Multidisciplinary Care and the Standards of Care for Transgender and Gender Nonconforming Individuals

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KEYWORDS

• Transgender • Multidisciplinary care • WPATH • Standards of care • Transgender surgery

KEY POINTS

- The surgeon is to be part of an affirmative, multidisciplinary team of trans health providers that includes medical and mental health specialists.
- The surgeon should have familiarity with the latest revision of the World Professional Association for Transgender Health Standards of Care, which provide the framework for this model of multidisciplinary care.
- Key learning competencies include the caregiver/care receiver relationship, content knowledge, interdisciplinary practice, and professional responsibility and ethics.
- To promote good outcomes and ethical practice, there must be open communication and cooperation among care providers and with patients throughout the entire time patients are in the health care system.

The care of transgender patients can involve health professionals from many disciplines, including mental health, medicine, and surgery. Patients may present with distress about the incongruence between their identity and their body and social role. This distress may first be diagnosed as gender dysphoria by a mental health practitioner or by a primary care practitioner. At some point in care, a patient may seek surgical care to help with the distress of gender dysphoria and to otherwise improve quality of life, with a body more congruent with their identity. Even as surgeries are sought, the patient may continue to receive care from mental health providers and medical practitioners for both ongoing hormone treatment and general primary care.

The process and progression of care as well as interaction between disciplines are choreographed by the Standards of Care (SOC) of the World Professional Association for Transgender Health (WPATH). Since its initial publication in 1979, WPATH (initially the Harry Benjamin International Gender Dysphoria Association) periodically updates these guidelines, available for download at wpath.org. Each revision reflects a consensus of international experts, based on the literature at the time.[1]

The most recent SOC for the Health of Transsexual, Transgender, and Gender Nonconforming People, version 7 (SOC 7), was released in 2011 (as of this writing, SOC, version 8, is in development). SOC 7 allows primary care providers as well as mental health clinicians to evaluate

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individuals for initiation of hormones. For the initial evaluation for surgery, 1 or 2 assessments from mental health practitioners with expertise in trans health are required—1 letter for surgery on the chest and 2 for genital surgery. SOC 7 supports chest surgery in minors when clinically appropriate, but age of majority is a requirement for genital surgery. In practice, some surgeons are doing genital surgery at the ages of 16 years and 17 years.[2] The criteria discussed are for adults.

For adults, each assessment establishes the capacity to give informed consent, the presence of persistent gender dysphoria that might benefit from surgery, and that co-occurring mental health and medical conditions are reasonably well-controlled or well-controlled.[1]

Chest surgery for adult trans men, per SOC 7, does not require social transition or hormones. Chest surgery can facilitate social transition, allowing a patient to feel comfortable in male clothes without binding the chest. Some individuals, in particular those who are nonbinary identified, may not desire hormones and may present androgynously yet still have dysphoria from their breasts. These individuals may benefit from mastectomy and male chest reconstruction, or, in some situations, breast reduction.

Feminizing mammoplasty in SOC 7 has a recommendation, but not requirement, of at least 12 months of hormones before surgery.

For genital surgery, SOC 7 requires 2 mental health evaluations. For orchiectomy and hysterectomy with salpingo-oophorectomy, there is a requirement that patients have been on hormones for the past year, in addition to the requirements, discussed previously. Social transition is not required. For vaginoplasty, metoidioplasty, and phalloplasty, in addition to having been on hormones the past year, 1 year of living in the social role in which a patient plans to live is required.

Note binary transition—from male-to-female or female-to-male—is not a requirement for any surgery. A nonbinary person assigned female at birth may have substantial dysphoria about their breasts and benefit greatly from mastectomy with male chest reconstruction or, in other cases, from breast reduction. A nonbinary, eunuch-identified person might benefit from orchiectomy after a year on testosterone blockers, without social transition to a female presentation. Other patients might benefit from vaginoplasty but not have a binary female identity. When there are questions about whether surgery is indicated, discussion with the mental health professionals who provided their written consultations (referred to as “letters”) may be helpful.

The SOC 7 criteria for each surgery include the requirement that co-occurring medical or mental illness be “reasonably well-controlled” for chest surgery and “well-controlled” for genital surgery. The stability of medical illness is an issue for any surgery, and risks and benefits of proceeding with surgery versus waiting for increased medical stability are weighed. Mental health stability has importance for any surgery in terms of capacity for informed consent. In addition, unstable mental illness may affect the ability of a patient to prepare for surgery, establish plans for the perioperative period, keep doctors’ appointments, and follow-up with postoperative care, such as wound aftercare and dilation after vaginoplasty. Unstable mental illness can make it more difficult for patients to recognize and cope with complications, which may require repeated visits to their doctors.

Mental health stability includes addressing co-occurring substance abuse. Substance abuse may impede planning and aftercare in the perioperative period and lead to withdrawal after surgery. Tobacco does not impair mental functioning but may impair healing and increases the risk of surgical complications.[3] Substance intoxication and tolerance can be an issue for anesthesia and may lead to postoperative withdrawal.[4]

In many cases, the presence of unstable medical or mental illness or substance abuse may not prevent a patient from obtaining surgery but may delay surgery until stability is reached. The SOC are meant to be flexible and to allow for clinical judgment while not serving as a barrier to receiving necessary care. Communication among a patient’s care providers is helpful, because a co-occurring condition might have been well-controlled at the time of the writing of the letters but then destabilize while the patient awaits surgery. The mental health provider can re-engage with patients as necessary and assist in restabilizing them and helping with a plan for support during the perioperative period.[5]

Ideally, transgender care is provided within an interdisciplinary structure, with established and regular communication between mental health providers, primary care providers and endocrinologists, and surgeons. More commonly, the disciplines practice independently, and communication is minimal and centered on the mental health practitioners’ letters of evaluation for surgery. Each of those letters should end with an invitation for the surgeon to contact the letter writer if more information is desired. There should be a signed release for providers to share information, and surgeons should contact letter writers if more information is desired to establish a patient’s stability for surgery.

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