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SHORT REPORT

Providing Gender-Affirmative Care During the Severe Acute Respiratory Syndrome Coronavirus 2 Pandemic Era: Experiences and Perspectives from Pediatric Endocrinologists in the United States

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Abstract

Transgender and gender diverse (TGD) youth are at risk of worsened health disparities during the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic. Health care delivery by pediatric endocrinologists, including rapid implementation of telemedicine services, during the pandemic has not been documented. The Pediatric Endocrine Society's Transgender Health Special Interest Group met virtually to survey practice patterns during the SARS-CoV-2 pandemic. The majority of pediatric endocrinologists continued to provide most aspects of medical transition; however, we also identified several barriers to care. Overall, the survey results demonstrated that telemedicine can be utilized as an effective way to provide gender-affirming medical care to TGD youth.

Keywords: endocrinologists; gender-affirmative care; pandemic; pediatrics; transgender

Introduction

Transgender and gender diverse (TGD) youth in the United States face unique challenges during the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic, and medical professionals maintain an important role in continuing to provide gender-affirmative care during this era.¹ TGD youth are at increased risk of health disparities due to discrimination, societal stigma, lack of social support, and barriers to accessing adequate medical care.^{2,3} The SARS-CoV-2 pandemic has the potential to further worsen these disparities, compounded by the impact of concomitant racial and/or ethnic disparities.⁴ However, TGD youth also exhibit remarkable resilience.^{5,6} Providing access to pediatric transgender health care during the pandemic is critical, as TGD youth who receive gender-affirmative care, including gonadotropin-releasing hormone agonist (GnRHa) therapy and gender-affirmative

sex steroids, demonstrate improved mental health outcomes and quality of life.^{7–12}

During the SARS-CoV-2 pandemic, medical institutions have had to prioritize and define “essential” medical care in the context of local disease prevalence rates, government and hospital-based policies, institutional technological infrastructure, and medical licensing restrictions.¹³ Before the pandemic, recognized barriers to accessing gender-affirmative care include, but are not limited to, local provider expertise in pediatric transgender health and sometimes long physical distances between provider and patient.^{14,15} Telemedicine has been an effective model in delivering medical and mental health services to transgender veterans.^{16,17} In pediatrics, before the SARS-CoV-2 pandemic, telemental health services have had a more established role while telemedicine has had an emerging role in pediatric medicine, including in transgender health.^{18,19} Telemedicine has an

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important role in facilitating continuity and establishment of gender-affirmative care, especially since the TGD population already had lower rates of overall health care utilization and poorer self-reported health before the pandemic.³

Over the last decade, a growing number of multidisciplinary pediatric programs have been established that provide gender-affirmative care, many of which are based within pediatric endocrinology.^{20,21} While the impact of rapid implementation of telemedicine for adolescent health has begun to be described during the pandemic, the impact of pediatric endocrinologists in delivering these services has not been reported. This is particularly important to promote delivery of medical transition by pediatric endocrinologists in the setting of over two dozen proposed bills introduced in 16 U.S. states with the goal of criminalizing the delivery of gender-affirmative health care by medical providers and justified fear this will lead to worsening mental health and increased suicidal ideation.^{22,23} This study aimed to assess the current practice patterns in providing gender-affirmative care by pediatric endocrinologists during the SARS-CoV-2 pandemic, which has not been previously reported and serves to inform all pediatric transgender health providers.

Methods

On April 24, 2020, the Pediatric Endocrine Society (PES) Transgender Health Special Interest Group (SIG) met virtually (Zoom Video Communications, Inc., San Jose, CA, USA) for its annual meeting. The focus of the meeting was to discuss access and barriers to providing gender-affirmative care of TGD youth during the SARS-CoV-2 pandemic. Meeting attendees participated in a 16-question survey focused on current practice patterns utilizing a remote, interactive polling service (Poll Everywhere, Inc., San Francisco, CA, USA) that allowed real-time data collection, disseminated to all SIG members. In addition, qualitative data were collected from attendees during an open forum after each survey question. Approximately 80 attendees were recorded, and nearly half of the attendees submitted answers to the live survey questions. The majority of attendees were pediatric endocrinologists, with a few adolescent medicine providers. The University of California, San Francisco Institutional Review Board (IRB) determined that IRB approval was not necessary to report the results of the survey.

Results

A total of 80 attendees were recorded, with pediatric endocrinologists making up the large majority. The

number of respondents per survey question ranged from 28 to 40, the maximum allowed with the version of the interactive polling service used. Pediatric endocrinologists represented a diverse geographical location within the United States (13% West Coast, 42% East Coast, 37% Midwest, 8% South), the majority of whom practiced in an academic setting (90% academic, 2.5% private practice, 7.5% other). The majority of pediatric endocrinologists (87.5%) were not offering virtual health care in their pediatric transgender health programs before the SARS-CoV-2 pandemic (Table 1). In contrast, during the pandemic, only 8.3% of respondents were not offering virtual health care, including telemedicine visits for gender care, with the majority of medical programs (91.7%) offering video and/or telephone virtual visits. Most respondents (67.6%) were continuing to see some TGD youth for in-person care, primarily for physical examinations to determine the onset of puberty and testosterone injection teaching, but nearly a third (32.4%) were not offering in-person visits.

All respondents were evaluating new patients with gender dysphoria. The majority of survey respondents (87.9%) were initiating GnRHa therapy for pubertal suppression for gender dysphoria, and all respondents were continuing GnRHa therapy. Some respondents (12.5%) were not starting gender-affirmative hormones (exogenous estradiol or testosterone) during the SARS-CoV-2 pandemic, but all respondents were continuing previously prescribed gender-affirming sex steroids. Some pediatric endocrinologists (21.4%) were delaying testosterone injection training until stay-at-home restrictions were lifted. Most respondents were obtaining patient or guardian signature on consent forms for medical therapies remotely (72.4%), with a minority (13.8%) requiring consent forms be signed during an in-person medical visit, and 13.8% of pediatric endocrinologists were not previously requiring consent forms for medical therapies in the management of gender dysphoria.

Interestingly, medical care delivery to TGD youth varied among survey respondents. Of the respondents who were not actively initiating gender-affirming hormones during the SARS-CoV-2 pandemic, there was no difference in the type of hormone (e.g., estradiol, testosterone) that was not being prescribed. Respondents cited reasons for not initiating gender-affirming hormones that included institutional barriers, inability to obtain signed consent in person, and legal barriers to prescribing testosterone via virtual health care due to it being a controlled substance. Respondents from two

Table 1. Survey Questions and Responses

Demographics	
"Where do you practice?" (n = 38)	West Coast: 13.2% (5/38) East Coast: 42.1% (16/38) Midwest: 36.8% (14/38) South: 7.9% (3/38) International: 0% (0/38)
"What is your primary clinical setting?" (n = 40)	Academic (University-based) : 90.0% (36/40) Private Practice: 2.5% (1/40) Rural Clinic: 0% (0/40) Other: 7.5% (3/40)
Telehealth and face-to-face visits for gender-affirmative care	
"Did you offer telehealth/virtual visits for gender care before the COVID-19 pandemic?" (n = 40)	Yes: 12.5% (5/40) No: 87.5% (35/40)
"Are you using telehealth/virtual visits for gender care now?" (n = 36)	Yes, video only: 16.7% (6/36) Yes, phone only: 0% (0/36) Yes, both video and phone: 75% (27/36) No: 8.3% (3/36)
"Are you seeing any patients face-to-face for gender care clinic visits currently?" (n = 37)	Yes: 32.4% (12/37) No: 67.6% (25/37)
Starting or continuing gender-affirmative care	
"Are you starting puberty blockers during the COVID-19 pandemic?" (n = 33)	Yes: 89.9% (29/33) No: 12.1% (4/33)
"Are you continuing puberty blockers during the COVID-19 pandemic?" (n = 36)	Yes: 100% (36/36) No: 0% (0/36)
"Are you starting testosterone or estradiol therapy during the COVID-19 pandemic?" (n = 32)	Yes, testosterone only: 3.1% (1/32) Yes, estradiol only: 3.1% (1/32) Yes, both testosterone and estradiol: 81.3% (26/32) No: 12.5% (4/32)
"Are you continuing testosterone or estradiol therapy during the COVID-19 pandemic?" (n = 36)	Yes, testosterone only: 0% (0/36) Yes, estradiol only: 2.8% (1/36) Yes, both testosterone and estradiol: 97.2% (35/36) No: 0% (0/36)
Multidisciplinary care/mental health providers	
"Are your telehealth/virtual clinics being conducted as multidisciplinary?" (n = 34)	Yes: 35.3% (12/34) No: 47.1% (16/34) My clinic is not multidisciplinary: 17.7% (6/34)
"Are your mental health providers available for telehealth/virtual visits?" (n = 35)	Yes: 80.0% (28/35) No: 5.7% (2/35) Not applicable: 14.3% (5/35)
"How are you handling testosterone injection training in your practice?" (n = 28)	Telehealth (video visit) : 28.6% (8/28) In person: 35.7% (10/28) Delaying until stay-at-home orders are lifted: 21.4% (6/28) Other: 4.3% (4/28)
Volume and access to care	
"Have you been able to see new gender patients in your practice?" (n = 29)	Yes: 100% (29/29) No: 0% (0/29)
"How has the volume of referrals for gender concerns changed during the COVID-19 pandemic?" (n = 28)	Increased: 0% (0/28) No change: 60.7% (17/28) Decreased: 39.3% (11/28)
Barriers to care	
"Have you experienced cuts to your salary/support staff/other resources that have affected your ability to provide gender care?" (n = 33)	Yes: 21.2% (7/33) No: 78.8% (26/33)

different programs stated that they were not initiating hormones due to the local political environment and fear of medical–legal repercussions. Several participants not actively prescribing gender-affirmative hormones to new patients stated that they were working within their institutions to reduce these barriers.

While 80% of respondents had mental health providers as part of the multidisciplinary pediatric transgender health programs, only 35.3% of respondents were conducting or had the ability to conduct virtual health care as a shared multidisciplinary visit. The type of telemedicine delivery platform was implicated in the reasons for this limitation. Participants cited several advantages of telemedicine for delivering gender-affirming care: youth feeling more comfortable in their home setting, ease of incorporating caregivers who were not physically present with the youth at the time of the visit, and reduction of geographic barriers. They also discussed disadvantages of telemedicine, which included concerns about confidentiality when speaking with youth, some youth feeling uncomfortable on video, inability to perform physical examination, concerns about reimbursement, and lack of access to technology or service needed for virtual visits.

In the setting of the SARS-CoV-2 pandemic, all respondents were seeing new TGD youth, with 60.7% of respondents reporting no perceived change in referral volume from primary care providers to pediatric transgender health programs. Approximately one in five pediatric endocrinologists had experienced reductions in their compensation and/or support staffing that affected their ability to continue to provide gender-affirmative care.

Discussion

This study provides novel insights into the effect of the SARS-CoV-2 pandemic on pediatric endocrinologists providing care to TGD youth. This is noteworthy, as lack of access to gender-affirmative medical and behavioral health providers has consistently been one of the most significant barriers TGD youth experience and has the potential to worsen mental health outcomes and increase health disparities.^{2,3} While the number of pediatric transgender health programs delivering gender-affirmative care has increased over the last decade, the large majority of pediatric transgender health programs are still located in urban settings and academic centers.²⁰ Lack of proximity to a multidisciplinary gender clinic may affect TGD youths' ability to access this care and contribute to lower health care utilization by TGD youth.^{3,14,15}

Rapid implementation of telemedicine during the pandemic for pediatric patients has begun to be documented.^{24,25} Results from this survey demonstrated that pediatric endocrinologists and their institutions worked to rapidly convert gender-affirmative care from in-person to virtual health care visits to ensure continuity of care for previously established patients; all respondents were continuing GnRHa therapy for pubertal suppression and nearly all were continuing gender-affirming sex hormones for established patients.

Several important themes emerged from this study that impact pediatric transgender health. First, the rapid implementation and expansion of telemedicine in delivering gender-affirmative care may enhance TGD youths' ability to access health care and can continue to be a model of delivering care beyond the duration of the pandemic.^{3,14} However, this highlights the need for educational trainings and best practice guidelines for medical providers delivering care to adolescents via telemedicine as some providers cited discomfort with some aspects of the patient/provider interaction; current guidelines only support telemental health services.¹⁸ Our study highlights the need for advancement in telemedicine platforms to deliver multidisciplinary care, which is a key element of current transgender health guidelines as well as efforts to support medical providers who may restrict options for medical transition based on their local political climate.^{10,22,23}

There are several limitations to this study. First, since the participants primarily included academic pediatric endocrinologists, the practice patterns of other transgender health programs led by other specialties and nonacademic pediatric endocrinologists may differ. In addition, only a subset of meeting participants participated in the live survey. Future studies should focus on delivering gender-affirmative care to TGD youth from different disciplines to more accurately reflect the experience across the United States and to learn from shared experiences. This study also did not explore in depth the reasons providers may not be providing particular aspects of gender-affirmative care via telemedicine (e.g., level of comfort, level of experience, challenges in obtaining informed consent, and institutional limitations). However, this is the first report of how the SARS-CoV-2 pandemic has influenced health care delivery to TGD youth by pediatric endocrinologists in the United States. Finally, this study did not explore the experiences of TGD youth and their caregivers receiving virtual health care, which is a necessity as the goal is to provide patient-centered care and should be a high priority in future studies.

Conclusion

In summary, gender-affirmative care is considered medically necessary by pediatric endocrinologists and has been continued through the SARS-CoV-2 pandemic via telemedicine services. This is significant as TGD youth already face disparities in accessing health care, and the SARS-CoV-2 pandemic has the potential to worsen these disparities if the numbers of providers delivering gender-affirmative care become even more limited. Telemedicine can be considered an effective way to provide gender-affirmative care to youth and reduce barriers to youth accessing this care. Therefore, pediatric endocrinologists and other pediatric transgender health providers may consider utilizing a hybrid model of virtual and in-person visits to deliver gender-affirmative care to TGD youth, even after resolution of the SARS-CoV-2 pandemic.

Ultimately, the impact of the SARS-CoV-2 pandemic may result in innovation in the delivery of gender-affirmative care to TGD youth. As the SARS-CoV-2 pandemic has continued over several months, it would be reasonable to expect that telemedicine will become a permanent facet of future gender-affirmative care of TGD youth, especially if forthcoming literature shows that telemedicine is an effective and acceptable method of care delivery. While in-person clinical care may not be completely replaced by telemedicine for gender-affirmative care of TGD youth, it can certainly lessen the burden of travel and time away from work or school for visits that may not necessarily require a physical examination. Future directions would include a follow-up survey to assess changes in the delivery of telemedicine services as the pandemic continues or resolves. The prospect of expanded access to high-quality gender-affirmative care has the potential to positively impact health care delivery for TGD youth.

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Disclaimer

The content is solely the responsibility of the authors and does not necessarily represent the official view of the National Institutes of Health.

Authors' Contributions

J.Y.L., T.E., J.L.R., K.J.C., and S.A.R. contributed to the design and implementation of research and have

reviewed and edited the article. J.Y.L. assembled the results, and the article was written by J.Y.L., T.E., K.J.C., and S.A.R.

Author Disclosure Statement

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Abbreviations Used

GnRH α = gonadotropin-releasing hormone agonist
 PES = Pediatric Endocrine Society
 SARS-CoV-2 = severe acute respiratory syndrome coronavirus 2
 SIG = Special Interest Group
 TGD = transgender and gender diverse