Transgender Healthcare Demands Multispecialty Care

**Bruce Jenner's Story Sparks Interest in Gender Issues**

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**What Does It Mean to Be "Transgender"?**

**Editor's Note**: *Bruce Jenner's recent declaration that he thinks of himself as a woman was puzzling for many people, whether they formerly knew him as an Olympic athlete or as the father on a reality TV show. But for clinicians who routinely treat transgender patients, his story was not that unusual.*

*The underlying issues of being transgender are much better understood by clinicians today than a few decades ago, but that understanding continues to evolve. Medscape recently discussed those issues with Wylie Hembree, MD, who helped write the first clinical practice guidelines on transgender treatment, issued by the Endocrine Society in 2009.[1] He has been treating transgender patients for more than 20 years.*

**Medscape: In the guidelines, you recommend that the first place a person with gender dysphoria start is with a mental health professional. Is that right?**

**Dr Hembree**: Yes. I have to laugh, because I was the chair of the committee then that wrote it and am again the chair of the committee revising it. The question that you hit upon is indeed something that is controversial among the nine committee members. It was not controversial in 2007 when we started working on it before. So I can't really give you a straightforward answer on that. You are correct that we said, with great clarity, that we felt at that point that the diagnosis is usually made by a mental health professional.

Now there have been changes—even in the coding—and we'll actually change some of the terms. This time, we will use the word "transgender" as opposed to "transsexual," because "transgender" has evolved into a broader term, and we are now using "gender dysphoria" as opposed to "gender identity disorder."

The individual who has gender dysphoria and wants to do everything possible to live in the opposite gender is today referred to as being transsexual—not only taking hormones but also having available surgery.

**Identifying Gender Dysphoria in Youth**

**Medscape: Does the patient's age make a big difference in terms of how you approach them?**

**Dr Hembree**: We are treating people of two age groups: the childhood/adolescent age group, and the adult. In the adolescent, we recommend giving medication at the onset of puberty that blocks pubertal development for a period of time until it's appropriate to start giving hormones of the opposite sex.

In those cases, a mental health professional generally will have seen the patient sometime during childhood and would have been the one who says, "Yes, this individual has gender dysphoria, and they are having difficulties with that dysphoria. It's interfering with their life, and they wish strongly to do everything that they can to live in the opposite gender from their natal sex." At that point, we would block puberty in those individuals.

**In childhood, there is no hormonal issue.**

It's usually the mental health professional who calls up the endocrinologist/pediatric endocrinologist to start the blockade of puberty, and then later to move forward with the sex steroids of the opposite gender.

**Medscape: At that stage, are children experiencing hormonal changes, or is it mostly a mental health issue?**

**Dr Hembree**: In childhood, there is no hormonal issue. After about the first 6 months of life, hormone levels in males and females are identical, until they begin to go through puberty. If you took random blood samples, the overwhelming majority of 8-year-olds would have the same hormone levels, regardless of their natal sex.

**Medscape: What should pediatricians and other clinicians tell parents of children who are exhibiting or expressing signs of gender dysphoria?**

**Dr Hembree**: According to the best information we have, in no more than 20% of children with gender dysphoria does it persist into puberty. It desists in about 80%, according to the literature.

Now, the data are controversial, and some people don't believe this is the case. But I think the bottom line is that if you're a clinician talking to a parent who believes their child may have gender dysphoria, you could say—conservatively—that more than one half do not continue to experience that into adulthood.

I think in most of those cases, the parent would then seek out a mental health professional who has experience with gender dysphoria. Fortunately, there are several places that are quite good across the country. And I'm quite impressed that school psychologists are very well trained in this and are very sensitive to it.

**Diagnosing Transgender Adults**

**Medscape: What is the process like for adults who are first seeking care well after puberty?**

**Dr Hembree**: In adults—and I am an internist/endocrinologist, so for the most part I see adults—they may seek out either an endocrinologist or a primary care physician, someone who has specialized in or is at a clinic that specializes in giving hormones to transgender individuals. Those individuals may then have their first long discussion about their experience with gender dysphoria.

In my experience, which began in 1993, most of the adults talk about their feelings when they were a child. They remember being 5 years old and being expected to be a nice little girl, when they only wanted to play with boys' things and dress like a boy and so forth, or the opposite situation depending on their natal sex. And they remember that they went on and did what their parents asked them to do, and they were sort of forced into behaving in a particular way.

They got into puberty and they became more uncomfortable. They didn't really know how to deal with it, so they just suppressed a lot of feelings and went on and did what society, family, and everybody expected them to do; they may even have gotten married and had children.

At some point in their lives, however, they probably were so bothered by gender dysphoria that they may have gone to a mental health professional to discuss it. But it may have been frustrating, because it was not as easy then to find someone who specializes in transgender issues or gender dysphoria.

**What they want to do will complicate their lives.**

Now, when I work with someone who has had a great deal of psychological difficulties—whose gender dysphoria has interfered with their life and their relationships—I still encourage them to see a mental health professional. I say, "I'd really like to get all of this confirmed by a mental health professional, and I think it would be good for you as you go through the transition. There are going to be parts of it that won't be very easy, that will be difficult to cope with. As the doctor giving you hormones, that's the easy part. I can do that for you and I can take care of you, but there may be other, more complex psychological issues."

Particularly in very young adults in their 20s or so, who still are maturing and growing up, there may be developmental issues that come up that I think would be very good to discuss. Sometimes they haven't really figured out their sexuality, their sexual preferences.

So, should a mental health professional play a role in dealing with adults? In many cases, yes, but there are also some clinicians who have sufficient experience with transgender individuals that they feel comfortable enough to say, "This is a classic case of gender dysphoria, and this individual has thought this out, and I'm ready to start talking about hormone therapy."

**Medscape: Of the adult patients you've seen, in how many were you confident that they had gender dysphoria vs situations in which it was harder to tell?**

**Dr Hembree**: I would say that in no more than 5%-10% of the people I saw did I have some real questions.

**Medscape: So it is definitely a minority.**

**Dr Hembree**: When I saw my first few transgender patients, I might have been a little insecure about making a diagnosis, but after seeing several individuals, it became much easier to recognize what they are experiencing, and to accept that they knew what they wanted.

Part of the reason for this is that what they want to do will complicate their lives to such an extent that it would be hard to believe anyone would proceed unless there were real, deep-seated reasons.

**"A Little Estrogen," or Complete Transition?**

**Medscape: In your practice, do you make referrals if, for instance, a female wants to transition to male or the reverse? Do you then refer them to a urologist or a gynecologist or a plastic surgeon?**

**Dr Hembree**: First, you need to see whether this individual falls into one of two categories. One category is the person who wants to do everything humanly possible to live their life in the gender that is opposite their natal sex. That would include surgery and all kinds of other things, as well as hormones. Then there are those individuals who know that these are options, but they choose not to take them.

I even get some people who come in and say, "You know, I'd just like to lower my testosterone a little bit." Or they say, "I'm not really quite sure where we're going to go with this, but I'd like to start hormone therapy." I've even had someone who said, "I can't do anything that my wife can ever know about...but can you give me a little bit of estrogen that would not be enough for her to notice?"

**Medscape: And what would that do for them?**

**Dr Hembree**: Although it might make them feel better and it might make them function better, I generally discourage that kind of thing, because I don't know what dose of estrogen you can give a male that I can reassure them would never be noticed by their wife. But it's an opportunity to talk about it, to ask, "Why do you want to do this? What do you expect as an outcome, and how is it going to help you in the long run?" I've had men say, "My life would be ruined if my wife found out about this," so do you think I'm going to give them a prescription for estrogen? No.

With those patients, I often suggest that we get a mental health professional involved. I tell them, "I want to help you do what's best for you, but it's not clear to me exactly what is the best, safest, most reasonable, and easiest thing to do."

On the other hand, some patients bring in their wives or their friends, and there are many indications that they have thought this through and they know what the consequence will be.

**Issues of sex and sexuality are difficult for physicians.**

You know, as good doctors, we take not only a medical history and a personal and social history, but we also take psychiatric histories from patients. As long as we have the freedom to be a good doctor, no matter how long it takes, then I think that we pursue all aspects of the patient history.

That's what's fun about being an endocrinologist, because things are often very complex. Rather than just saying, "Oh, okay, you're transgender and you want to be a transsexual; here's a prescription and I'll see you"—that's not the way we do it.

**Medscape: Do most of your patients come by referral from a mental health professional or a primary care provider?**

**Dr Hembree** In general, transgender individuals will go to a mental health professional to talk about this before they'll talk about it with their general practitioner, especially if the general practitioner has known them for years. Most people have been struggling for years with the "what gender am I?" issue, and I think they are more likely to seek mental health care for that.

**Medscape: So, do you think it's even an issue for primary care doctors? Is it something that they should be looking out for?**

**Dr Hembree**: I do think they need to be more aware of this. Of course, you're talking to someone who took an interest in testosterone and estrogen as a sophomore in medical school. I did a lot of evaluation and treatment of male infertility, which was something that most men didn't want to deal with and were embarrassed to discuss. They certainly wouldn't talk about it with their regular doctor.

Women may have discussed these issues more, because many women have better relationships with their gynecologists. Now still—and not inappropriately—gynecologists play a major role in being primary care physicians to natal women.

**Getting Back to the H&P**

**Medscape: I imagine that working with transgender patients is very challenging for doctors who haven't dealt with it much. Even the terminology can be tricky, and as you said, it changes over time. Have you ever felt like you had to be really careful about how you talk about it, or how you talk to patients about it? How do you get to that point where you feel comfortable enough as a physician to talk with the patient about this issue?**

**Dr Hembree**: I think it's just like anything else that you do. I went to Columbia University in 1968 and I have taught medical students about issues involving sex and sexuality, but it's a struggle to even get it into the curriculum. In general, issues of sex and sexuality are difficult for physicians, and they've been limited on what they're taught about asking the right questions.

But being transgender is not a sexuality issue, and it may not even be a sexual preference issue; it's really more about "who I am."

Do I recommend that all general practitioners ask their patients whether they're really comfortable being treated as a male or a female? No. But I think we should ask certain questions anytime a patient is being put on a medication, or being put in a situation where their sexual function might be affected.

**You're going to be uncomfortable with what you have to do.**

No adult male should be put on high blood pressure medication until the clinician knows a bit about that person's sexual function and what role it plays in their life. Sexuality does not need to come up in every encounter, but it should come up in a lot more than it usually does.

Clinicians should be able to ask a patient, "How frequently do you masturbate? How often do you wake up in the morning with an erection?" They should be as comfortable asking those questions as they are asking about allergies, for example. If you do that, patients will open up and ask more questions.

That's what I've been preaching for my 40 or 50 years as a doctor—that you really need to be quite comfortable asking questions about sex, sexual function, reproduction, and so forth, and once you are, you open up all kinds of avenues that are going to be invaluable to your patient and your ability to care for them. In my past 20-plus years of working with transgender individuals, it has been even more critical.

For someone who's not comfortable with that, you have to go back to what they taught you in medical school. If you look in the books, there are all of the things that you should ask and all of the things that you could say.

**Medscape: So it's just back to basics—taking a history and physical.**

**Dr Hembree**: Psychiatry is important, too. I had a really good psychiatry team in medical school and residency, and they were very good at raising these kinds of issues. They basically said, "You're going to be uncomfortable with what you have to do. You're going to feel like you're invading people's privacy."

But again, this is something that has to do with how one feels. Being transgender is, simply put, feeling differently about being a man or a woman than would have been expected.

**Clinicians Can Make a Big Difference**

**Medscape: Did you happen to watch the Bruce Jenner television interview?[2]**

**Dr Hembree**: I did not; I went to the opera. My daughter taped it for me, but then she left for a week, and I don't know how to watch it.

**Medscape: The reason I asked is because at one point, they discussed how being transgender is something that happens in the brain as opposed to being about genitalia.**

**Dr Hembree**: Exactly.

**Medscape: In some ways, that sort of demystifies it, by explaining the science behind it.**

**Dr Hembree**: Yes, and I think that we are at a time when we're beginning to get beyond the rigidity of genetics. I'm not minimizing the importance of genes, but we're now beginning to understand that we're not simply a product of these little nodules on our chromosomes, which may be structured the "wrong way", and that we will turn out to be "like Bruce Jenner."

It's just not that simple. I think that the way the brain probably functions is not based on chromosomes and genes, but on networks more than anything else. These are probably determined by the DNA, but they are far more complicated than that and far more transient. I like to think of the fact that they're sort of overlapping networks that are involved in a lot of our function.

**We are learning about issues that affect all of us.**

I think people are more comfortable feeling that it's not a right-or-wrong, yes-or-no kind of thing—that indeed, there may be aspects of your DNA that are involved. And as demonstrated in transgender people, even though you may be unaware of what's happening to you as a 5-year-old, you may have a gender network that was configured at age 2 in such a way that, at 35, you say, "I can't be a male anymore."

It's especially interesting to talk to physicians who have gone through this process. I have talked to maybe four or five of them, and they have discussed how much more effective they have been in their interactions with patients and in their personal lives once they finally were able to live in the right gender.

**Medscape: I was surprised, though, to see the statistics about the low prevalence of transgender individuals in the United States.**

**Dr Hembree**: Yes; it depends on how we get the data. It may be as high as 1%, whereas we have always thought it was about 0.3%.[3] We also always thought that there were many more transgender women than transgender men—that is, men who became women compared with women who became men. But I think the data on that are evolving.

**Medscape: Clinicians may wonder whether they really need to be aware of all of this if it relates to such a small number of people, especially when they are dealing with things like cardiovascular risks and cancer.**

**Dr Hembree**: The answer to that is yes, you need to be aware of it, even though it's very rare, because you can make a big difference in people's lives. It's not just about the good that we can do for a very small percentage of our population; we are also learning about issues that affect all of us, including reproduction, sexuality, and sexual function and who we are as men and women.

We have learned a great deal from transgender individuals about that, and the more we continue to learn, the healthier our population is going to be.

**References**

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