Doi: 10.32481/djph.2025.07.17

Building Comprehensive Gender Affirming Care Programs:

Recommendations Based on Planned Parenthood of Delaware's Model of Care

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Abstract

To truly embrace gender-affirming care, society must also address the broader social determinants of health that impact transgender and nonbinary individuals. This entails tackling issues such as housing instability, unemployment, and mental health challenges through tailored programs and inclusive policies. Holistic support mechanisms can help create a foundation where individuals not only access care but also feel empowered to lead fulfilling lives. Moreover, research and data collection must evolve to include and accurately represent gender-diverse populations. This can shape targeted interventions and foster a deeper understanding of the unique challenges faced within these communities. By prioritizing inclusive research practices, public health systems can ensure that policies and programs are grounded in evidence that reflects lived experiences. As the journey toward equitable care continues, it is essential to celebrate the resilience and strength of transgender and nonbinary individuals. Their voices and lived experiences should remain central in shaping policies, practices, and narratives surrounding gender-affirming care. Together, communities, policymakers, and healthcare providers can drive systemic change that affirms and uplifts every individual, embodying the true essence of equity and justice.

An Overview of Gender Affirming Care

Gender Affirming Care (GAC) is currently one of the most politicized and debated forms of medical care in the United States and is often the most misunderstood and misrepresented. GAC Programs offer a wide range of services that are designed to affirm an individual's identity and offer treatment for symptoms of Gender Dysphoria or Gender Incongruence.[1] These interventions are interdisciplinary and expansive, ranging from psychotherapy to Hormone Replacement Therapy or Gender Affirming Surgery, with many services in between.

While treatment modalities such as Hormone Replacement Therapy (HRT) or surgery are the most widely known aspects of GAC, many programs offer other vital services such as hair removal, voice therapy, and assistance with the legal transition process (i.e. name changes and gender marker changes,) as well as fertility preservation. Comprehensive GAC programs hold the ability to collaborate with other disciplines, such as urology, pelvic floor therapy, reproductive medicine, gynecology, and provide non-judgmental medical care using an affirming approach.

While every patient will not require the full spectrum of care available, it is essential that GAC programs are holistic, incorporating an interdisciplinary approach to care-and avoiding an "one size fits all" approach to treatment. A comprehensive GAC program, such as what is offered by Planned Parenthood of Delaware, provides the ability to offer individualized services which present the patient with a range of options allowing for the most collaborative care possible,

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facilitating improved positive health outcomes.[2] This article will review the existing evidence supporting Gender Affirming Care, explore the importance of comprehensive and multifaceted GAC programs, as well as identify the potential risk to patient outcomes related to current legislative changes.

Evidence-Based Care

The World Health Organization (WHO) defines **transgender** as an umbrella term for people whose gender identity differs from the sex they were assigned at birth (as opposed to **cisgender,** which refers to people whose gender identity aligns with the sex they were assigned at birth). **Gender incongruence** is characterized by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex at birth. Gender Incongruence often leads to a desire to "transition" to live and be accepted as a person of the experienced gender, through HRT, gender affirming surgeries, or other healthcare services to align one's body with their experienced gender. The distress some individuals experience due to this incongruence is referred to as **gender dysphoria**. The World Professional Association for Transgender Health (WPATH) Standards of Care Version 8 states a diagnosis of Gender Incongruence or Gender Dysphoria may be necessary in some regions for patients to access transition-related care. The ability to access care heavily relies upon the health care provider's experience using the above definition for a formal diagnosis. Providers' understanding of the proper usage of criteria shapes the overall treatment and patient experience.

Transgender patients report a significantly worse overall health compared to the general population, including primary healthcare needs, sexual and reproductive health, and mental health. Barriers to improved overall health outcomes include access to competent healthcare providers, cost (including lack of insurance coverage for medications and procedures under a diagnosis of gender incongruence), in addition to the avoidance of seeking healthcare due to fear of discrimination or threats to safety. About half of trans patients report that they have experienced at least one negative interaction with a healthcare provider, including using the wrong name or pronouns, and patients having to teach their providers about trans appropriate care.[3] However, better health was reported in respondents who had the means and access to be able to socially and medically transition.[3] In a study observing changes in mental health over the first year of receiving either puberty blockers (PB) or gender affirming hormone therapy (GAHT), it was concluded that there was a 60% lower odds of depression, and 73% lower odds of suicidality compared with trans youths who had not received PBs or GAHT.[4] Like many studies involving transgender participants, there were limitations, for example this study only studied 104 youths (13-20 years old), however the overwhelmingly positive outcomes of GAC in this prospective observational cohort study are still impressive and significant.

Mental health services continue to be an integral component for transgender individuals. In a 2022 U.S. Transgender Survey (USTS) of over 84,000 binary and nonbinary trans people, 78% of transgender adults considered suicide, and 40% attempted suicide in their lifetime (compared to 13.2% and 2.4% respectively in the general population).[3] Unfortunately, the incidents of suicide attempts are increasing among transgender and nonbinary young people, as state-level anti-transgender laws are on the rise.[5] Not only are counseling services essential, having access to affirming mental health counselors cannot be overstated. Among respondents in the 2022 USTS survey who discussed their gender identity with a counselor, 12% reported that their

mental health provider tried to persuade them to identify only as their sex assigned at birth, with 50% reporting similar experiences having consulted with religious counselors or therapists.[3]

As more comprehensive research is conducted, we are seeing an increase in **detransitioning** (discontinuing GAC and returning to living as one's sex assigned at birth) from 1% to 2-10%, although this data requires an understanding of the social, legal, and financial contributing factors that typically lead to a person's decision to detransition. This decision is distinct from the concept of 'regret', and the decision may be based on a number of reasons, including expansion of one's gender identity, changes to financial status or insurance coverage, competing health concerns, lack of social and family support, discrimination, and anti-trans legislation or worsening political climate.[6] This phenomenon is understood to be both highly nuanced in terms of complexity and rarely occurring. While a small percentage of respondents report detransitioning due to a deeper understanding of their gender and the reclamation of a cisgender identity, almost all respondents cite lack of family and community support, lack of access to gender affirming healthcare and legislative protection, lack of financial and insurance stability, and risks to their employment, housing, or general safety as their primary motivation.[7] What can be gleaned from this data, which is the largest and most comprehensive study focusing on detransitioning to date, is that most individuals who detransition due to these stressors eventually retransition later in life once they are in a more stable and supportive environment.[7] While continued research is needed, more enthusiastic, visible, and meaningful support for the trans community is vital to both life satisfaction and positive health outcomes, underscoring the need for GAC.[8] With 98% of respondents reporting that GAC increases their overall satisfactions with their lives, the research is overwhelming: Gender Affirming Care is evidence-based and, for many, lifesaving.[3]

Evolution of Planned Parenthood of Delaware's Services

Planned Parenthood of Delaware's Gender Affirming Care Program began in 2019 and has evolved into one of the largest programs in the state, serving over 900 patients. Like other GAC programs, Planned Parenthood of Delaware (PPDE) initially focused only on prescribing HRT and using a trans-affirming approach to other routine services like family planning, STI testing and treatment, abortion care, and annual preventative exams. In 2021, PPDE expanded its existing GAC program by offering behavioral health care, case management, crisis intervention and wrap around services to meet both social determinant needs as well as assistance with the legal transition process and letter writing services for Gender Affirming Surgery. The evolution of PPDE's GAC program was strategic, offering a seamless continuity of care for its patient population, while also carving out space for the specific needs of transgender patients. Over the years, this program continues to grow, offering a wider spectrum of options for Hormone Therapy, strengthening relationships with other trans-affirming specialists, and building strong referral relationships.

In the spirit of PPDE's values of patient autonomy and increasing access to healthcare, the organization has worked to decrease barriers to GAC by creating an informed consent structure within the program. Informed Consent in the context of GAC facilitates a robust collaborative relationship between the clinician and the patient. The patient is comprehensively educated on the risks, benefits, and alternatives to their potential treatment using educational materials, timelines of expected changes to their sexual and reproductive functioning (ex. vocal tone, fat redistribution, body hair, etc.). Patients are given extensive time to ask their provider questions

about changes, what changes are permanent or reversible, and other GAC opportunities for affirming their gender. Providers work with patients to establish a collaborative relationship that allows for patient autonomy in choosing a treatment that meets their needs and anticipated goals. Barring complications related to medical or mental health concerns, patients can access GAC without the additional burdens of antiquated requirements such as a minimum amount of time spent in mental health treatment or a minimum amount of time spent publicly presenting as their chosen gender.

Early pioneers in GAC programming relied heavily on the co-facilitation of care with mental health professionals, often creating barriers to patients accessing the care in the hopes of avoiding transition regret. Research now shows that this method of gatekeeping does not decrease regret, but instead negatively impacts mental health outcomes by delaying access to care that affirms patients, helps more appropriately integrate them into their community, and increases their sense of confidence, safety, and wellbeing.[7]

With the integration of behavioral health services directly into the clinic, clinicians are able to quickly assess and screen potential mental health related risks at the time of service. Standardized suicide and depression screenings and a thorough review of mental health history are all standard parts of patients' intakes. Patients are screened for Social Determinants of Health (SDOH) needs, allowing for immediate linkage to case management and resources. Intimate Partner Violence (IPV) screenings are conducted at every visit, assessing not only for potential family or partner-based physical and emotional abuse, but also abuse related to tampering with or restricting access to birth control or other medications, a type of abuse that is most commonly reported among transgender individuals, who often experience restricted access to HRT, threats of being outed, and intentional misgendering.[9]

Behavioral health services being available at the time of each patient's visit is vital for continued positive health outcomes and acts as the conduit to ensuring a fully comprehensive GAC program. After being screened for risk factors and opting in for care related to therapy, case management, legal transition assistance, or letter writing services, patients are able to directly access this care during the same visit. This eliminates barriers around going back on a waitlist, taking additional time off of work or school, paying an additional copay or out-of-pocket expense, or having to miss appointments due to lack of childcare or transportation. If there are mental health related concerns that are giving pause to starting HRT, patients can be assessed for readiness in-house with providers that can collaborate efficiently to help them reach stability and start treatment. If we can get patients in the door and fully meet their needs while they are here, we can ensure that they do not fall through the gaps while waiting for treatment.

Case Study

Many patients struggle to access consistent, comprehensive, and affirming care. Below are two case examples, one that is typical of many patient-reported experiences and one that is a positive example of affirming care.

A 27-year-old, Mexican, transgender male using he/him pronouns presents for routine follow up for ongoing Hormone Replacement Therapy. The patient, Santiago, has been on HRT for five years and is experiencing typical, satisfactory changes to facial hair, fat redistribution, voice deepening, and decreased dysphoria and normal bloodwork. During the rooming process, the Medical Assistant (MA) reviews his chart and clarifies demographic information, asking him to

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confirm his name and date of birth. When Santiago confirms his full name, the MA clarifies, “no, like your real name - the one on your insurance.” Santiago confirms that this is his legal name, and the visit continues.

When the Clinician enters and reviews Santiago’s chart, the two agree that changes are progressing appropriately and Santiago is happy with the results from HRT. Santiago mentions that he has been experiencing intermittent spotting despite not having menstruated for several years and is experiencing vaginal dryness and discomfort during intercourse. The Clinician, who has not completed an organ inventory or comprehensive and open ended sexual history, struggles to understand the way in which Santiago uses his body during sexual intercourse and dismisses the symptom, stating “well, I can’t imagine you would want to have penetrative sex anyway if you’re trans, so I’m sure it’s not too much of an issue.”

The Clinician then moves to the issue of intermittent spotting, assuring Santiago that this is “just something that happens” after a few years on testosterone, and that there is nothing to worry about, but he is free to discontinue HRT if these symptoms bother him. After a few more minutes of discussing Santiago’s bloodwork, the Clinician advises Santiago to schedule a follow up in three months if he continues to experience symptoms. Santiago leaves the visit without being offered STI testing, without any solutions for his vaginal atrophy or intermittent bleeding beyond stopping HRT, and without having a medical team that understands his sexual history or medical needs. Santiago does not return to the clinic.

Consider, instead, an example based on care received at PPDE:

A 27-year-old, Mexican, transgender male using he/him pronouns presents for an initial Gender Affirming Hormone Therapy visit and is transferring care from a local Primary Care office. The patient, Santiago, has been on HRT for five years and is experiencing typical, satisfactory changes to facial hair, fat redistribution, voice deepening, decreased dysphoria and normal bloodwork. When scheduling his appointment, the Patient Access Center asks Santiago for his name and date of birth and other demographic information, as well as the legal name on his insurance and ID, if it is different from his chosen name.

Santiago arrives at the clinic and sees art hanging in the waiting room of patients that look like him and is able to read literature tailored to patients seeking similar types of care. The MA that rooms him greets him with a smile and confirms his name, pronouns, and date of birth, and shares their own name and pronouns. The MA, Tori, sits with Santiago and conducts a comprehensive intake, including a full sexual history; Santiago and Tori review an organ inventory to better understand how Santiago’s body functions, and they review the organs that Santiago’s sexual partners have in order to best assess for sexual health risks and interventions.

When the Clinician enters and reviews Santiago’s chart, the two agree that changes are progressing appropriately and Santiago is happy with the results from HRT. Santiago mentions that he has been experiencing intermittent spotting despite not having menstruated for several years and is experiencing vaginal dryness and discomfort during intercourse. The Clinician asks Santiago open-ended and non-judgmental questions about his symptoms and potential contributing factors and works to establish a baseline for Santiago’s body. The provider explains the limitation of research around intermittent spotting in transgender men, but works through several potential causes and interventions, including a hysterectomy, which Santiago had been interested in but did not know was an option.

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Well-versed in gynecological health, the Clinician educates Santiago on the relationship between increased testosterone and vaginal atrophy and proposes the use of topical estrogen to alleviate symptoms. Given Santiago's reported sexual history and lack of appropriate sexual health screenings from his last provider, she offers STI testing, which he accepts. Finally, the Clinician proactively offers to connect Santiago with PPDE's co-located behavioral health services. PPDE's LCSW is an expert in transgender mental health and can work with Santiago to write a letter of medical necessity for his hysterectomy or connect him to local support groups and community resources. Santiago leaves the clinic with several solutions, feeling heard and valued by his provider, and is looking forward to his follow-up visit.

In this example, there are common themes throughout the visit that contribute to its success: respect, non-judgement, and the ability to view the big picture. Santiago is valued and respected throughout every interaction, from the Patient Access Center to the MA, to the Clinician. All of Santiago's options are explored, and his health needs are comprehensively assessed. Care provided at PPDE is grounded in mutuality, cultural humility, and a high degree of expertise with transgender patients, allowing health to be approached as a full picture, not just individual pieces of a puzzle. Santiago's continuation of care increases his opportunities for basic cancer screenings, mental health maintenance, vaccinations, and blood pressure monitoring, all opportunities that are missed when a patient is lost to follow up or deterred from seeking care. By working to meet his needs in a way that is efficient, comprehensive, and meaningful, Santiago is able to have a positive clinic experience and remain an active participant in his **healthcare.**

Policy Implications and Advocacy

Nationally, the Planned Parenthood Federation of America (PPFA) lobbies for federal protections, while PPDE engages in state-level advocacy to ensure that Delaware remains a haven for transgender individuals seeking care. A new development at the federal level could impact this work. The U.S. House of Representatives narrowly passed the "One Big, Beautiful Bill Act" on May 22 with a 215-214 vote. This budget reconciliation measure includes a provision that prohibits the use of federal funds for Gender Affirming Care. As the bill moves to the Senate for consideration, the outlook for federal support of these healthcare services remains unclear. Should this legislation become law, it could significantly restrict access for LGBTQ+ patients relying on Medicaid. Services such as STI testing, HIV treatment, and mental health support might become unavailable under federally funded programs. Additionally, the complete elimination of federal funding for Gender Affirming Care would increase out-of-pocket expenses, potentially making these services unaffordable for many and creating serious barriers for receiving their care. PPDE's ability to engage in advocacy work, collaborate with legislators and other stakeholders, and commitment to evolving with best practices ensures that patient needs remain on the forefront.

Delaware stands as a progressive beacon for LGBTQ+ rights, particularly in the realm of Gender Affirming Care. In 2025, then-Governor Bethany Hall-Long established the state's inaugural LGBTQ+ Commission through Executive Order No. 1, aiming to enhance services and remove barriers for LGBTQ+ individuals. In June of 2025, Governor Matt Meyer signed Executive Order No. 11, creating extensive legal and practice protections for transgender Delawareans and GAC providers.

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However, as the evolving political landscape and external pressures loom, consistent vigilance and advocacy allows for continued safeguarding against advancements that will adversely impact care. Delaware currently provides Gender Affirming Care for minors and adults. The First State has gone a step further by working to protect access to GAC through the introduction of bills like House Bill 205, spearheaded by Rep. Cyndie Romer, to fortify protections for gender-affirming care. This bill seeks to shield providers from out-of-state legal actions, ensure insurance coverage, and uphold patient confidentiality. This bill is currently in the Delaware Legislature.

Planned Parenthood of Delaware (PPDE) plays a crucial role as a vanguard in delivering GAC treatment and supportive resources for adults. While Delaware's commitment to supporting GAC access is laudable, it will take all of us to be vigilant. Residents are urged to engage in advocacy, stay informed, and support affected individuals in the Delaware community and beyond. By actively participating in advocacy efforts, Delawareans can help ensure-the state continues to be a safe haven for Gender Affirming Care.

GAC Practice Considerations and Recommendations

Transgender patients are in the disadvantaged position of having to work harder to receive the same quality and standard of care that their cisgender peers receive. PPDE acknowledges many of these barriers or anxieties around providing care are born, not out of discriminatory attitudes, but out of misinformation or ignorance. Multiple studies show new healthcare providers feel unprepared to work with LGBTQIA+ patients and cite inadequate education and lack of clinical rotations focused on GAC as the basis for their limitations.[10] Moreover, a significant number of healthcare providers report having never worked with a transgender patient or talked to a transgender person about their experiences in healthcare.[11] If GAC is not a standard part of routine medical education, new and (more seasoned) clinicians are left to their devices which presents a disservice to transgender patient populations that often find themselves disenfranchised from the mainstream healthcare system.

This lack of foundational education results in a frustrating provider-patient relationship, where patients are often educating their providers on their bodies, experiences, risk factors, and medical needs instead of the other way around. This dynamic creates a lack of trust and is a deterrent to seeking care. Twenty-nine percent of transgender patients' report being refused care by a provider, solely based on the fact they are transgender and 21-29% of transgender patients report being physically, sexually, or emotionally abused by a provider.[12] These negative experiences significantly decrease motivation to seek care and serve to perpetuate cycles of illness and exacerbation of chronic disease, limiting the opportunity for early prevention and education by health care providers. This results in deleterious consequences such as unemployment, homelessness, and poverty. Nearly twenty-five percent of transgender patient’s report postponing or avoiding seeking care entirely due to experiences of discrimination.[13] These circumstances must change and will only happen when GAC is a requisite component of medical education.

A more open culture of learning will help facilitate needed education on new research, practice standards, and intervention with the goal of decreasing avoidable missteps and improving patient satisfaction with their care. As clinicians continue to strengthen their knowledge, PPDE recommends a targeted focus on understanding current and upcoming legislation, especially as it relates to changes to the legal transition process and insurance coverage for GAC. Staying abreast of these important changes will allow practices to stay current and meet the needs of

patients. Clinicians will be better equipped to engage in patient-centered care and meet the often-times complex needs of their patients.

PPDE urges clinicians to understand that many aspects of Gender Affirming Care include interventions that are already part of their routine wheelhouse practice. For example, many primary care providers are comfortable prescribing hormone therapy for cisgender patients with low hormone levels, topical estrogen to cisgender women experiencing vaginal atrophy, or supporting cisgender patients through postoperative care for procedures such as breast augmentations or mastectomies. These treatments require the same skills and scope of practice as they would in providing care for transgender patients. Similarly, mental health clinicians are well versed in performing biopsychosocial assessments and exploring motivation and readiness for change but often feel unprepared to perform similar interventions such as writing a surgical letter for a transgender client.

Many therapists have the knowledge and skillset to provide these services but may feel disinclined to work with transgender patients due to the personal and professional risks that are posed by providing GAC in this current political climate. This leaves a gap that clinicians working in GAC endeavor to fill but are met with intense threats. An example of this concerns The Gender Affirmative Letter Access Project (GALAP). GALAP is a database which was created for patients that provides information on therapists who pledge to provide low-cost or free surgical letters, which is a requisite step to accessing Gender Affirming Surgery. This database has recently been doxed and is no longer operational, leaving pledging providers vulnerable to threats and violence. These providers are now subject to false reports to their licensing board, sharing their private information on messaging boards, anti-GAC forums, and right-wing websites. Collectively, these actions serve to further disenfranchise transgender patients from accessing needed care. Instead of backing away from treating transgender patients out of fear, PPDE encourages clinicians to provide transgender patients with needed and lifesaving GAC services. In increasing the number of clinicians who feel comfortable incorporating GAC into their practice (and advertising that they do so), GAC will become more normalized and less stigmatized, ideally decreasing targeting of GAC providers who are seen as outliers in the medical field.

PPDE encourages providers to acknowledge the real and perceived barriers disproportionately impacting transgender patients. During the process of building, expanding, or revamping a GAC program, it is vital to seek the input of actual transgender people through hiring transgender consultants, transgender providers, and seeking feedback from transgender patients. Allowing transgender individuals to see themselves as decision makers in the creation and maintenance of a GAC program will afford them the autonomy that they deserve in seeking care. This inclusion does not start when the provider walks into the exam room, but instead begins with the way that services are advertised, the art in the waiting room, the scripting from staff in asking about pronouns, chosen and legal names, organ inventories, and the care that the provider takes when documenting in their chart, or speaking about them to other medical staff. Simple interventions, such as using a patient's correct name and pronouns, can reduce depression by 71% and reduce suicidal thoughts by 34%, offering a free, low effort opportunity that is literally lifesaving for many patients.[14]

Most importantly, PPDE urges you to view Gender Affirming Care as lifesaving, evidence-based, and medically necessary care. Treating transgender patients with dignity and respect and allowing them autonomy and partnership in their medical care is always within our scope. Doing

our own learning, understanding our limitations, and acknowledging the reality of legislation, lack of supportive community, and barriers to seeking care are all part of the oaths that we take. Providers already understand these interventions and have the ability to navigate complex patient histories and risk factors. Working with transgender patients is no different than working with any other patients. Collectively, providers have the ability to make access to GAC a routine, standard aspect of their practice. Everyone has a role to play in ensuring care for the transgender community is holistic, compassionate and grounded in evidence which is supportive of meeting all of their individual needs.

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