Advance Directives to Manage Fears and Anxieties of Transgender People via Dementia Planning

Ames Simmons[1]

1. DUKE UNIVERSITY, DURHAM, NORTH CAROLINA, USA.

Keywords: Transgender, Aging, Dementia, Discrimination, Advance Directive

Abstract: As increasing proportions of our global population age, transgender people are experiencing higher rates of dementia, and many are afraid to enter long-term care. Structural interventions such as advance directives may help mitigate fears around entering long-term care by managing specific anxieties that transgender people may have about dementia, loss of decision-making capacity, and discrimination in long-term care settings.

Transgender health has been less researched compared to the health of the broader lesbian, gay, bisexual, transgender, and queer (LGBTQ) community or overall population health. There is a particular need for more studies of the experiences of older transgender people generally and of dementia in particular.[1] But as the proportion of older adults increases, more research is emerging. The purpose of this integrative synthesis is to bring together research on aging, dementia, mental health, discrimination, and advance care planning among transgender adults in order to propose a new tool to assist transgender people with planning for dementia.

Ames Simmons, J.D., *is a queer white transgender man who holds a senior fellowship at Duke University School of Law, and teaches transgender health at George Washington University. Ames is a member of the National Advisory Council of the SAGE and Human Rights Campaign Foundation's Long-Term Care Equality Index, and the Trans Elders Special Interest Group of the U.S. Professional Association for Transgender Health.*

Methods

Because this literature review was based in law and policy and sought to bring together multiple disparate areas of study, a review protocol was not strictly followed.

Eligibility Criteria

This review looked for evidence related to (a) people who identify as transgender, nonbinary, or any other gender identity than cisgender (although not always overlapping, these identities are referred to throughout this article as "transgender"), (b) diagnosis and treatment of dementia in transgender people, (c) fears and anxieties that transgender people may have about loss of legal decision-making capacity, (d) vulnerability to discrimination in long-term care settings related to maintaining gender identity, and (e) advance care planning among transgender people.

Information Sources

A Web of Science search was conducted for dates 1/1/2018 – 1/4/2023. Additional articles that were published during drafting or found through citation searching were also included.

Results

The Web of Science search netted 2,640 results which were screened by title, 182 studies by title and abstract, and 24 articles by full text review. Analysis yielded themes related to the five topics above, which in turn shaped the sections of the discussion. Direct quotes from transgender people are used when relevant, but there remains a need for more stories shared by transgender people living with dementia.[2]

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.
DOI: 10.1017/jme.2024.136

Discussion

A. The Background Context of Transgender People's Lives

The population of the United States is rapidly aging, with the population aged 65 and over projected to nearly double by 2060.[3] Current estimates are that there are 171,700 transgender people aged 65+ in the US, with almost twice as many in the US South than any other part of the country,[4] important because the South has so few legal protections for transgender people.[5]

Transgender people who might prefer aging in place may be faced instead with entering a residential long-term care facility.[6] One reason is that it may be more difficult for them to find supportive family members to be caregivers.[7] Among transgender adults age 65+, new survey data show that only 63% reported support from immediate family members.[8] Higher proportions of transgender people who are Asian and Pacific Islander,[9] Black,[10] and Latine[11] (a gender-neutral term for people of Latin American ethnicity[12]) experienced family rejection, with the biggest disparity among transgender Indigenous people.[13]

Another reason is that transgender people are less likely to be able to afford in-home care. Affordability is an issue since transgender people are more likely to be low-income (34%).[14] Transgender Black, Indigenous, and people of color (BIPOC) are disproportionately likely to be low-income, with the biggest disparity among transgender Latine people at 43%.[15] Some state Medicaid programs do cover in-home care under Home- and Community-Based Services waivers, but almost always with a waiting list.[16] Even if in-home care providers are affordable, they often have a learning curve with caring for transgender people.[17]

Almost 1 in 2 transgender people, including 68% of transgender people of color, reported experiencing mistreatment from a healthcare provider.[18] Transgender people have reported being misgendered and subject to ridicule, receiving substandard or delayed care, and being denied care altogether by long-term care providers.[19]

Higher levels of marginalization have been associated with negative reports of health among LGBTQ older adults.[20] Therefore, it is not surprising that chronic minority stress in LGBTQ elders heightens the risk for premature cognitive aging.[21] Black and Latine LGBTQ older adults were significantly more likely to report cognitive difficulties.[22]

B. Dementia Among Transgender People

The same association with brain health disparities is true for transgender people who experience heightened marginalization. Older transgender people may face more health disparities than cisgender people, including higher rates of depression, stress, disability, and poor health.[23] Transgender people are more likely to report poorer brain health as they age: nearly 16% of transgender and nonbinary participants rated their memory as poor/fair, and 17% reported that their memory was worse than the previous year.[24] A study of administrative data shows the prevalence of risk factors for Alzheimer's disease is 2–3 times higher for transgender adults,[25] and the same rates have been reported in England.[26] Rates were almost nine times higher in a study of over 1,200 transgender veterans.[27]

Higher levels of marginalization have been associated with negative reports of health among LGBTQ older adults. Therefore, it is not surprising that chronic minority stress in LGBTQ elders heightens the risk for premature cognitive aging. Black and Latine LGBTQ older adults were significantly more likely to report cognitive difficulties.

Transgender people were 5.7 times as likely to report subjective cognitive changes with memory or logic, a possible early precursor of Alzheimer's disease, compared to cisgender people.[28] There may be a race- and/or ethnicity-based disparity related to subjective cognitive changes among transgender people.[29] Subjective cognitive changes were highest among transgender and nonbinary BIPOC people at 21.6% in one study, even compared to transgender White people.[30] However, there remains a pressing need for more dementia data disaggregated by gender identity.[31]

It is less understood whether, to what extent, or how dementia affects transgender people's experience of their gender identity. Studies have reported transgender people who created a backstory supporting their current gender identity, such as a transgender woman who told clinicians stories about birthing her children,[32] or a transgender man who consistently

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

attempted to urinate standing up without a device or having had urethral lengthening.[33] Transgender people with dementia may forget that they have had gender-affirming surgeries or that they have been taking gender-affirming hormones, or may even not be aware that their gender expression has changed.[34] However, a newer qualitative sample showed that the transgender people interviewed had a deep sense of their gender identity and that none had forgotten it.[35]

Ethnic and cultural dimensions including Indigeneity may create different understandings of how a core self functions with dementia. For example, Joan, a Métis Two Spirit person of Aboriginal and Canadian ancestry, understands her ethnicity as well as her gender to be mixed, and that her identities exist in liminal space. Therefore, her core self is accustomed to border crossing in a way that can accommodate cognitive changes.[36] In fact, scholars have called for reconsideration of the way gender is discussed in the context of dementia lest it be reduced to limited categories based on structurally biased conceptions of biology.[37] Structural considerations related to sex and gender have been noted not just in the US but globally.[38]

C. Theorized Treatment Approaches for Transgender People with Dementia

Geriatricians and long-term care workers may be ill-equipped to establish and implement care pathways without a nuanced understanding of transgender identities. Best practices for person-centered care for patients with Alzheimer's disease call for clinicians to acknowledge[39] and then validate patients in the subjective reality they are experiencing at any given time.[40] Applying this protocol to a transgender patient living with dementia may seem to require acknowledging whichever gender identity they are expressing at that time as opposed to only validating their historical or past identity.[41] Baril and Silverman call this a "trans-affirmative fluid approach," which may fit the situation but also may expose the patient to the risk of non-affirmation or even violence by clinicians who do not understand gender fluidity.[42]

Avoiding acknowledgement of gender at all, whether by pronouns or by clothing or something else,[43] infantilizes the patient by removing their decision-making opportunities, as well as being dismissive of gender fluidity.[44]

Affirming a binary gender could be an appropriate approach, if confirmed by the patient. Some transgender people may be profoundly unsettled by the prospect of their gender changing as their cognition changes, particularly if they understand their affirmed gender identity as a hard-fought achievement of gender congruence that they do not want to be threatened.[45] However, this "trans-affirmative stable approach" in isolation could imply that gender instability is a pathological symptom of dementia and that transgender people lack decisional capacity to be gender-fluid.[46] Nevertheless, this approach might be the one favored by many transgender people[47] — which raises the question, where does the voice of the transgender patient fit into the treatment plan?

D. The Perceived Powerlessness Feedback Loop

A feedback loop occurs when the output of a system is returned to the input, and transgender older adults can be caught in one. Transgender adults experiencing cognitive changes may be more likely to experience discrimination in healthcare settings in the future.[48] It seems that not only is chronic minority stress making transgender people sicker, but some healthcare providers who are supposed to be helping patients to mitigate the minority stress are making it worse by discriminating against patients: 64% of palliative care team members in one study reported that they believe that transgender patients are more likely to be discriminated against, and 21% reported actual observation of discrimination toward transgender patients.[49]

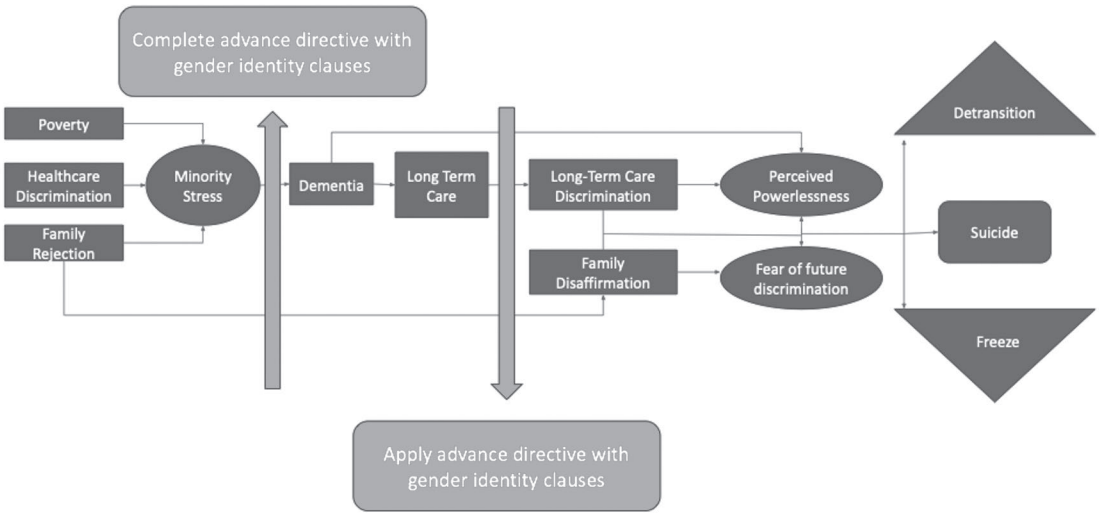
Given that inverse relationship, transgender people understandably report fear of mistreatment and lack of affirmation of their gender identity in long-term care.[50] Transgender people may fear arbitrary termination of hormone therapy due to advanced age[51] or after onset of cognitive changes[52] (which has been reported by transgender people, even after ten years of hormone therapy[53]). Transgender people may fear that their transness itself will be seen as a symptom of dementia[54] (also reported by transgender people, such as providers saying "you have memory issues, so I don't really know if I can trust what you're saying [about your gender]").[55]

Transgender people thinking about end-of-life care report fear for their safety, particularly if they hold multiple marginalized identities: "The poorer you are, the blacker you are, being a transwoman — all make you more vulnerable."[56] Socioeconomic status and education may also affect transgender people's experience receiving healthcare.[57]

Thus, the feedback loop continues: fear of accessing services has been shown to be a significant mediator across poor outcomes in both physical and mental health.[58] Experiences with healthcare discrimination in the past cause transgender people to fear additional discrimination and worse treatment in long-term care.[59] A transgender person's sense of their own agency to fight that discrimination may be compro-

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.

Figure 1
Breaking the Feedback Loop



mised after the onset of cognitive changes. Indeed, if a transgender person is perceived by healthcare providers to be experiencing cognitive changes, their ability to advocate for themselves in long-term care settings may be discounted.[60] Loss of agency is the aspect of dementia that transgender people report the most fear about, because of perceived loss of control over their gender identity and expression.[61]

The powerlessness that transgender people perceive to result from the onset of cognitive changes has sown seeds of fear and anxiety about dementia deeply into many transgender people's sense of their future. There is clear evidence that older transgender people have specific concerns about dementia and end-of-life care.[62] One in six transgender respondents to a 2022 survey reported concern about becoming disempowered if they need care because of cognitive changes, with transgender people of color reporting almost twice the level of concern as White transgender people.[63] These fears of not being affirmed or supported may make it hard to see a future of healthy aging.[64]

This constellation of fears related to discrimination by long-term care providers and the perceived powerlessness to respond to it[65] may leave transgender people feeling frozen into this feedback loop, worrying that they will be treated as the wrong gender in long-term care, or that dementia will "steal their TNB identity" — one transgender woman worried "Am I just gonna forget who I am? Or that I've transitioned…[W]hat's gonna happen to me there as I'm left alone?"[66] A transgender person's expression of their gender to others may be one of the few acts of personal sovereignty that they perceive as available to them.[67]

There might be exit ramps from the feedback loop if the patient has the resources to afford care at home[68] and/or gender-affirming medical procedures that might reduce the risk of involuntary disclosure of transgender status: "[I]t'd be difficult for me to pretend I wasn't transgender. My body is not…boobs…and that stuff."[69] However, higher rates of poverty may put these options out of reach. Some transgender people may feel the safest off-ramp is to express the gender assigned to them at birth[70] and "being relegated back into the closet."[71] For others the dysphoria associated with their birth sex forecloses this route and leads directly to hoping for fatal accidents or serious illness, or even thoughts of ending their life before needing institutional long-term care.[72] **Figure 1**, "Breaking the Feedback Loop," provides a graphic representation of a potential way forward.

E. Structural Interventions to Manage Fears of Transgender People

When the end of their life is the only off-ramp from aging, dementia, and long-term care discrimination that many transgender people see, there has been a broad systemic failure. Our society must respond to this emergency with creative solutions that use every tool at our disposal, including law and policy.

Advance directives are one form of medical decision-making and consist of documents that specify the healthcare treatment a person would want if they lost legal capacity to make decisions for themselves. States may vary slightly in the requirements or names of the documents in an advance directive, but they are generally easy to find.[73] An advance directive typically

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.

includes a statement of treatment preferences (commonly called a living will) which usually becomes activated at end of life. Increasingly, advance directives include a statement of treatment preferences in the event of conditions which may reduce someone's legal decision-making capacity prior to end of life, such as dementia. Compassion and Choices maintains a Dementia Values and Planning Tool web form to help users create a dementia addendum to an advance directive.[74] Advance directives usually also contain a healthcare power of attorney in which a person designates a surrogate healthcare decision-maker to carry out their wishes if they are unable to do so themselves.

In the absence of express treatment wishes and/or directives to a healthcare agent, healthcare workers usually default to a patient's family members about the goals of patient care and treatment modalities to achieve those goals. Most states have a statute specifying default healthcare surrogate decision-makers that typically begin with spouse, then adult child, parent, and other family members related by marriage or blood. While some states have recently added close friends or nonfamily adults as surrogate decision-makers, they are at the bottom of the consultation hierarchy below family of origin.[75]

Given the historical marginalization of transgender people, their family members may not be accepting or supportive of their relative's gender transition. In the absence of a written specification of a healthcare agent, an unsupportive family member may try to take over decisions about medical care,[76] and they may even seek to use this opportunity to undermine their relative's gender identity. For example, one transgender woman related: "The thing I fear the most is certain members of my family who might survive me … and how they would put pressure on my own children to make sure I'm listed as my dead name and male."[77] For many transgender people, it is a realistic fear that their gender expression may be hampered or changed by unsupportive family of origin.[78]

Long-term care providers may not be prepared for transgender people experiencing cognitive changes who begin expressing a different gender identity. In the absence of clear direction from clinical guidelines or the patient themselves, long-term care providers may be persuaded by non-affirming family members that the resident is not actually transgender.[79]

To help avoid this outcome, a transgender person can designate a gender-affirming surrogate healthcare decision-maker. If a transgender patient can identify such a person in their life, they may be able to avoid a biased surrogate who may make harmful decisions.[80] Statements of treatment preferences that direct healthcare providers to provide gender-affirming care may also be useful in avoiding discrimination by non-affirming clinicians.[81] A healthcare agent can also be assertive with advocacy in ways that may not feel safe for a transgender person to do themselves.[82] A key competency for providers of healthcare to transgender people is advocacy to help patients with advance care planning to ensure that their wishes are respected.[83]

Long-term care providers may not be prepared for transgender people experiencing cognitive changes who begin expressing a different gender identity. In the absence of clear direction from clinical guidelines or the patient themselves, long-term care providers may be persuaded by non-affirming family members that the resident is not actually transgender.

Despite the peace of mind and additional certainty that can accompany setting down one's wishes ahead of time, uptake of advance directives in the US has been low. Only about one in three adults in the US has completed any type of advance directive.[84] Black and Latine people are almost four times less likely to have advance directives in place than White people,[85] though situating advance care planning in African American faith communities has been shown to be a promising practice.[86] LGBTQ people may avoid advance care planning out of fear of discrimination and doubt that their wishes would be honored by providers.[87]

Transgender people are even less likely (as low as 13.1%)[88] than LGBQ people to have advance directives in place, especially in the southern US.[89] Some transgender people have said that the experience of gender transition made them feel they are "starting life anew" and that end-of-life planning seems too far off during this hopeful phase.[90] Other transgender people said that they "never imagined they could live long enough to grow old" and need an advance directive.[91]

Other reasons include basic practical considerations that prevent transgender people from pursu-

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.

ing advance directives. For many transgender people, food, shelter, and basic life necessities take precedence over planning for what may seem like a distant future,[92] particularly since these services are perceived to have high legal and administrative costs.[93] Additionally, many transgender people's support networks may be too thin to readily identify someone appropriate to serve as a healthcare proxy.[94]

A study of gender non-conforming adults age 18–30 about gender-affirming end-of-life conversations found that only 2 out of 20 had talked with their family about their gender identity in the context of death.[95] In addition to the obstacles presented by the stigma of talking about death, plus the stigma of openly discussing gender identity, many of them also had struggled with mental health issues in the past that triply stigmatized such a discussion: these young adults were afraid that talking about death might lead their family to think they were contemplating suicide.[96] These obstacles were magnified for the many biracial participants in the study, who said negotiation of racial and ethnic identities during these conversations adds to their difficulty.[97]

A recent study found that most Black, Latine, and multiracial respondents had a strong desire to complete an advance directive.[98] However, a study of Medicare claims data indicates that Black transgender beneficiaries receive the lowest rates of advance care planning services.[99]

While these newer studies show the tide may be turning, there is generally a dearth of data about transgender people's use of advance directives that is disaggregated by race and ethnicity.[100] The Medicare study authors mentioned above note that while advance care planning interventions tailored for race and ethnicity have proven to be more successful in the general population, they were not aware of any advance care planning services tailored for transgender people of color, and they recommend the development of such interventions in collaboration with transgender patients of color.[101] Such tailored services that take into account upstream discrimination and stigma have been described as an element of structural competency for both medical and legal professionals.[102]

As mentioned above, Medicare has provided reimbursement since 2016 to providers for voluntary, face-to-face services provided by a physician or other qualified health professional to a patient, family member, caregiver, or surrogate about the patient's wishes for healthcare treatment if they become legally incapacitated.[103] These thirty-minute discussions can include discussion of advance directives and assisting the patient with completing appropriate forms.[104] Since Medicare providers are already accustomed to reviewing advance directives, a document with specific gender-affirming instructions may help them provide the care that transgender people need.

However, the practice of advance care planning has not developed alongside the aging of the transgender population. Care staff need to be educated to be able to grapple with questions such as how to provide care to a transgender person who does not remember that they have transitioned, or whether to validate a past or present gender identity.[105] By asking about how transgender people understand their gender identity and what their values are when it comes to dementia, we can help to preserve autonomous decision-making for transgender people.

A detailed gender-affirming advance directive can provide guidance to clinicians about how a transgender person wishes their gender identity to be respected if they can no longer advocate for themselves. There are some objections based in ethics that advance care planning around gender identity may not account for future gender fluidity.[106] However, advance care planning can take into account that a transgender person understands their gender identity to be fluid (or even if not fluid today, they would welcome any gender fluidity that may develop as they age). Baril and Silverman advocate for a "Trans-Affirmative Fluid Crip- and Age-Positive" approach based in disability rights with two central tenets: cognitive changes that affect gender identity should not be seen as decline, and gender expression should be supported for transgender people living with dementia as much as it is for people without dementia.[107] In order to avoid ableism, priority must be placed on supporting the transgender person with retaining as much agency and decision-making capacity as possible.[108] Consideration must be given if gender-fluid patients are currently receiving gender-affirming medical treatments such as hormone therapy or daily dilation, which may not be able to be started and stopped simply, quickly or repeatedly.[109]

G. Implementing Gender-Affirming Advance Directives

Practitioners should assist transgender people with advance care planning.[110] It is important for our rapidly aging population that advance care planning is increased and brought to scale quickly. Advance care planning should be thought of as early life planning conversations that may help prevent acute situations where transgender patients need an advance directive but have not developed one.[111] In fact, in one study, several patients said they hope their clinician brings up advance care planning proactively, and by surfac-

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.

Table 1

Guiding Questions and Advance Directive Clauses

Guiding Questions About Values		
I experience my gender identity as:		
A permanent transition from my past from the sex I was assigned at birth to the gender I am now.	A fluid state — sometimes I feel masculine. Other times I feel feminine. Sometimes I may feel neither. Sometimes I may feel both. Sometimes I feel some other combination of genders.	A less binary experience — I am masculine but am comfortable with some femininity, or I am feminine but am comfortable with some masculinity.
If I have forgotten that I am a transgender person and begin feeling like the sex I was assigned at birth, how would I want people around me to relate to me?		
I would want people to relate to my true self, the gender identity that I fought for a long time to be recognized.	I would want people to relate to me as whatever gender I present to them on any given day, regardless of my historical gender identity.	This question doesn't feel applicable to my situation.
The idea that I might one day have dementia and begin expressing a different gender identity:		
Is deeply unsettling to me. Expression of my gender identity is one of the most important ways that I exercise control over my life.	Seems like a normal part of life for me. I would not view gender fluidity as a decline in my ability to understand myself.	This question doesn't feel applicable to my situation.
One of the things I worry about with dementia is that someone from my family who does not support my gender identity will try to convince my care team that I'm "not really transgender."		
I worry about this and want to take actions to prevent this from happening.	This is not something I'm concerned about.	This question doesn't feel applicable to my situation.
I would feel less worried about dementia if I knew that people around me would have to follow my written directions about how to relate to me as a transgender person.		
Yes, I would want people to relate to me with my correct name and pronouns. I would want them to continue any medical treatments needed to preserve my gender identity.	Yes, my gender identity is fluid. I would feel violated if anyone forced me to dress a certain way or be called by different pronouns than how I felt on that day.	Although I feel sure about my gender identity today, I am not sure I would want to be forced to dress a certain way or be called by different pronouns if dementia caused me to see myself as a different gender.
These are my values with respect to gender identity and fluidity:		
My gender identity is something I fought hard to ensure that people around me recognize. I would not ever want to lose that.	Gender fluidity should be supported for people with dementia just as much as it is for people without dementia.	This question doesn't feel applicable to my situation.
When I think about dementia:		
It is important to me to keep the gender identity I have now, even if I might feel just as sure about a different gender identity after I have dementia.	My ability to direct my own life and gender expression in the moment is most important.	It feels wrong to try to guess today what my gender identity will be in the future.

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.

Table 1 (Continued)

Guiding Questions and Advance Directive Clauses

How to Read the Next Section of the Table:		
If you answered mostly (a), you may want to write a gender-affirming advance directive. You may find more peace of mind when you think about dementia if you have written down the treatment you want to receive.	If you answered mostly (b), you may want to write a gender fluid advance directive. You might feel less fearful about dementia if you have written about your gender fluidity. It might help your care team if you say you would like to express your gender however it feels right.	If you answered mostly (c), you should still consider completing an advance directive, but specific gender identity clauses in an advance directive might not be the right answer. You might later regret having "boxed yourself in" to a particular gender identity that might not feel right anymore if you develop dementia.

Suggested Advance Directive Clauses to Add		
Gender-Affirming Treatment Preferences	**Gender Fluid Treatment Preferences**	**No Special Treatment Preferences**
During any period of treatment, I direct my physician, all medical personnel, and anyone who is caring for me to refer to me by the name of _____ and to use _____ pronouns in reference to me, my chart, and my treatment, irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any gender-affirming treatment.	During any period of treatment, I direct my physician, all medical personnel, and anyone who is caring for me to refer to me by the name and pronouns that I am using for myself that day in reference to me, irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any gender-affirming treatment.	No special treatment preferences
During any period of treatment, if I am unable to personally maintain my appearance, I direct my physician, all medical personnel, and anyone who is caring for me to do so to the extent reasonably possible, irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any transition-related treatment.	During any period of treatment, if I am unable to personally maintain my appearance, I direct my physician, all medical personnel, and anyone who is caring for me to do so in accordance with my gender expression on that day, to the extent reasonably possible, irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any transition-related treatment.	No special treatment preferences
I want my healthcare representatives, agents, proxies, medical providers, family members, caregivers, long-term care providers, and other loved ones to know and honor my wishes regarding the type of care I want to receive if I develop an advanced stage of Alzheimer's disease or another incurable progressive dementia. Regardless of my physical and mental state, I would like the following treatment: maintenance of my gender-affirming healthcare and gender expression.	I want my healthcare representatives, agents, proxies, medical providers, family members, caregivers, long-term care providers, and other loved ones to know and honor my wishes regarding the type of care I want to receive if I develop an advanced stage of Alzheimer's disease or another incurable progressive dementia. I value my gender fluidity, do not see it as a symptom of cognitive decline, and want to be supported in the gender expression that I am showing on that day or occasion, which may change in the future.	No special treatment preferences

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

Table 1 (Continued)

Guiding Questions and Advance Directive Clauses

Suggested Advance Directive Clauses to Add		
Gender-Affirming Healthcare Powers of Attorney	**Gender Fluid Healthcare Powers of Attorney**	**No Special Healthcare Powers of Attorney**
My Healthcare Agent's authority to act on my behalf concerning my medical care includes but is not limited to, requesting, asserting my rights to, giving consent for, and withdrawing consent for any medical treatment related to maintaining my gender identity, including but not limited to: 1. Administration of exogenous hormones, including but not limited to estrogen, androgen blockers, and testosterone, as applicable; 2. Ongoing treatment related to surgical interventions, including but not limited to continued dilation of vagina, scar treatment such as silicone, collagen, massage, and any other medically necessary treatment, as applicable; 3. Any other diagnostic and treatment procedures ordered by or under the authorization of a licensed healthcare provider under Medical Orders for Scope of Treatment.	My Healthcare Agent's authority to act on my behalf concerning my medical care includes but is not limited to, requesting, asserting my rights to, giving consent for, and withdrawing consent for: 1. Use of the name, pronouns, and forms of address that I am using that day. 2. Clothing and grooming in accordance with my gender expression on that day.	No special healthcare powers of attorney
Use of my affirmed name, pronouns, and forms of address, to preserve my dignity as a transgender person, in all healthcare contexts.		No special healthcare powers of attorney
Placement, housing, clothing, grooming, medical records including death certificate, obituary, and disposition of my remains are all done in accordance with my gender identity, affirmed name, pronouns, and forms of address, including after my death. This authority takes precedence over any provision to the contrary in any prepaid funeral contract.		No special healthcare powers of attorney
These powers are enforceable regardless of whether I have obtained a court-ordered name change, changed the gender marker on any identification document, or undergone any transition-related medical treatment.		No special healthcare powers of attorney

ing the issue earlier in life, transgender patients will have more time to locate an appropriate person to serve as healthcare proxy.[112]

Given that advance care planning for dementia is a multidisciplinary process that may involve both physical and mental healthcare providers as well as legal staff and community advocates, the multidisciplinary approach of medical-legal partnerships (MLPs) may make them a good laboratory to begin asking these questions. LGBTQ primary care MLPs can provide expertise on potentially health-harming legal needs that arise for LGBTQ patients.[113] It is also important to not overlook faith channels such as chaplains and spiritual care givers in hospice care.[114] At the same time, advance care planning should not be reserved for end-of-life discussions. Advance care planning can

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.

best be thought of as ongoing health planning that can be revisited and revised periodically as circumstances change, including regular check-ins to obtain ongoing consent or assent to the terms of advance directives.[115]

Practices should adapt existing dementia planning tools to include guiding questions about how a transgender person views gender fluidity and whether and how they might want to memorialize those thoughts in an advance directive. This author in consultation with SAGE and Transgender Law Center has developed a tool, summarized in **Table 1**, that presents guiding questions for transgender people to use to help them identify their values around gender identity and dementia, depending on whether a person's gender identity feels more set or more fluid, and clauses that can be included in advance directives.[116]

Limitations

The guiding questions tool mentioned above has not yet been validated by research with transgender people, particularly whether these approaches would be effective interventions for BIPOC transgender people. The disproportionality of subjective cognitive changes among BIPOC transgender people should make these communities the top priority for further research, including effective outreach methods.

There are also ethical questions that need to be explored further in order to further refine the tool. For example, if a transgender person feels strongly that they want their gender identity to be recognized throughout processes of cognitive change, it is unclear how, or even whether, clinicians will be able to honor the patient's wishes if those wishes would prove to be upsetting to the patient when dementia advances.

Though the research base about the physical, mental, and emotional processes of aging among transgender adults is developing, there are significant gaps that could affect the viability of the planning tool. Without greater understanding or protocols about how long transgender people can or should include gender-affirming hormones and/or post-surgical interventions in their routine care, it is hard to know the extent to which those considerations may affect the manner in which new or increased gender fluidity can be affirmed in a patient undergoing cognitive changes.

Conclusion

Transgender people need more research in almost every area of health, but especially in the adaptation of successful interventions to be culturally responsive to transgender people with multiple marginalized identities. While this approach may be the road (thus far) not taken, it may be a more health-sustaining offramp from fear and anxiety for transgender people encountering dementia than the limited options that currently exist.

Acknowledgements

Thank you to Alisa Huffman for assistance with the initial advance directive legal language. Thank you to Dr. Kat Carrick at George Washington University for advising my capstone project, which this manuscript represents in part. Thank you to Lauren Catlett at University of Virginia, Ellen DiPaola at Honoring Choices, Kylie Madhav at SAGE, Jennifer May at Duke University School of Nursing, and Osha Towers at Compassion and Choices for their review and comments. Positionality statement: I am a queer, White, age 50+ transgender man, raised in the deep South in a middle-class family and educated formally in law school and experientially through 25 years of legal practice and policy advocacy. My interest in this topic arose from my personal experience of healthcare discrimination as a transgender person and fear that I could lose my legal capacity to direct my care, and that healthcare providers would not treat me as the gender I know myself to be. My race, gender, class, and education provide me with unearned advantage to cope with those fears. While this project could benefit all transgender and nonbinary people, it is important to emphasize the needs as well as the strengths of intersecting identities such as transgender and nonbinary people who are older and people of color.

Note

The author has no conflicts of interest to disclose. All disclosure fiorms are on file with the Journal.

References

1. S. Butler, "Sexual and Gender Minority Mental Health among Older Adults," in E. Rothblum, ed., *The Oxford Handbook of Sexual and Gender Minority Health* (New York: Oxford University Press, 2021): 245–255, at 254.
2. L. Smith et al., "Investigating the Lived Experience of LGBT People with Dementia and Their Care Partners: A Scoping Review," *Ageing and Society* (epub May 30, 2022): 1–24.
3. US Census Bureau, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060* (2020).
4. J.L. Herman, A.R. Flores, and K.K. O'Neill, The Williams Institute, UCLA School of Law, "How Many Adults and Youth Identify as Transgender in the United States?" (June 2022), *available at* <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf> (last visited September 19, 2024).
5. Movement Advancement Project, Equality Maps: Snapshot: LGBTQ Equality by State, *available at* <https://www.lgbtmap.org/equality-maps/> (last visited September 13, 2024).
6. M. Silverman and A. Baril, "'We Have to Advocate So Hard for Ourselves and Our People': Caring for a Trans or Non-binary Older Adult with Dementia," *LGBTQ+ Family: An Interdisciplinary Journal* 19, no. 3 (2023): 187–210.
7. N.M. Lampe, "Satisficing Death: Ageing and End-of-Life Preparation among Transgender Older Americans," *Sociology of Health and Illness* 46, no. 5 (2024): 887–906.
8. S.E. James, J.L. Herman, L.E. Durso, and R. Heng-Lehtinen, National Center for Transgender Equality, TransLatin@ Coalition, Black Trans Advocacy Coalition, and National Queer Asian Pacific Islander Alliance, "Early Insights: A Report of the 2022 U.S. Transgender Survey" (2024), *available at* <https://transequality.org/sites/default/files/2024-02/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf> (last visited September 19, 2024).
9. S.E. James and G. Magpantay, National Center for Transgender Equality and National Queer Asian Pacific Islander Alliance, "2015 U.S. Transgender Survey: Report on the Experiences of

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.

Asian, Native Hawaiian, and Pacific Islander Respondents" (2017), *available at* <https://transequality.org/sites/default/files/docs/usts/USTS-ANHPI-Report-Dec17.pdf> (last visited September 19, 2024).
10. S.E. James, C. Brown, and I. Wilson, National Center for Transgender Equality, Black Trans Advocacy Coalition, and National Black Justice Coalition, "2015 U.S. Transgender Survey: Report on the Experiences of Black Respondents" (2017), *available at* <https://transequality.org/sites/default/files/docs/usts/USTS-Black-Respondents-Report.pdf> (last visited September 19, 2024).
11. S.E. James and B. Salcedo, National Center for Transgender Equality and TransLatin@ Coalition, "2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents" (2017), *available at* <https://transequality.org/sites/default/files/docs/usts/USTSLatinReport-Nov17.pdf> (last visited September 19, 2024).
12. Merriam Webster Dictionary, Latine definition, *available at* <https://www.merriam-webster.com/dictionary/Latine> (last visited September 13, 2024).
13. S.E. James, T. Jackson, and M. Jim, National Center for Transgender Equality, "2015 U.S. Transgender Survey: Report on the Experiences of American Indian and Alaska Native Respondents" (2017), *available at* <https://transequality.org/sites/default/files/docs/usts/USTS-AIAN-Report-Dec17.pdf> (last visited September 19, 2024).
14. See James et al., *supra* note 8.
15. See James and Magpantay, *supra* note 9; James et al., *supra* note 10; James and Salcedo, *supra* note 11; and James et al., *supra* note 13.
16. H. Pearsall, "Improving the Long-Term Care Landscape for LGBTQ+ Adults through Home- and Community-Based Care Reform," *Drexel Law Review* 15 (2023): 183-225.
17. K.G. Cloyes et al., "Providing Home Hospice Care for LGBTQ+ Patients and Caregivers: Perceptions and Opinions of Hospice Interdisciplinary Care Team Providers," *Palliative and Supportive Care* 21, no. 1 (2022): 1–9.
18. C. Medina, T. Santos, L. Mahowald, and S. Gruberg, Center for American Progress, "Protecting and Advancing Health Care for Transgender Adult Communities," (Aug. 18, 2021), *available at* <https://www.americanprogress.org/article/protecting-advancing-health-care-transgender-adult-communities/> (last visited September 19, 2024).
19. D. Flunker and K.A. Knochel, Minnesota Transgender Aging Project, "Minnesota Transgender Aging Project Community Report: Focus on Providers" (Dec. 2017), *available at* <https://rainbowhealth.org/wp-content/uploads/2021/06/MTAP_2017_PDF_Full_Report.pdf> (last visited September 19, 2024).
20. K.I. Fredriksen-Goldsen, H.J. Kim, A.E. Bryan, C. Shiu, and C.A. Emlet, "The Cascading Effects of Marginalization and Pathways of Resilience in Attaining Good Health among LGBT Older Adults," *The Gerontologist* 57, suppl 1 (2017): S72–S83.
21. A.N. Correro and K.A. Nielsen, "A Review of Minority Stress as a Risk Factor for Cognitive Decline in Lesbian, Gay, Bisexual, and Transgender (LGBT) Elders," *Journal of Gay and Lesbian Mental Health* 24, no. 1 (2020): 2–19.
22. K.I. Fredriksen-Goldsen et al., "Cognitive Impairment, Alzheimer's Disease, and Other Dementias in the Lives of Lesbian, Gay, Bisexual, and Transgender (LGBT) Older Adults and Their Caregivers: Needs and Competencies," *Journal of Applied Gerontology* 37, no. 5 (2018): 545–569.
23. K.I. Fredriksen-Goldsen et al., "Physical and Mental Health of Transgender Older Adults: An At-Risk and Underserved Population," *The Gerontologist* 54, no. 3 (2014): 488–500.
24. N.H. Lambrou et al., "Subjective Cognitive Decline Associated with Discrimination in Medical Settings among Transgender and Nonbinary Older Adults," *International Journal of Environmental Research and Public Health* 19, no. 15 (2022): 9168.
25. Y. Guo et al., "Prevalence of Alzheimer's and Related Dementia Diseases and Risk Factors among Transgender Adults, Florida, 2012–2020," *American Journal of Public Health* 112, no. 5 (2022): 754–757.
26. C.L. Saunders et al., "Demographic Characteristics, Long-Term Health Conditions and Healthcare Experiences of 6333 Trans and Non-Binary Adults in England: Nationally Representative Evidence from the 2021 GP Patient Survey," *BMJ Open* 13 no. 2 (2023): e068099.
27. G.K. Jasuja et al., "Social Stressors and Health among Older Transgender and Gender Diverse Veterans," *LGBT Health* 10, no. 2 (2023): 148–157.
28. M.J. Brown and R. Patterson, "Subjective Cognitive Decline among Sexual and Gender Minorities: Results from a U.S. Population-Based Sample," *Journal of Alzheimer's Disease* 73, no. 2 (2020): 477–487.
29. J.M.W. Hughto et al., "Disparities in Health Condition Diagnoses among Aging Transgender and Cisgender Medicare Beneficiaries, 2008-2017," *Frontiers in Endocrinology* 14 (2023): 1102348.
30. E.C. Cicero et al., "Transgender Adults from Minoritized Ethnoracial Groups in the U.S. Report Greater Subjective Cognitive Decline," *The Journals of Gerontology: Series B* 78, no. 6 (2023): 1051–1059.
31. J.D. Flatt and E.C. Cicero, "Advancing Equity in Alzheimer's Disease and Mental Health Research for LGBTQIA+ Older Adults," *Nature Mental Health* 1 (2023): 385–387.
32. E.A. Scharaga, A. Chang, and J.F. Kulas, "What Happens When We Forget Our Own Narrative: Transgender Dementia Case Study," *The Clinical Neuropsychologist* 35, no. 8 (2021): 1485–1497.
33. See Silverman and Baril, *supra* note 6.
34. N. Henriquez, K. Hyndman, and K. Chachula, "It's Complicated: Improving Undergraduate Nursing Students' Understanding Family and Care of LGBTQ Older Adults," *Journal of Family Nursing* 25, no. 4 (2019): 506–532.
35. A. Baril and M. Silverman, "'We're Still Alive, Much to Everyone's Surprise': The Experience of Trans Older Adults Living with Dementia in an Ageist, Cisgenderist, and Cogniticist Society," *Journal of Aging Studies* 68 (2024): 101208.
36. W. Hulko, "LGBT* Individuals and Dementia: An Intersectional Approach," in S. Westwood and E. Price, eds., *Lesbian, Gay, Bisexual and Trans* Individuals Living with Dementia* (New York: Routledge, 2016): 35–50, at 47.
37. P.B. Adkins-Jackson et al., "The Structural and Social Determinants of Alzheimer's Disease and Related Dementias," *Alzheimer's & Dementia* 19 (2023): 3171–3185.
38. M.M. Mielke et al., "Consideration of Sex and Gender in Alzheimer's Disease and Related Disorders from a Global Perspective," *Alzheimer's & Dementia* 18, no. 12 (2022): 2707–2724.
39. S. Fazio et al., "Alzheimer's Association Dementia Care Practice Recommendations," *The Gerontologist* 58, no. S1 (2018): S1–S9, at S2.
40. S. Fazio et al., "The Fundamentals of Person-Centered Care for Individuals with Dementia," *The Gerontologist* 58, no. S1 (2018): S10–S19, at S12.
41. C. Hunter, J. Bishop, and S. Westwood, "The Complexity of Trans*/Gender Identities: Implications for Dementia Care," in S. Westwood and E. Price, eds., *Lesbian, Gay, Bisexual and Trans* Individuals Living with Dementia* (New York: Routledge, 2016): 124–137, at 129.
42. A. Baril and M. Silverman, "Forgotten Lives: Trans Older Adults Living with Dementia at the Intersection of Cisgenderism, Ableism/Cogniticism and Ageism," *Sexualities* 25, nos. 1–2 (2022): 117–131, at 122–123.
43. J. Marshall, M. Cooper, and A. Rudnick, "Gender Dysphoria and Dementia: A Case Report," *Journal of Gay & Lesbian Mental Health* 19, no. 1 (2015): 112–117.
44. See Baril and Silverman, *supra* note 42.
45. T.M. Witten, "Trans* People Anticipating Dementia Care: Findings from the Transgender MetLife Survey," in S. West-

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.

wood and E. Price, eds., *Lesbian, Gay, Bisexual and Trans* Individuals Living with Dementia* (New York: Routledge, 2016): 110–123, at 113.
46. See Baril and Silverman, *supra* note 42, at 121–122.
47. *Id.*
48. See Lambrou et al., *supra* note 24.
49. G. Stein et al., "Experiences of Lesbian, Gay, Bisexual, and Transgender Patients and Families in Hospice and Palliative Care: Perspectives of the Palliative Care Team," *Journal of Palliative Medicine* 23, no. 6 (2020): 817–-824.
50. R.V. Walker, S.M. Powers, and T.M. Witten, "Transgender and Gender Diverse People's Fear of Seeking and Receiving Care in Later Life: A Multiple Method Analysis," *Journal of Homosexuality* 70, no. 14 (2023): 3374–3398.
51. E. Fink-Samnick, "End of Life Care's Ongoing Evolution," *Professional Case Management* 25, no. 3 (2020): 111–131.
52. See Silverman and Baril, *supra* note 6.
53. See Baril and Silverman, *supra* note 35.
54. P. Willis et al., "'I'm Going to Live My Life for Me': Trans Ageing, Care, and Older Trans and Gender Non-Conforming Adults' Expectations of and Concerns for Later Life," *Ageing and Society* 41, no. 12 (2021): 2792–2813.
55. See Baril and Silverman, *supra* note 35, at 7.
56. C. Campbell et al., "Transgender Think Tank: Recommendations on End-of-Life Care for Transgender Elders" (2023), at 8, *available at* <https://transhealth.org/wp-content/uploads/2023/04/Transgender-Elders-Action-Brief.pdf> (last visited September 13, 2024).
57. L. Lintott et al., "A Rapid Review of End-of-Life Needs in the LGBTQ+ Community and Recommendations for Clinicians," *Palliative Medicine* 36, no. 4 (2022): 609-624.
58. See Fredriksen-Goldsen et al., *supra* note 23.
59. V.D. Fabbre and E. Gaveras, "The Manifestation of Multilevel Stigma in the Lived Experiences of Transgender and Gender Nonconforming Older Adults," *American Journal of Orthopsychiatry* 90, no. 3 (2020): 350–360.
60. See Fredriksen-Goldsen et al., *supra* note 22.
61. M. Adan et al., "Worry and Wisdom: A Qualitative Study of Transgender Elders' Perspectives on Aging," *Transgender Health* 6, no. 6 (2021): 332-342.
62. S.M. Benbow, C. Eost-Telling, and P. Kingston, "A Narrative Review of Literature on the Use of Health and Social Care by Older Trans Adults: What Can United Kingdom Services Learn?" *Ageing & Society* 42, no. 10 (2022): 2262–2283.
63. See Walker et al., *supra* note 50.
64. R.V. Walker, S.M. Powers, and T.M. Witten, "Impact of Anticipated Bias from Healthcare Professionals on Perceived Successful Aging Among Transgender and Gender Nonconforming Older Adults," *LGBT Health* 4, no. 6 (2017): 427–433.
65. R.S. Henry et al., "Transgender and Gender Non-Conforming Adult Preparedness for Aging: Concerns for Aging, and Familiarity with and Engagement in Planning Behaviors," *International Journal of Transgender Health* 21, no. 1 (2020): 58–69.
66. K.A. Knochel and J. Flunker, "Long-Term Care Expectations and Plans of Transgender and Nonbinary Older Adults," *Journal of Applied Gerontology* 40, no. 11 (2021): 1542–1550, at 1545.
67. S. Sloan and J.J. Benson, "Toward a Conceptual Model for Successful Transgender Aging," *Qualitative Social Work* 21, no. 2 (2022): 455–471.
68. T.M. Witten, "End of Life, Chronic Illness, and Trans-Identities," *Journal of Social Work in End-of-Life & Palliative Care* 10, no. 1 (2014): 34–58.
69. K. Kortes-Miller et al., "Dying in Long-Term Care: Perspectives from Sexual and Gender Minority Older Adults about Their Fears and Hopes for End of Life," *Journal of Social Work in End-of-Life & Palliative Care* 14, nos. 2-3 (2018): 209–224, at 216.
70. See Flunker and Knochel, *supra* note 19.
71. See Fabbre and Gaveras, *supra* note 59, at 357.
72. See Knochel and Flunker, *supra* note 66.
73. See, e.g., AARP, Advance Directive Forms by State, *available at* <https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/> (last visited September 13, 2024).
74. Compassion and Choices, Dementia Values and Priorities Tool, *available at* <https://www.pathlms.com/compassion-and-choices/courses/46982> (last visited September 13, 2024).
75. See, e.g., American Bar Association, Recent Updates to Default Surrogate Statutes, *available at* <https://www.americanbar.org/groups/law_aging/publications/bifocal/vol44/bifocal-vol-44-issue3/recent-updates-to-default-surrogate-statutes/> (last visited September 13, 2024).
76. K. Johnson et al., "Gay and Gray Session: An Interdisciplinary Approach to Transgender Aging," *The American Journal of Geriatric Psychiatry* 26, no. 7 (2018): 719–738.
77. J. Lowers, "End-of-Life Care Planning for Lesbian, Gay, Bisexual, and Transgender Individuals," *Journal of Hospice & Palliative Nursing* 19, no. 6 (2017): 526–533, at 529.
78. C. Barrett et al., "Understanding the Experiences and Needs of Lesbian, Gay, Bisexual and Trans Australians Living with Dementia, and Their Partners," *Australasian Journal on Ageing* 34, suppl. 2 (2015): 34–38, at 36.
79. S.M. Benbow and P. Kingston, "Older Trans Individuals' Experiences of Health and Social Care and the Views of Healthcare and Social Care Practitioners: 'They Hadn't a Clue,'" *Educational Gerontology* 4, no. 4 (2022): 160–173, at 167.
80. S. Steadman, "It's Still Me: Safeguarding Vulnerable Transgender Elders," *Yale Journal of Law & Feminism* 30, no. 2 (2018): 371–399.
81. N.J. Knauer, "LGBT* Individuals Living with Dementia: Rights and Capacity Issues in the United States," in S. Westwood and E. Price, eds., *Lesbian, Gay, Bisexual and Trans* Individuals Living with Dementia* (New York: Routledge, 2016): 174–189, at 183.
82. See Campbell et al., *supra* note 56.
83. N.M. Javier, "Palliative Care Needs, Concerns, and Affirmative Strategies for the LGBTQ Population," *Palliative Care and Social Practice* 15 (2021): 26323524211039234.
84. K.N. Yadav et al., "Approximately One in Three US Adults Completes Any Type of Advance Directive for End-of-Life Care," *Health Affairs* 36, no. 7 (2017): 1244–1251.
85. C. Koss and R. Hensley, "Race and Educational Disparities in Advance Directive Completion: Encouraging Trends in the United States," *Innovation in Aging* 4, supp. 1 (2020): 331.
86. L. Catlett and C. Campbell, "Advance Care Planning and End of Life Care Literacy Initiatives in African American Faith Communities: A Systematic Integrative Review," *American Journal of Hospice and Palliative Medicine* 38, no. 6 (2021): 719–730.
87. A.J. Reich, S. Perez, and J. Fleming, "Advance Care Planning Experiences Among Sexual and Gender Minority People," *JAMA Network Open* 5, no. 7 (2022): e2222993.
88. See Witten, *supra* note 68.
89. L. Dickson et al. "Appointment of a Healthcare Power of Attorney Among Older Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Adults in the Southern United States," *American Journal of Hospice and Palliative Medicine* 38, no. 11 (2021): 1291–1298.
90. C. Pang, G. Gutman, and B. de Vries, "Later Life Care Planning and Concerns of Transgender Older Adults in Canada," *The International Journal of Aging and Human Development* 89, no. 1 (2019): 39–56, at 50.
91. L. Catlett et al., "End-of-Life Care for Transgender Older Adults," *Global Qualitative Nursing Research* 10 (2023): 23333936231161128, at 6.
92. B. de Vries et al., "End-of-Life Preparations Among LGBT Older Canadian Adults: The Missing Conversations," *The International Journal of Aging and Human Development* 88, no. 4 (2019): 358–379.
93. See Lampe, *supra* note 7.
94. See Lowers, *supra* note 77.

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

95. S.B. Whitestone and D. Linz, "End-of-Life Topic Avoidance Among Gender-Diverse Young Adults: The Importance of Normalizing Gender-Affirming End-of-Life Conversations," *Human Communication Research* 49, no. 2 (2023): 127–138.
96. *Id.*
97. *Id.*
98. N.M. Lampe et al., "Health Disparities Among Lesbian, Gay, Bisexual, Transgender, and Queer Older Adults: A Structural Competency Approach," *International Journal of Aging and Human Development* 98, no. 1 (2024): 39–55.
99. A.J. Reich et al., "Use of Advance Care Planning Codes Among Transgender Medicare Beneficiaries," *LGBT Health* 9, no. 7 (2022): 520–524.
100. L. Catlett, "Healthcare Needs and Assets of Gender Diverse Older Adults: A Systematic Integrative Review," *Journal of Nursing Scholarship* 56, no. 1 (2024): 119–141.
101. See Reich et al., *supra* note 99.
102. See Lampe et al., *supra* note 98.
103. Medicare Learning Network: *Advance Care Planning Fact Sheet* (Feb. 2023).
104. Centers for Medicare and Medicaid Services, *Medicare Claims Processing Manual: Chapter 4, Part B Hospital*, § 200.11 "Billing Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)," *available at* <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf> (last visited September 13, 2024).
105. See Witten, *supra* note 45, at 117.
106. A. Baril et al., "Forgotten Wishes: End-of-Life Documents for Trans People with Dementia at the Margins of Legal Change," *Canadian Journal of Law and Society* 35, no. 2 (2020): 367–390.
107. See Baril and Silverman, *supra* note 42, at 126–127.
108. M. Silverman and A. Baril, "Transing Dementia: Rethinking Compulsory Biographical Continuity through the Theorization of Cisism and Cisnormativity," *Journal of Aging Studies* 58 (2021): 100956.
109. See A.E. Radix et al., "Gender-Affirming Care for Older Transgender and Gender-Diverse Adults," *Clinics in Geriatric Medicine* 40, no. 2 (2024): 261–271 (stopping hormones after gonadectomy can result in bone loss and requires close monitoring).
110. R.M. Gamble et al., "Trans-Specific Geriatric Health Assessment: An Inclusive Clinical Guideline for the Geriatric Transgender Patient in a Primary Care Setting," *Maturitas* 130 (2020): 70–75.
111. T.M. Witten, "It's Not All Darkness: Robustness, Resilience, and Successful Transgender Aging," *LGBT Health* 1, no. 1 (2014): 24–33.
112. See Lowers, *supra* note 77.
113. M. Regenstein et al., "Addressing Social Determinants of Health through Medical-Legal Partnerships," *Health Affairs* 37, no. 3 (2018): 378–385.
114. C.L. Campbell and L. Catlett, "Silent Illumination: A Case Study Exploring the Spiritual Needs of a Transgender-Identified Elder Receiving Hospice Care," *Journal of Hospice & Palliative Nursing* 21, no. 6 (2019): 467–474.
115. See Baril et al., *supra* note 106.
116. A. Simmons, K. Madhav, and A. Ortiz, Transgender Law Center, "Planning for Lifelong Care: Guiding Questions for Transgender and Non-Binary People to Plan for Dementia and Other Serious Illness" (2023), *available at* <https://lgbtagingcenter.org/library/item/planning-for-lifelong-care-guiding-questions-for-transgender-non-binary-people-to-plan-for-dementia-and-other-serious-illness/> (last visited September 19, 2024).

The Journal of Law, Medicine & Ethics, 52 (2024): 704-716.