Letters

Transgender care

October 2022—I read with great interest your article "Transgender care, in and beyond the lab" (July 2022). In the article Gabrielle Winston-McPherson, PhD, talks about her desire to improve health outcomes, identify problems in the preanalytical process, develop training material, assemble data and information prior to implementation, address informatics challenges, and ensure proper allocation of limited resources—all of which is laudable and appears to align perfectly with our mission as pathologists. The writer reminds readers that the topic has landed in the middle of court cases, state laws, and policy debates, with "words like 'controversial,' 'issue,' 'politics,' 'traditional family values,' and 'beliefs' awkwardly mixed in with medical realities."

"But strip away the rhetoric," the article continues, "and labs continue to be charged with the same, enduring task: how to provide the best care to patients."

Given that I agree with these premises, I am left to wonder whether my divergence from the views expressed elsewhere in the article could be ascribed to mere matters of technical implementation.

If a patient is transgender, nonbinary, or gender fluid, the article says, it's important for physicians to know whether they're on gender-affirming hormones. But this point is not necessarily limited to people who identify as transgender because we should always strive to append reference intervals that are as specific, accurate, and clinically useful as possible, to the extent we can. Dina Greene, PhD, makes this point in the article when she says "We do stuff like this all the time" and cites the example of therapeutic ranges for the drug tacrolimus that reflect the specific use of the drug and the clinical context (liver versus kidney transplant). Given the small size of the transgender population and its heterogeneity, accomplishing this would pose its own methodological challenges.

Dr. Greene said the following comment could be appended to test results: "Please note that these are transgender reference intervals specific to people on gender-affirming therapy. If the patient is not on gender-affirming therapy, please use sex assigned at birth to interpret these results." Another possible comment: "For transgender individuals on hormone therapy, use adult cisgender male for transgender men or people on masculinizing therapy; use adult cisgender female for transgender women or people on feminizing therapy." I find this verbiage cumbersome and confusing, especially given that the goal of a laboratory report is to relay data in a manner that is concise and as immune from miscommunication as possible. Instead of a straightforward comment directed at a patient's taking a particular steroid, we have a paragraph about transgender patients who may or may not be on "gender-affirming therapy." Instead of simply referring to a female taking testosterone, we have "transgender men or people on masculinizing therapy" (assuming I understood that correctly).

Including these comments in a laboratory report, in my view, is a misappropriation of our roles as laboratory physicians and scientists, which is to report our objective findings. Furthermore, we might do well to remember that it is our clinical colleagues who order tests with specific questions in mind and who, with their patients, must ultimately decide, using the results we provide, how best to proceed clinically. Our role in this process is best served by providing results, reference ranges, and commentary that are as accurate, concise, and objective as possible—and nothing more. These results are useful to the extent they reflect reality and provide guidance to the clinician and patient to assist them in making the clinical decisions they must make together. Trying to do anything else, including helping the doctors metaphorically see things our way, is inappropriate.

Dr. Winston-McPherson says misgendering a patient is a common problem among phlebotomy staff—for example, using an incorrect pronoun or title. She suggests that a transgender person's possible hesitancy to return to the laboratory for sample collection as a result of a perceived negative interaction with a phlebotomist be considered a "preanalytical variable." For reference I unearthed my *Henry's* textbook, which defines preanalysis as all the complex steps that must take place before a sample can be analyzed. The text provides a relatively comprehensive list of possible sources of preanalytical error; it includes "patient-related variables (diet, age, sex,

etc.), specimen collection and labelling techniques, specimen preservatives and anticoagulants, specimen transport, and processing and storage." Nowhere is the use of a correct pronoun or anything remotely similar listed as a preanalytical variable.

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In reply: *We read with interest the concerns outlined by Dr. Harari. Embracing gender diversity in medicine requires a learning curve. We understand there might be confusion around nomenclature, and we respect that it can be complex. However, we believe adopting appropriate language is a baseline requirement for respecting transgender and nonbinary people. We do not believe that the verbiage is cumbersome, but rather it is new. Language evolves, and it is our responsibility as medical providers to maintain a cultural awareness of the patients we serve. The recent incorporation of sexual orientation/gender identity fields in electronic health records is an example of how the practice of medicine and associated medical records adapts at a broad level to changes in cultural norms and language.*

As laboratory directors and pathologists, we are responsible for ensuring our reports are medically sound and respectful and offer interpretation to the person reading the material. Clinicians ***and*** *patients read pathology reports. We agree that the specific details of a pathology report may be confusing to people outside of health care, but stress that there is universal competency related to understanding one's own gender. A transgender man who is appropriately utilizing testosterone is not a "female taking testosterone." He is a man receiving appropriate medication. As such, it is an error to dictate differently on a pathology report. We are not speaking metaphorically; we are speaking about the lived experiences of human beings. We want to ensure that patients are respected for their identities across the health care system.*

Our understanding of preanalytical error is not stagnant but iterative. Like other quality standards, it must adapt to new challenges. We believe that respecting people's gender identity is a preanalytical issue. As Dr. Harari mentions, phlebotomy is one of the "complex steps" that must be completed before samples are analyzed. Indeed, all components of the blood collection process have long been recognized as a part of the preanalytical phase. This includes mutually respectful interactions between patients and phlebotomy staff. To this point we reference CLSI GP41, which states that "during the blood collection process the phlebotomist should establish a rapport and gain the patient's confidence." We believe this guidance is sound and applies to all our populations, including those who are gender-diverse. Moreover, the recent editions of Tietz *state that "preanalytical error should be assessed with a focus on patient outcomes and prevention of patient harm." The chapter emphasizes that laboratorians should identify situations where patient outcomes may be affected and focus on the most critical errors. Failure of our front-end team to respect a patient's gender can lead to failure to get necessary testing and can have a dramatic impact on patient outcomes.*

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