The primary care of older transgender and gender diverse people



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Background
Older transgender and gender diverse (TGD) people have often experienced repeated episodes of transgender (trans)-related discrimination resulting in health inequalities including poorer physical and mental health, and reduced screening rates.

Objective
General practitioners' (GPs) roles with TGD older people include providing culturally safe and trans inclusive care, as well as delivering healthcare for conditions that are more prevalent in this population, such as cardiovascular disease, depression or anxiety and cognitive impairment. GPs may initiate and maintain gender affirming hormone therapy and refer for gender affirming surgery. Assisting with advance care planning is particularly important as decision makers can be identified to support dignity and safety.

Discussion
GPs are pivotal in supporting older TGD people, providing gender-affirming care and preventive screening, and navigating healthcare systems. By fostering trust through culturally safe, inclusive practice and advocating for gender-affirmed autonomy in aged care, GPs can reduce health inequities and enhance resilience and wellbeing in this population.

OLDER TRANSGENDER AND GENDER DIVERSE (TGD) PEOPLE need and deserve our concerted attention as primary care providers. Their health is almost universally shaped not only by the ubiquitous effects of ageing, but by the cumulative effects of socio-cultural-political hostility to their gender diversity across their life course.[1] The majority will have experienced suicidality themselves or been directly affected by it within the TGD community.[2] Many will have been rejected by families of origin, by intimate partners, or their own children during or after their gender affirmation journey.[3] Education and employment trajectories might have been disrupted by transphobia, resulting in financial insecurity, housing insecurity, and reduced opportunity to achieve their potential.[4] Furthermore, TGD people experience mortality from cardiovascular disease and cancers at higher rates than the general population.[5]

Older TGD people are also very likely to have experienced negative attitudes or even outright denial of care from healthcare providers, undermining trust in the healthcare system.[6,7] Understanding this social context for TGD older people is vital, not least to remove the propensity for victim-blaming, but particularly to provide inclusive and effective primary care.[8] Alongside broader political and community change, primary care has a vital role in improving health equity for TGD people.[9] We acknowledge that healthcare providers frequently express the need for more training on TGD issues,[10,11] and hope that this special issue will contribute to addressing this need.

Objective

There are specific areas of competency that GPs need to develop in caring for older TGD people. This has been identified in the UK and Ireland,[12] and increasingly called for in Australia.[13,14] Australia's legislative and policy context is supportive: it was the first country in the world to develop a national lesbian, gay, bisexual, transgender and intersex (LGBTI) Ageing and Aged Care strategy in 2012, enabling initiatives such as the Silver Rainbow Ageing and Aged Care program run by LGBTIQ+ Health Australia. LGBTIQ+ Health Australia is the national peak health organisation in Australia for organisations and individuals that provide health-related programs, services and research focused on lesbian, gay, bisexual, transgender, intersex and queer people. The '+' in LGBTIQ+ Health Australia acknowledges and signifies people and communities with diverse sexualities, genders and bodies beyond those represented by the initials LGBTIQ. This program has trained service

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providers in LGBTIQ+ inclusive practice, contributing to increasingly transgender (trans)-inclusive aged services. Further, Australia has strong human rights protections including the anti-discrimination laws and the *Aged Care Act*, which all include gender identity as a protected attribute (Box 1).

Two key principles should guide care for older TGD people: cultural safety and trans inclusion. Cultural safety relates to understanding each person's journey through historical trans injustices, their gender affirmation experience, and their current chosen family and community.[15] Trans inclusion requires recognising and actively avoiding cisgenderism: the pervasive assumption that all people identify with their sex at birth and that gender is strictly binary (Box 2).[16]

Both cultural safety and trans inclusivity require us to routinely ask about gender identity and expression, while creating environments that are safe and comfortable to disclose. TGD people usually prefer that GPs consistently use their chosen name and pronouns, regardless of their legally recognised gender. While TGD people can currently change identity documents, including Medicare details and birth certificates in all Australian states and territories, some older people might never have done so and might continue to use documents reflecting their birth-assigned sex. GPs can assist people to navigate these processes if desired. Equally, at times it can be medically important to know a person's assigned sex at birth. For example, when addressing the need for prostate or cervical cancer screening. Our medical records have the capacity to include both birth-assigned sex and gender identity, and GPs can explain the medical relevance of this information to TGD patients in the context of their holistic healthcare.

Understanding preferred community connections is also important, as loneliness and social isolation are key determinants of poor health and wellbeing among TGD people.[17] During the COVID-19 pandemic, LGBTIQ (including 'queer' identified) people were found to be particularly vulnerable to isolation and family violence.[18,19] Reliance on LGBTIQ community supports might diminish with age, partly because of ageism within LGBTIQ communities themselves.[20] Identifying affirming referral networks within the aged care sector is therefore essential (Table 1).

Older TGD people are more likely to have unmet medical needs because of long-standing barriers to access and reduced opportunities for preventive care earlier in life, with barriers often even greater for non-binary people.[21] A systematic review found that older TGD people had higher risks of cardiovascular diseases, depression and disability, as well as being under-screened compared with cisgender peers.[22] The authors note a significant lack of research in this population and suggest that cumulative stress (allostatic load), along with higher rates of smoking, obesity and diabetes, contribute to this burden of ill health.

Gender affirming hormone therapy (GAHT) is another important area of care for many TGD people.[23] We have presented two brief case vignettes illustrating GAHT issues

Box 1. Aged care statement of principles[29]

The Commonwealth aged care system offers accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed funded aged care services, if required by an individual and based on the needs of the individual, regardless of the individual's location, background and life experiences.

Note: This may include individuals who:[A]

(a) are Aboriginal or Torres Strait Islander persons, including those from stolen generations; or
(b) are veterans or war widows; or
(c) are from culturally, ethnically and linguistically diverse backgrounds; or
(d) are financially or socially disadvantaged; or
(e) are experiencing homelessness or at risk of experiencing homelessness; or
(f) are parents and children who are separated by forced adoption or removal; or
(g) are adult survivors of institutional child sexual abuse; or
(h) are care-leavers, including Forgotten Australians and former child migrants placed in out of home care; or
(i) are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or are gender diverse or bodily diverse; or
(j) are an individual with disability or mental ill-health; or
(k) are neurodivergent; or
(l) are deaf, deafblind, vision impaired or hard of hearing; or
(m) live in rural, remote or very remote areas.

[A]The authors note that transgender and gender diverse people may have several intersecting marginalised identities listed here.

Box 2. Examples of experiences of cisgenderism in healthcare[16]

> *I was seeing an aged care service provider for the first time. During the appointment, I saw the worker check 'female' for gender on the intake screen. My partner said, 'excuse me. They are actually not a woman or a man, just Alex.' The aged care worker looked at me like I had two heads. The service had lots of social activities that were only for women or just for men. 'There isn't a category for you', she said.*

> *They had gay-friendly posters on the wall, but nothing that spoke to me and to my experiences as a heterosexual trans woman.*

> *A difficulty is that many transgender people want to quietly live their lives as the man or woman they are, and don't want to be visible or identified as transgender … I was very embarrassed when one care worker found out and started referring to me as 'a female-to-male' or 'FTM'; I am just a man, I don't consider myself female.*

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in primary care (Box 3). While evidence on the long-term effects of GAHT in older age is limited, concerns include increased risks of venous thromboembolism (VTE), stroke, myocardial infarction and, for those using feminising hormones, a risk of osteoporosis and breast cancer.[24] For people over the age of 45 years using oestrogen-based therapy, a transdermal route is recommended to reduce thromboembolic risk.[24] There is no evidence that target levels of oestradiol or testosterone should be lower solely based on a person's age, and individual preferences should be respected. In the context of these data, a comprehensive assessment of cardiovascular risk, mental health, bone density and cancer screening are important aspects of care. GPs can also consider the possibility of undiagnosed disabilities, particularly conditions that are 'hidden' such as neurodiversity, which has a higher prevalence among TGD people.[25]

There is emerging evidence that older TGD people might be at higher risk of cognitive impairment and Alzheimer's disease, potentially related to the impact of chronic stress on accelerating brain ageing.[22] While best-practice guidance for supporting TGD people living with dementia is limited, unique challenges have been identified,[3] including being pressured to 'detransition' (ie assume their birth assigned gender) by families of origin or aged care providers. Fears of this and other forms of trans discrimination can discourage help-seeking, increase reliance on partners or friends for support, or lead to social withdrawal.

End of life planning is critically important for all TGD older people. Primary care has a key role in supporting advance care plans, enduring power of attorney and enduring guardianship. Reassurance that domestic partners of any sex or gender are legally regarded as next of kin in Australian healthcare settings can allay fears of loss of control. In an Australian study of older LGBT people, most trans people wanted their domestic partner to be their alternative decision maker at the end of life.[26] However, in the whole cohort, only 29% had an enduring power of attorney, 18% an enduring guardian and 12% an advance care directive. This lack of documentation can result in disputes regarding decision makers for TGD older people, particularly during health crises, adding further distress.

Box 3. Case vignettes regarding gender-affirming hormone therapy in older transgender and gender diverse people

CASE VIGNETTE 1

Jules, a non-binary person assigned female at birth aged 65 years, attends your general practice clinic regularly. They have been considering chest masculinisation surgery for some time and would like to explore referral options. You review the publicly available AusPATH provider list (https://auspath.org.au) and identify several surgeons with relevant experience. You discuss with Jules the differences in surgical approaches, wait times, cost and the importance of a preoperative assessment, and together you agree on a suitable referral pathway.

Over several extended consultations, Jules raises the possibility of testosterone as part of their gender affirmation. You explore their goals, expectations and concerns, including the range of possible physical, emotional and metabolic effects. You review reversible and non-reversible changes, monitoring requirements and alternative approaches. After a shared decision-making process, Jules decides they would like to trial a low-dose testosterone gel to achieve some body masculinisation. You plan for close follow-up, dose adjustments as needed and ongoing review of whether the therapy continues to meet their goals.

CASE VIGNETTE 2

Soula, a woman assigned male at birth aged 71 years, has been using oral oestrogen for gender affirmation for many years. She presents highly distressed after being diagnosed with deep vein thrombosis following a long-haul flight. In the emergency department she was advised to cease oestrogen indefinitely, which has caused significant anxiety given the central role oestrogen plays in her wellbeing and identity.

You review her history, risk factors and the circumstances of the clot. You discuss the complexities of balancing thrombotic risk with the psychological and functional importance of gender affirming hormone therapy. You consult with a local haematologist (https://auspath.org.au) to clarify the risks of various oestrogen formulations, the role of anticoagulation and the evidence supporting different approaches. Together, you, Soula and the haematologist discuss the option of recommencing oestrogen using a transdermal preparation, which carries a lower thrombotic risk, alongside long-term anticoagulation. You emphasise the need for ongoing monitoring, shared decision making and revisiting the plan if her risk profile changes.

Discussion

Finally, GPs play a crucial part in supporting older TGD people to navigate complex systems such as in-home care, palliative care and residential aged care services. Many fear being 'forced back into the closet' to avoid discrimination in these services,[27] abusive treatment from staff or other residents, or being housed in settings that do not align with their gender identity. The potential for elder abuse is high in all of these situations, and TGD people fear losing access to gender affirming treatments – both medical and social.[28] Dedicated training for staff working in aged care is needed. GPs can support self-advocacy and work alongside LGBTIQ community advocacy organisations to enhance agency, safety and dignity for older TGD people in these settings (Table 1).

Conclusion

TGD people have unique life trajectories and unique health and healthcare needs as they age. GPs and other primary care providers are uniquely placed to provide care that is trans inclusive, culturally safe and tailored to the needs of each individual. GPs have particular skills in teasing out not only the stories of lifelong stress but also the strategies that TGD people have honed to deal with these stressors. GPs can celebrate their resilience and achievement of older age while supporting their end-of-life planning to uphold their dignity and agency right to the end.

Key points

- Older TGD people have often experienced health impacts from lifelong stigma

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Table 1. Lesbian, gay, bisexual, transgender, queer/questioning, intersex, aromantic/asexual and other gender and sexual diversity referral networks, resources and information

Network	Details	Website
Qlife	Australia-wide anonymous and free LGBTIQ+ peer support and referral service for people wanting health support in relation to their sexuality, gender, bodies, feelings or relationships	https://qlife.org.au
Black Rainbow	Suicide prevention and mental health support for Aboriginal and Torres Strait Islander LGBTIQA+SB people	https://blackrainbow.org.au
Australian GLBTIQ Multicultural Council (AGMC)	A national body that advocates for the rights of multicultural and multifaith LGBTIQ individuals and communities	https://agmc.org.au
Alice's Garage	A social enterprise empowering older LGBTQIA+ people	www.facebook.com/LGBTIelders
LGBTIQ+ Health Australia (LHA)	The national peak health organisation in Australia for organisations and individuals that provide health-related programs, services and research focused on LGBTIQ+ people and communities	www.lgbtiqhealth.org.au Silver Rainbow aged care training: www.lgbtiqhealth.org.au/silver_rainbow Fact sheets on coming out, dementia, families of choice, living with HIV, social isolation, elder abuse, palliative care for older LGBTIQ+ people: www.lgbtiqhealth.org.au/silver_rainbow_factsheets e-learning modules for healthcare providers on LGBTIQ+ inclusive palliative care: www.lgbtiqhealth.org.au/palliative_care Silver Pride Advocacy Network: www.lgbtiqhealth.org.au/silver_pride_advocacy_network
Switchboard Victoria	Aged care volunteer visitor scheme (Victoria)	www.switchboard.org.au/out-and-about
ACON Health	Aged care volunteer visitor scheme (New South Wales)	www.aconhealth.org.au/aged_care_volunteer_visitors_scheme
GLBTI Rights in Ageing Inc (GRAI)	LGBTIQ+ advocacy and rights organisation (Western Australia)	https://grai.org.au
Trans Justice Project	LGBTIQ+ advocacy and rights organisation	https://transjustice.org.au

LGBTIQA+SB, lesbian, gay, bisexual, transgender, intersex, queer, asexual, sistergirl, brotherboy, plus; LGBTQIA+, lesbian, gay, bisexual, transgender, queer/questioning, intersex, aromantic/asexual and other gender and sexual diversities.

and healthcare exclusion but might also embody significant resilience.

- Culturally safe, trans-inclusive primary care builds trust by routinely affirming gender identity, using chosen names and pronouns and actively avoiding cisgenderism.
- With appropriate access to care, older TGD people benefit from preventive screening and management of chronic conditions such as cardiovascular disease, mental illness and cognitive impairment.
- GPs can develop competencies to provide GAHT alongside holistic, age-appropriate primary care and coordinated referrals.
- Proactive advance care planning and advocacy in aged care settings support autonomy, dignity and safety for older TGD people.

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