart significantly from traditional gender norms (24). Persons who have a "marked difference" between their anatomical sex at birth and their expressed or experienced gender may be diagnosed with gender dysphoria, which is a diagnosis under the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (25).

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Evidence shows that individuals with gender identity variants face increased discrimination, threats of violence, and stigma. The National Gay and Lesbian Task Force and the National Center for Transgender Equality conducted a national survey of transgender and gender-nonidentifying persons and found high rates of harassment (78%), physical assault (35%), and sexual violence (12%) (20). More than 90% of survey participants

reported harassment or discrimination in the workplace, and they experience double the rate of unemployment than the general population (20). Therefore, LGBT persons are more likely to lose their job or not be hired (26).

Employers have the option to include gender identity as part of their company's nondiscrimination or antiharassment policies even if their state does not, and many companies have chosen to include comprehensive protections policies. To reduce the potential for discrimination, harassment, and physical and emotional harm toward persons who are not covered by current protections, the medical community should include both sexual orientation and gender identity as part of any comprehensive nondiscrimination or antiharassment policy.

2. The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.

The LGBT community is at increased risk for physical and emotional harm resulting from discrimination or harassment, and transgender persons may face greater inequalities in the health care system than the general population. Of note, 19% of transgender persons lack any type of health insurance (20). A handful of states have laws about insurance coverage for transgender health care, such as hormone replacement therapy or sexual reassignment surgery, which may be considered medically necessary as part of the patient's care. Eight states and the District of Columbia have

prohibitions on insurance exclusion of treatments for sex reassignment surgery (27).

The World Professional Association for Transgender Health has developed health care standards for transgender persons who have been diagnosed with gender dysphoria. The standards emphasize treatments that will achieve "lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment" and may or may not include modification to a person's gender expression or how this individual appears or presents physically to others (28). Research shows that when transgender persons receive individual, medically appropriate care, they have improved mental health, reduction in suicide rates, and lower health care costs overall because of fewer mental health-related and substance abuse-related costs (29). However, not all health plans cover all services associated with transgender health or consider such services medically necessary; some plans may issue blanket exclusions on transgender health care, not cover certain services for a transgender person as they would for nontransgender persons, or only cover the cost of gender reassignment surgery if certain conditions are met. For example, an insurance company may cover posthysterectomy estrogenic hormone replacement therapy for biological women but will not cover a similar type of hormone therapy for a postoperative male-to-female transgender patient. Many professional medical organizations, including the American Medical Association, American Psychological Association, American Psychiatric Association, American Congress of Obstetricians and Gynecologists, and

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American Academy of Family Physicians, consider gender transition–related medical services medically necessary (30).

The decision to institute a hormone therapy regimen or pursue sexual reassignment surgery for transgender individuals is not taken lightly. Transgender patients and their health care team, which may include primary care physicians, endocrinologists, mental health professionals, and others, are in the best position to determine the most appropriate care plan unique to the patient's needs. Throughout the course of treatment, patients and their physicians or health care team should discuss available options and the evidence base for those treatments in which such evidence exists. It is especially important that transgender patients whose health care team has determined that treatment should include cross-sex hormone therapy or sexual reassignment surgery and postoperative hormone therapy be well-informed about the potential health risks associated with the long-term use of some hormonal replacement therapies before treatment.

Without insurance coverage, the cost of treatment for persons with gender dysphoria may be prohibitively expensive. The most extensive and expensive sexual reassignment surgeries may cost tens of thousands of dollars; this does not include associated costs, such as counseling, hormone replacement therapy, copays, or aftercare. The high costs of treatment can result in persons who cannot access the type of care they need, which can increase their levels of stress and discomfort and lead to more serious health conditions. In 2014, the HHS lifted the blanket ban on Medicare coverage for gender reassignment surgery (31) and the federal government announced it

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would no longer prohibit health plans offered on the Federal Employees Health Benefits Program from offering gender reassignment as part of the plan (27). Transgender health advocates are hopeful this will result in wider coverage for transgender care in private health plans.

The cost of including transgender health care in employee health benefits plans is minimal and is unlikely to raise costs significantly, if at all. A survey of employers offering transition-related health care in their health benefit plans found that two thirds of employers that provided information on actual costs of employee utilization of transition-related coverage reported 0 costs (32). This is the result of a very small portion of the population identifying as transgender and a smaller portion of that group having the most expensive type of gender reassignment surgery as part of their treatment. An analysis of the utilization of transgender health services over 6 years after transgender discrimination was prohibited in one California health plan found a utilization rate of 0.062 per 1000 covered persons (33). The inclusion of transgender-related health care services within a health plan may also result in an overall reduction of health care costs over time because patients are less likely to engage in self-destructive behaviors, such alcohol or substance abuse.

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3. The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.

The term "family" as it is seen in society is changing and no longer means married heterosexual parents with children. An analysis shows only 22% of

families fall into this category (34). Stepparents, single parents, grandparents, same-sex couples, or foster or adoptive parents all make up the changing face of U.S. families. Across the country, LGBT persons are raising children, and demographic data shows that 110 000 same-sex couples are raising as many as 170 000 biological, adopted, or foster children and 37% of LGBT adults have had a child (35). This modern concept of family is no longer dependent on parental status and does not only include adult heads of household with minor children. Same-sex couples and different-sex couples who do not have children may nevertheless have persons in their lives that they consider family.

Despite research that shows a growing trend toward acceptance of LGBT individuals and families (36), there is no widely used standard definition of family inclusive of the diverse nature of the family structure and definitions vary widely: They can differ from state to state, within the Internal Revenue Service for tax purposes, by employers to determine eligibility for health plans, and by hospitals for the purposes of visitation or medical decision making. If LGBT spouses or partners are not legally considered a family member, they are at risk for reduced access to health care and restricted on caregiving and decision making; further, they are at increased risk for health disparities, and their children may not be eligible for health coverage (34). Therefore, LGBT persons and families may already be at a financial disadvantage, with single LGBT parents 3 times more likely to live near the poverty line than their non-LGBT counterparts and LGBT families twice as likely to live near the poverty threshold (35). These financial disadvantages can translate into lack of access to medical care and poorer health outcomes

similar to those experienced by non-LGBT persons and their families who are uninsured or underinsured, in addition to the health disparities that are already reported among the LGBT community.

The Human Rights Campaign's definition of family for health care organizations, developed with multistakeholder input, is inclusive of same- and different-sex married couples and families and is an example of a broad, comprehensive definition of family that includes a person's biological, legal, and chosen family:

Family means any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual. Members of "family" include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" includes a minor patient's parents, regardless of the gender of either parent. (37)

A definition of family inclusive of all types of families, including the LGBT population, is not only fundamental to reducing the disparities and inequalities that exist within the health care system, but also important for the equal treatment of LGBT patients and their visitors in the hospital setting. Countless accounts show loved ones being denied the right to visit; assist in the medical decision-making process for their partner, minor, or child; or be updated on the condition of a patient because hospital visitation policy broadly prohibits those who are not recognized family members from access to the patient. These policies are discriminatory against LGBT patients, their visitors, and the millions of others who are considered family,

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such as friends, neighbors, or nonrelative caregivers who can offer support to the patient.

4. The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.

When persons or their loved ones need emergency care or extended inpatient stays in the hospital, they do not often immediately think about access to visitors or hospital visitation policies, the ability to assist in medical decision making, or their legal rights as patients or visitors. Hospital visitation policies are not always clear or consistent about who can visit or make medical decisions for a patient if they become incapacitated or cannot do so themselves. The absence or limited access of loved ones can cause uncertainty and anxiety for the patient. In contrast, the involvement of family and outside support systems can improve health outcomes, such as management of chronic illness and continuity of care (38).

A highly publicized incident of LGBT families facing discrimination and being denied hospital visitation occurred in Florida in 2007. A woman on vacation with her family had an aneurysm and was taken to the hospital. Her same-sex partner and their children were denied the right to see her or receive updates on her condition, and she eventually slipped into a coma

and died (39). In response to this incident, President Obama issued a presidential memorandum recommending that the HHS review and update hospital visitation policies for hospitals participating in Medicare or Medicaid and critical-access hospitals to prohibit discrimination based on such factors as sexual orientation or gender identity (40).

Throughout the rulemaking process, the HHS revised the Medicare Conditions of Participation to require that all hospitals explain to all patients their right to choose who may visit during an inpatient stay, including same-sex spouses, domestic partners, and other visitors, and the patients' right to choose a person to act on their behalf. The Joint Commission, the nation's largest organization for hospital accreditation, also updated its standards to include equal visitation for LGBT patients and visitors (41). As a result of these updated policies, most hospitals and long-term care facilities are required to allow equal visitation for LGBT persons and their families.

The presidential memorandum also recommended that the HHS instruct hospitals to disclose to their patients that patients have a right to designate a representative to make medical decisions on their behalf if they cannot make those decisions themselves. The revised Conditions of Participation emphasized that hospitals "should give deference to patients' wishes about their representatives, whether expressed in writing, orally, or through other evidence, unless prohibited by state law" (42). With piecemeal regulations and policies governing the legal rights of LGBT persons and their families, some same-sex spouses or domestic partners choose to prepare advance directives, such as durable powers of attorney and health care proxies, in an

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effort to ensure their access to family members and their ability to exert their right to medical decision making if necessary.

5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of these persons and contribute to ongoing stigma and discrimination for LGBT persons and their families.

The health and financial benefits of marriage for different-sex couples are widely reported, and contemporary research supports similar benefits in same-sex marriage. On the other hand, denial of marriage rights for LGBT persons may lead to mental and physical health problems. Health benefits associated with same-sex marriage result from improved psychological health and a reinforced social environment with community support (43). Research suggests that being in a legally recognized same-sex marriage diminishes mental health differentials between LGBT and heterosexual persons (5). A comparison study on the utilization of public health services by gay and bisexual men before and after Massachusetts legalized same-sex marriage found a reduction in the number of visits for health problem mental health services. The study noted a 13% reduction in visits over after the legalization of same-sex marriage (44).

In contrast, denial of such rights can result in ongoing physical and psychological health issues. Thus, LGBT persons encountering negative societal attitudes and discrimination often internalize stressors and have poor health unseen to those around them; further, these stressors can lead to self-destructive behaviors (43). A study of LGBT individuals living in states

with a same-sex marriage ban found increases in general anxiety, mood disorders, and alcohol abuse (45). The denial of marriage rights to LGBT persons has also been found to reinforce stigmas of the LGBT population that may undermine health and social factors, which can affect young adults (46). The American Medical Association's broad policy supporting civil rights for LGBT persons acknowledges that denial of civil marriage rights can be harmful to LGBT persons and their families and contribute to ongoing health disparities (47).

Since 2003, the overall support for marriage equality has increased. The shift in attitudes toward acceptance of same-sex marriage has broad positive implications for the future of U.S. civil marriage rights. A 2013 survey by the Pew Research Center revealed that nearly half of U.S. adults expressed support for same-sex marriage. Of note, millennials (those born after 1980) showed the highest rate of support for same-sex marriage rights at 70%. Not only has overall opinion changed, but individually, 1 in 7 respondents reported they had changed their minds from opposing to supporting same-sex marriage. The Pew survey found that 32% of respondents changed their mind because they knew someone who identified as lesbian or gay (36).

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The legal landscape is also shifting in favor of inclusive civil marriage rights for same-sex couples. The American Bar Association has adopted a resolution recognizing "that lesbian, gay, bisexual and transgender (LGBT) persons have a human right to be free from discrimination, threats and violence based on their LGBT status and condemns all laws, regulations and rules or practices that discriminate on the basis that an individual is [an]

LGBT person" (48). In June 2013, the U.S. Supreme Court struck down a provision of the Defense of Marriage Act that defined marriage as a "union between a man and a woman." The decision allowed legally married same-sex couples to have the same federal benefits offered to heterosexual couples (49). Currently more than half of the states and the District of Columbia allow same-sex marriage, and several states have rulings in favor of same-sex marriage that are stayed pending legal appeals (50). In April 2015, the Supreme Court heard oral arguments in a case involving same-sex marriage bans in Michigan, Ohio, Kentucky, and Tennessee; this will ultimately determine the constitutionality of same-sex marriage bans, including whether states would be required to recognize same-sex marriages performed legally out of state (51).

6. The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.

Previous efforts to understand the LGBT population by including sexual orientation or gender identity in health surveys and data collection are a good first step, but there is a long way to go to understand the unique health needs of all members of the LGBT community. Understanding the demographics of the persons who make up this community is a key first step to understanding how environmental and social determinants may contribute to the health disparities they face. Overwhelming evidence shows that racial and ethnic minorities experience greater health disparities than

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the general population. In 2010, ACP published an updated position paper on racial and ethnic disparities in health care, which identified various statistics on health disparities in racial and ethnic minority groups, such as higher levels of uninsured Hispanics than white persons (34% vs. 13%) and lower rates of medication adherence in minority Medicare beneficiaries diagnosed with dementia (52). Persons who are part of both the LGBT community and a racial or ethnic minority group may face the highest levels of disparities. For example, data show that 30% of African American adults who identify as lesbian, gay, or bisexual are likely to delay getting a prescription compared with 19% of African American heterosexual adults (26).

Transgender persons may also face certain increased risk factors that can affect their health that are not included when discussing the LGBT population as a whole, which creates research gaps with the LGBT community. A survey study of transgender persons shows elevated reports of harassment, physical assault, and sexual violence (20). In addition, transgender persons are more likely to face discrimination in education, employment, housing, and public accommodations than other sexual, racial, or ethnic minority groups. The lack of and unfamiliarity with research focused on the physical health issues of transgender persons, such as hormone replacement therapy and cancer risk, limit the understanding or development of best practices that could reduce the disparities felt by this population. The dearth of such research is detrimental to physicians' understanding of issues unique to transgender patients and reduces their ability to care for these patients.

Data that have been gathered in the relatively short time since the inclusion of sexual orientation, gender identity, and same-sex marital status have revealed information that can be used to create tailored plans to decrease health disparities in in the LGBT community. For example, in 2009 the California Health Interview Survey collected information on certain health indicators and included sexual orientation along with racial and minority status. The survey found a higher rate of uninsured lesbian, gay, or bisexual Latino adults in the state than their African American counterparts (36% vs. 14%) (20).

In addition to obtaining information from population surveys, including gender identity and sexual orientation as a component of a patient's medical record (paper or electronic) may help a physician to better understand an LGBT patient's needs and provide more comprehensive care. This can be particularly useful in the care of transgender persons, whose gender identity and gender expression may differ from their sex assigned at birth and are not in line with the standard sex template on many forms. Including this information—especially in electronic health records that can standardize information, such as anatomy present and the preferred name/pronoun can create a more comfortable experience for the patient and keep the physician up to date on the patient's transition history, if applicable (53). If a physician uses paper medical records, the patient's chart should be flagged using an indicator, such as a sticker, to alert staff to use the preferred name and pronoun of the patient (54).

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7. *Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.*

Establishing understanding, trust, and communication between a physician and a patient is key to an ongoing and beneficial physician–patient relationship. However, reported instances of physician bias or denial of care to LGBT patients may influence patients to withhold information on their sexual orientation, gender identity, or medical conditions that could help the physician have a better understanding of the potential health needs of their patients. Physicians can play an integral role in helping an LGBT patient navigate through the medical system by providing respectful, culturally, and clinically competent care that underscores the overall health of the patient. In an article published in *The New England Journal of Medicine*, Makadon noted how physicians can create a welcoming and inclusive environment to LGBT patients:

[G]uidelines for clinical practice can be very simple: ask the appropriate questions and be open and nonjudgmental about the answers. Few patients expect their providers to be experts on all aspects of gay and lesbian life. But it is important that providers inquire about life situations, be concerned about family and other important relationships, understand support systems, and make appropriate referrals for counseling and support when necessary. (55)

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Providing clinically and culturally competent care for transgender persons in the primary care setting may present a challenge to physicians who are not knowledgeable about transgender health. Transgender persons have reported encounters with physicians who are unaware of how to approach treatment of a transgender person, and half of transgender patients reported having to "teach" their physician about transgender health (20). The National Transgender Survey found that 19% of participants had been denied medical care because of their transgender status (20). Resources for physicians on how to approach the treatment of transgender patients should emphasize respecting the patient's gender identity while providing prevention, treatment, and screening to the anatomy that is present (56).

To better understand the unique health needs of the LGBT community, physicians and medical professionals must develop a knowledge base in cultural and clinical competency and understand the factors that affect LGBT health; this should begin in the medical school setting and continue during practice. Assessment of LGBT-related content at medical schools found a median of 5 hours spent on LGBT-related issues over the course of the curriculum (57). Exposure to members of the LGBT population in medical school has been shown to increase the likelihood that a physician will take a more comprehensive patient history, have a better understanding of LGBT health issues, and have a more positive attitude toward LGBT patients (58). Studies show that undergraduate students pursuing a career in medicine are receptive to incorporating LGBT-related issues into their education and agree that it applies to their future work (59). The College recognizes the importance of incorporating LGBT health into the medical

school curriculum and publishes a comprehensive medical textbook on LGBT health, *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2nd Edition* (60).

In November 2014, the Association of American Medical Colleges Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development released a comprehensive report recommending strategies on how to implement changes in academic medical institutions to better address the needs of LGBT patients; further, the committee identified challenges and barriers to carrying out these changes. The report recognizes 3 methods of integrating LGBT health into the medical school curricula: full curriculum revision, the addition of a required class, or LGBT health study as a part of elective materials. The report also identifies barriers to curricular changes, including but not limited to a lack of material that has been shown to be effective, reluctance of faculty and staff to teach the new material, and a shortage of institutional time that would permit teachers to participate in continuing education on the topic (61).

For some LGBT persons interested in pursuing careers in medicine, the continues to be an underlying concern that their sexual orientation or gender identity may affect their selection into a medical school or residency program and acceptance by their peers. In 2012, Dr. Mark Schuster published his personal story about being gay in medicine starting in the 1980s when he entered medical school, through residency, and into practice. In his article, he spoke of a former attending physician he worked under who acted as an advisor and had indicated he would offer him a

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recommendation for residency, only to find this physician later renege on that offer after Dr. Schuster shared that he was gay (62). Little research has been done on the recruitment of LGBT physicians into the practice of medicine or how disclosing sexual orientation may affect training. One survey measuring the perceptions and attitudes toward sexual orientation during training found that 30% of respondents did not reveal their sexual orientation when applying for residency positions for fear of rejection (63).

Academic medical institutions can make efforts to create a welcoming and inclusive environment for students and faculty. The University of California, San Francisco, LGBT Resource Center developed a checklist for medical schools to assess LGBT curriculum, admissions, and the working environment within their institution. The checklist includes inclusive application procedures, measurement of retention of LGBT students, and efforts and resources dedicated to student well-being (64). In a 2013 white paper, the Gay and Lesbian Medical Association made several recommendations to support an LGBT-inclusive climate at health professional schools in such areas as institutional equality, transgender services and support, diversity initiatives, admissions, staff and faculty recruitment and retention, staff and faculty training, and other areas that underscore simple yet thoughtful ways to create an accepting environment for LGBT students, faculty, and employees (65). Tools such as these can assist in recruiting and retaining LGBT physicians.

8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

Since 1973, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* has not considered homosexuality an illness (66). All major medical and mental health organizations do not consider homosexuality as an illness but as a variation of human sexuality, and they denounce the practice of reparative therapy for treatment of LGBT persons (67). The core basis for "conversion," "reorientation," or "reparative" therapy, which is generally defined as therapy aiming at changing the sexual orientation of lesbian women and gay men, is mostly based on religious or moral objections to homosexuality or the belief that a homosexual person can be "cured" of their presumed illness.

In 2007, the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change sexual orientation. It found serious flaws in the research methods of most of the studies and identified only 1 study that met research standards for establishing safety or efficacy of conversion therapy and also compared persons who received a treatment with those who did not. In that study, intervention had no effect on the rates of same-sex behavior, so it is widely believed that there is no scientific evidence to support the use of reparative therapy (68). The International Commission on Sexual Orientation and Gender Identity, the American Health Organization, the regional office for the Americas of the larger World Health Organization, also supports the position that there is no medical basis for reparative therapy and that the practice may pose a threat to the overall health and well-being of an individual (69). Dr. Robert Spitzer, the author of a 2003 research study often cited by supporters of the reparative therapy movement to purport that persons may choose to change their sexual orientation, has denounced the research as flawed and

apologized to the LGBT community in a letter for misinterpretations or misrepresentations that arose from the study (70).

Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons. Evidence shows that the practice may actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons. Research done at San Francisco State University on the effect of familial attitudes and acceptance found that LGBT youth who were rejected by their families because of their identity were more likely than their LGBT peers who were not rejected or only mildly rejected by their families to attempt suicide, report high levels of depression, use illegal drugs, or be at risk for HIV and sexually transmitted illnesses (71). The American Psychological Association literature review found that reparative therapy is associated with the loss of sexual feeling, depression, anxiety, and suicidality (68).

States have delved into the debate over the use of reparative therapy for minor children given the potential for harm. California; New Jersey; and Washington, DC, have enacted laws banning the practice. Several other legislatures, such as those in Washington state, Massachusetts, New York, and Oregon, have introduced or passed legislation through one chamber but failed to pass the bill into law (72). The New Jersey law was challenged on the grounds that the ban limited the free speech of mental health professionals, but the law was upheld by the Third U.S. Circuit Court of Appeals (73). In May 2015, the U.S. Supreme Court declined to hear a challenge to the law (74).

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9. The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.

Persons who are considered at increased or possible risk for certain infectious diseases, such as intravenous drug users, recipients of animal organs or tissues, and those who have traveled or lived abroad in certain countries, are prohibited by the U.S Food and Drug Administration from donating blood (75). Since the early 1980s, the policy has also included men who have sex with men (MSM) since 1977. This lifetime deferral of blood donation for MSM was instituted during a time when the incidence of HIV and AIDS increased to epidemic levels in the United States, and the disease and how it was transmitted were largely misunderstood by the scientific community. In the following years, concerted efforts by the medical community, patient advocates, and government officials and agencies resulted in advancements in blood screening technology and treatment of the virus. However, during that time of uncertainty, policies were implemented to balance the risk for contaminating the blood supply with what was known about the transmissibility of the disease.

Several medical organizations support deferral policy reform based on available scientific evidence and testing capabilities. The American Medical Association policy on blood donor criteria supports, "the use of rational,

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scientifically based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of risk" (76). The American Association of Blood Banks, America's Blood Centers, and the American Red Cross have long advocated for a modification to deferral criteria to be "made comparable with criteria for other groups at increased risk for sexual transmission of transfusion-transmitted infections" and recommend a 12-month deferral for men who have had sex with another man since 1977, which is in line with deferral criteria for others who have exhibited high-risk behavior (77). The eligibility standards and policies on the donation of tissues or tissue products (5-year deferral since last sexual contact) (78) and vascular organs (risk assessed individually, disclosed to transplant team, and consent required) (79) by MSM also reflect a measured assessment of disease transmission risk to donor recipients.

Many countries, including the United Kingdom, Canada, Finland, Australia, and New Zealand, have successfully instituted deferral periods ranging from 12 months to 5 years in lieu of a lifetime ban on blood donation by MSM without measurable increased risk to the blood supply. A study of the risk of blood donations from MSM after the implementation of shorter deferral periods in England and Wales 12 months after their last sexual encounter found only a marginal increase in the risk for transfusion-transmitted HIV (80). Australia changed the deferral policy for MSM from 5 years to 12 months over 1996 to 2000. A study that compared the prevalence of HIV among blood donors from the 5-year deferral period compared with the 12-month deferral period found no evidence that the 12-month period increased risk for HIV in recipients (81).

In late 2014, the HHS Advisory Committee on Blood and Tissue Safety and Availability voted in favor of recommending a 1-year deferral policy for MSM and increased surveillance of the blood supply. The U.S Food and Drug Administration announced it would be updating its policy on blood donation from MSM after considering recommendations made by the HHS, reviews of available scientific evidence, and recommendations from its own Blood Products Advisory Committee. The policy about indefinite deferral on blood donation from MSM is being updated to a 1-year deferral period from the last sexual contact, and the U.S. Food and Drug Administration will issue draft guidance on the policy change in 2015. In addition, the agency announced it has already taken steps to implement a national blood surveillance system to monitor what, if any, effects the new policy has on the nation's blood supply (82). Lifting the lifetime ban on blood donation by MSM is an important first step toward creating equity among those wishing to donate blood. The U.S Food and Drug Administration should continue to monitor the effects of a 1-year deferral and update its policy as information and data are gathered through surveillance to make further strides toward policies that assess donor eligibility on the basis of scientific data and individual risk factors such as the length of time since a high-risk behavior has occurred, type of sex that occurred, number of partners during a period of time, or a combination of factors (83).

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Comments

6 Comments

SIGN IN TO SUBMIT A COMMENT

Rex Moss, MD • Dallas, Texas • 27 May 2015

Comment

To the Editor: "ACP Takes a Stand against Health Disparities Affecting LGBT Individuals New policy paper aims to ensure high-quality health care for all" This is very disappointing. I love the Annals and very much enjoyed and learned a great deal at several ACP conferences. But I left the AMA as it stood up for abortion rights and I resign from ACP, now as you stand up for a number of foolish policies, more oriented to political ideology than medical care or logic. Your new policy states: For instance, health data related to marital status show a benefit for married heterosexual couples, but the committee found that the fact that LGBT partners and families live without the same protections and recognition appears to increase their risk for depression and other poor health outcomes. Does it really follow that society's protections and encouragement of heterosexual marriage has the power to prevent depression and poor health outcomes? Is it possible that heterosexual marriage is our natural state and that our minds and bodies work best when used in the appropriate way? ACP's Health and Public Policy Committee recommends: Including comprehensive transgender health care services in public and private health benefit plans. You recommend public and private insurance pay for sexual reassignment surgery. Is there data of benefit? Perhaps a reduction in mortality, disability or morbidity? Do those who have sexual reassignment surgery live longer or commit suicide less often? Why should anyone outside the person determined to change their body pay for it? Expanding the definition of "family" to include all who maintain an emotional connection to the patient, regardless of legal or biological relationship. Do you have data that children raised in families other than with their biological parents do better or as well? In absence of data, would it not be logical to encourage keeping biological parents together or at least permit states to make the judgment for themselves how to regulate/encourage marriage? (as opposed to having courts take over as the "determiners of all things not established by study or fact") Opposing the use of "conversion," "reorientation" or "reparative" therapies in the treatment of LGBT individuals. Do you have data that such therapies are harmful? If a deeply disturbed person is confused about his/her sexual identity and wants to focus attention on the opposite sex and seeks counseling to do so, is that wrong or harmful? LGBT individuals have a high incidence of depression and suicide. Do you wish to oppose possible the may help if you have no alternative therapy that will help? Political trends come and go. Slavery, racial marriage, cocaine, smoking, breast self-exam, and epinephrine have been normal, encouraged, discouraged and tossed away. Allowing a popular political idea to lead to policy changes not supported by data, that costs a great deal of money and is very disruptive to a current healthy institution: heterosexual marriage is a poor plan. ACP think before you act. When you act wrongly think again and change. Good-bye, Rex Moss MD

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Hilary Daniel, BS, Renee Butkus, BA • American College of Physicians • 11 September 2015

Response to Comments Made by Drs. Lacy and Ng

The two comments submitted by Drs. Lacy and Ng speak to the diversity of ACP's 143,000 internal medicine physicians and student members. ACP advocates on a wide variety of topics and the College

recognizes that not all ACP members will agree with our positions. The need to address the unique needs of the LGBT persons and their families is based on ACP's long standing commitment to advocate for those being negatively affected by health care disparities. Ignoring or glossing over some topics that affect health because they are controversial would be inconsistent with ACP's mission "To enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine" including "to advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members."

We appreciate Dr. Ng's support for our paper. As the paper was being developed, policies concerning same sex marriage, blood donation by men who have sex with men, and coverage for transgender health care services were undergoing change. The College recognizes the need for continued review of issues relating to LGBT health.

Dr. Lacy takes issue with our call for a more inclusive definition of family. As our paper points out, it's estimated that only 22% of U.S. families consist of married heterosexual parents with their own biological children. A modern definition of family that is inclusive of all types of families, including the LGBT population, is fundamental to reducing the disparities and inequalities that exist within the health care system and to equal treatment of LGBT patients and their visitors in the hospital setting. Our opposition to "therapy" to change the sexual orientation of an individual is based on the science that shows that sexual and gender orientation are not disability or disorder in need of treatment or cure, and that such "therapies" may be harmful to patients receiving them.

Hilary Daniel, BS
Renee Butkus, BA

1. Movement Advancement Project, Family Equality Council, Center for American Progress. All children matter: how legal and social inequalities hurt LGBT families: condensed version. Denver: Movement Advancement Project; 2011. Accessed at www.lgbtmap.org/file/all-children-matter-condensed-report.pdf on 11 February 2015

2. American Psychological Association Task Force. Report of the American Psychological Association Task Force on appropriate therapeutic responses to sexual orientation. Washington, DC: American Psychological Association; 2009. Accessed at www.apa.org/pi/lgbt/resources/therapeutic-response.pdf on 11 February 2015.

Paul J Hudson, MD, MPH, FACP • SIM • 22 June 2015

The policy on LGBT reaches beyond evidence

Dear friends at ACP,

I too am disappointed at the lack of evidence for this very broad set of policy changes, which not only goes beyond the evidence but becomes an agent for changing institutions that have stood the test of millenia. For example, defining a family as something other than biological is a step in the wrong direction. The evidence shows that children need a father and they need a mother; this has something to do with biology, and cannot be socially constructed.

Please reconsider your over-reach and return to medical evidence.

Thank you,

Paul Hudson, MD, FACP, MPH

Mark D Lacy • Lubbock, Tx • 3 June 2015

Access for All but losing our way in the Process

To advocate for the elimination of health care disparities among Lesbian, Gay, Bisexual, and Transgender (LGBT) persons is a worthy objective not just for these populations but all patients facing obstacles to quality care. Sadly, the American College of Physicians Position Paper published May 12, 2015 addressing LGBT Health Disparities goes beyond advocating health care access by promoting a damaging sociopolitical ideology. The Paper re-defines the meaning of family, marriage, and calls for denying LGBT persons choices in behavioral health services.

While alleging the Position Paper was the product following review of “numerous studies, reports, and surveys on LGBT health care and related health policy” many cited references are based on research neither well executed nor widely corroborated. Further, it appears the reviewers fail to account for sound, copious evidence contradicting the cited sources.

To redefine family as “those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship” is to deny the reality of paternity and maternity, both integral to most wholesome child-rearing environments. Dads contribute to the growth and development of children much differently than moms do. Asserting family as whatever one wants it to be is to succumb to the solipsistic notion that the self is the final arbiter of reality, to substitute the real and immutable childhood need for mothers and fathers with the sexual-romantic mutable desires of adults. Will the next Position Paper call for endorsing the aims of the North American Man Boy Love Association or Peter Singer’s call for granting civil rights to primates? Marriage is, and for millennia has been, rooted in the male-female complementarity that makes sexual reproduction possible and child-rearing wholistic. What is at play in this Statement are very imprudent mental maneuvers, “The moment you step into the world of facts, you step into a world of limits. You can free things from alien or accidental laws, but not from the laws of their own nature. You may, if you like, free a tiger from his bars, but not free him from his stripes. Do not free a camel from his hump; you may be freeing him from being a camel”. In “re-inventing” family and the meaning of marriage is to engage in the same sort of casuistry.

With regard to the American Psychological Association (APA) being invoked as the authority to repudiate psychotherapy for unwanted sexual behaviours recall the APA Task Force unequivocally posits “Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality.” If that is the a priori assertion, can objective assessment of “sexual orientation change efforts” (SOCE) be realistically expected? Probably not. To satisfactorily debunk SOCE entails more than citing the APA. In the meantime, persons who opt for SOCE should be given the prerogative in the same way, for example, the transgender person is offered high- dose estrogens in spite of the increased risk of thrombosis.

The LGBT Position Papers unfortunately makes the Annals a mouthpiece for the post-modern notion that we can write our own narrative and call it true, regardless of the facts. Once the Annals becomes a purveyor of ideology and asserts a world view which doesn't comport with facts, it is no longer a reliable source of guidance for physicians.

Mark D Lacy, MD, MA, FACP

Henry Ng, MD, MPH, FAAP, FACP • MetroHealth Medical Center, Case Western Reserve University School of Medicine • 2 June 2015

In support of the American College of Physician's Policy Position Paper on Lesbian, Gay, Bisexual and Transgender Health Disparities

As an internist-pediatrician who has worked in LGBT health care for the last decade, I am invigorated that the American College of Physicians (ACP), one of my professional homes, has developed a set of LGBT health focused policy statements. From my perspective as an LGBT health advocate and clinical director of a hospital-based LGBT health service line, these policy statements were sorely needed to assist internists around the US and internationally to improve the health experiences and outcomes, and ultimately eliminate health disparities of LGBT patients. I am proud to see the American College of Physicians join a growing group of professional organizations with LGBT-inclusive policies or mission statements including the American Academy of Family Physicians, the American Medical Association, the American Academy of Pediatrics, the American Academy of Physician Assistants, the American Academy of Nursing , the American College of Obstetrics and Gynecology, the American Psychological Association, the American Psychiatric Association, GLMA: Health Professionals Advancing LGBT Equality and others.

The nine policy statements developed by Daniel et al which compose the ACP's policy position paper are both bold and broad in their recommendations. Many of the recommendations are timely and remind internists to keep in-step with guidelines set forth by accrediting bodies such as the Joint Commission and the Centers for Medicare & Medicaid Services. This is especially important as more and more LGBT Americans enroll in health insurance through the Affordable Care Act and begin to routinely access the US health care system. However, the ACP's policy statements will only be as useful as they are complete and current and must be considered a living document with the capacity to grow and change based on