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Emergency care of LGBTQIA+ patients requires more than understanding the acronym

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CONCEPT PAPER

Emergency care of LGBTQIA+ patients requires more than understanding the acronym

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Abstract

Emergency physicians (EPs) frequently deliver care to members of the LGBTQIA+ community in the emergency department. This community suffers from many health disparities important to understand as part of comprehensive care, and these disparities are infrequently discussed in emergency medicine education. Previous data also suggest a need for broader education to increase the comfort of EPs caring for LGBTQIA+ patients. A group of content experts identified key disparities, opportunities for expanded education, and strategies for more inclusive care of LGBTQIA+ patients.

INTRODUCTION

Emergency physicians (EPs) encounter patients who identify as LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/a-romantic, and others) regularly in the emergency department (ED). The LGBTQIA+ community often suffers from inadequate health care and disparities in the population, and there is little formal training for physicians about the health care issues of this population. The complex intersection of gender, sexuality, and culture impacts patients' health and is important for EPs to understand to provide competent and sensitive care for LGBTQIA+ patients.

In 2012, the Department of Health and Human Services' Healthy People 2020 recognized the significant disparities in the treatment of the LGBTQIA+ community and prioritized research and efforts to minimize these disparities.[1] These disparities are complex and are rooted in the longstanding stigma, discrimination, and inequity faced by members of the community. This community of sexual minorities is multiplex, requiring health care professionals to deconstruct biological sex, sexual orientation, gender identity, and

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gender expression. Additionally, the intersectionality between sexual minority status (i.e., nonheterosexual and noncisgender) and other drivers of inequity like race, socioeconomic status, disability, and language accentuate these disparities.[2] Few areas of disparities have been explored. The paucity of research opens opportunities for future investigation.

Tobacco, alcohol, and drug use are more common in sexual minority groups, leading to increased risk of the long-term consequences of these substances.[1,3] Lesbian and bisexual women have high rates of obesity and elevated body mass, which increases their cardiovascular risk.[1,4] Furthermore, sexual minority women are less likely to engage in routine cancer screening. Some studies have suggested a higher risk of fatal breast cancer.[1,5] All sexual minority groups have higher rates of mental health disorders, with notably higher rates of suicide in LGBTQIA+ youth.[1,6] The minority stress model suggests that additional external stressors on a marginalized population contribute to poorer mental health. These additional stressors include stigma, discrimination, and victimization. They are unique to this population, chronic with repeat occurrences, and socially based.[7] Gay men and transgender women have high risks of STI and HIV infection.[1] Transgender persons, especially as adolescents, are less likely to be insured but more likely to be homeless.[1,2,8]

METHODOLOGY

This manuscript was developed by the LGBTQ+ committee of the Academy for Diversity and Inclusion in Emergency Medicine (ADIEM). The committee had identified continued dissemination of educational topics related to the LGBTQIA+ community as an objective within the academy. The writing group developed from those present at the national meeting and solicitation of additional authors by email. Through discussion and a structured review of the literature, committee members identified potential knowledge gaps of EPs in a general understanding of the LGBTQIA+ community, the disparities experienced by LGBTQIA+ patients, and the opportunities to enhance the care of these patients in the ED. The committee divided the work into two manuscripts, of which this is the second addressing disparities and care in the ED.

Current state of knowledge on the LGBTQIA+ community

Formal education on the care of LGBTQIA+ persons is inadequate at both the undergraduate medical education level (median 5 h of curriculum) and EM residency level (median 2 h per academic year).[9-11] A survey of EM residents reported that 24.6% found it challenging to do a history and physical on LGB patients, and 42.6% on transgender patients.[12] In that same survey, 6% of residents did not agree that LGBTQIA+ patients deserve the same quality of care as heterosexual counterparts. Inclusive care is essential as lesbian, gay, and bisexual persons use the ED more often than heterosexual counterparts.[13] Additionally, many LGBTQIA+ persons have suffered harassment, bullying, and physical and sexual assault, which emphasizes the importance of trauma-informed ED care.[2] Previous negative ED experiences and fear of discrimination by transgender patients leads to 43.8% avoiding EDs even when acute care is needed.[14] These data are not surprising as 82.5% of surveyed EPs reported no formal training in the care of transgender and gender-nonconforming patients. This lack of education likely further contributes to these disparities.[15]

Considerations for emergency care of LGBTQIA+ individuals

Implicit (and explicit) bias in medical providers

Frequently, implicit (unconscious) and explicit (intentional) biases affect how we, as health care providers, speak and behave both in the clinical and in the academic arenas of our profession. These biases can lead to inequitable care, either through biased clinical decisions or through communicating bias in conversation with patients. It is known that both implicit and explicit bias are exacerbated when interacting with sexual and gender minorities.[16,17] It is also important to note that these experiences are not limited to the patients. Health care practitioners (including medical students, residents, and faculty physicians) have reported higher incidents of workplace bias and discrimination based on their LGBTQIA+ identity.[18-20]

Individual interventions can be powerful in counteracting bias. The following suggestions are a nonexhaustive list:

- Introductions to patients can begin with “Can you tell me your name?”
- “How would you like to be addressed?”
- “Who do you have with you today?”
- Gender-neutral language should be used whenever possible (e.g., “partner/spouse” rather than “wife/husband”).
- The new neutral “their” pronoun when pronoun preferences are not known.

Signaling allyship can be as simple as wearing stickers or pins of the LGBTQIA+ rainbow flag and listing pronouns on name badges. Finally, team members should feel empowered to remind the care team about a patient's chosen name and pronouns to prevent misgendering situations where a patient repeatedly has to “come out” during an encounter.

The electronic health record

Electronic health records (EHRs) are not uniform. They vary in their ability to gather and display information on sexual orientation and gender identity (SOGI). In 2018, Epic (Verona, WI) was the first EHR to store pronouns and chosen names in patient charts.

Epic also included the capability to perform an organ inventory. However, keeping these fields up to date requires consistent and accurate intake processes where patients are asked SOGI questions. Additionally, EHRs can unintentionally misgender patients when macros and similar functions built into an EHR assume cisgender pronouns consonant with sex assigned at birth rather than self-identified pronouns. Sometimes, the chart is programmed to pull in names associated with a patient's insurance documentation, which may or may not display chosen names.[21] Asking for a patient's chosen name and which pronouns they use at the beginning of each encounter ensures the most up-to-date information and creates a more welcoming and inclusive encounter. Collaborate with triage and registration staff to change a patient's identifiers in the EHR when possible to match their identities. Review notes to ensure "macros" and "dot phrases" do not use the wrong pronouns for the patient. When writing one-liners, it is helpful to include a patient's chosen name and pronouns to orient the reader, especially if EHRs display conflicting information: "*Chosen Name (pronouns) is a X-year-old *gender* presenting with ….*" This becomes even more important as patients now have open electronic access to clinical notes per the 21st Century Cures Act.

Missed screening opportunities happen when EHRs use binary sex and gender classifications for automated health care maintenance reminders. For example, if a transgender woman who has a prostate is identified as female in the EHR, they may not receive appropriate PSA reminders. For this reason, EHRs that collect and display SOGI data should additionally offer the ability to perform an organ inventory for the purpose of health care maintenance. Exogenous hormone treatments must also be included. There are significant effects of sex and sex steroid hormones on physiological processes, susceptibility to infections, and pharmacokinetics.

Structural or institutional change

Large health organizations are policy driven, thus having inclusive policies that help patients feel welcomed is critical in effecting change. The minimum standard includes LGBTQIA+ representation in the development and implementation of systemwide policies and practice guidelines.[22]

One of the most critical actions for the next several years is inclusivity of nonbinary staff and patients and making sure that our hiring practices reflect our values as a specialty, supporting nonbinary or gender-fluid persons. Patient forms with patient identifiers should include fields for chosen name and pronouns, via a two-step process for collecting sex and gender identity information.[23] Forms collecting sexual orientation information should offer a broad range of identities and not be limited to lesbian, gay, or bisexual. In general, forms should use gender-neutral terminology. Other ways to create a safe and inclusive environment include widespread signage that explicitly welcomes LGBTQIA+ patients (including rainbows) and inclusion of LGBTQIA+ patients and partners in a hospital's patient bill of rights. Gender-neutral bathrooms must be ubiquitous, accessible, and available to all patients, staff, and students.

The hospital and department's nondiscrimination policies for patients and staff needs to be continually updated considering the rapidly changing LGBTQIA+ vernacular. Policies should be transparent, with accessible mechanisms to report discrimination or unequal treatment. Policy should ensure that partners of queer patients are guaranteed equal visitations; a broader definition of "family" will help ensure that our patients have the support persons they need. Equally important is continual feedback from LGBTQIA+ content experts in emergency medicine. Mandatory implicit bias and/or diversity and inclusion training for staff and students must consider evolving LGBTQIA+ issues.

Education

The AAMC has provided an undergraduate medical education resource to assist medical schools in LGBTQIA+ health education curricular change. Some institutions have adopted lectures to address this educational gap.[24] While didactic lectures have been shown to increase students' knowledge on LGBTQIA+ health and health disparities,[24] a multimodal longitudinal educational approach would likely be even more beneficial. Not only by increasing knowledge but also by increasing physician comfort in providing quality care for LGBTQIA+ patients. Case-based education has been shown to be a successful model for teaching LGBTQIA+ health education to medical students. Yang[25] demonstrated that effective cases link theory to clinical practice. Storytelling by LGBTQIA+ individuals is effective, and discussion promotes the effectiveness of case-based teaching. Educational programs should include, at minimum, a basic understanding of SOGI and how to take a comprehensive sexual health history.[26]

A critical component to improving LGBTQIA+ education would be training faculty. Current faculty likely have received minimal to no formal education and training in this area.[27] An educated faculty cohort can continue to educate students and residents. Education and training must extend beyond the physician to include nursing staff, ancillary personnel, and administrative personnel. Creating partnerships and connecting with LGBTQIA+ individuals and community organizations can also be highly valuable. Community organizations may have individuals who are willing to share their stories to help educate ED staff. Robust educational programming for all caregivers will improve LGBTQIA+ patients' outcomes.

Biases and microaggressions toward LGBTQIA+ individuals have several untoward effects on mental and physical health.[28-30] Unfortunately, many LGBTQIA+ persons experience bias and microaggression on a daily basis. Awareness of one's own bias and resultant microaggressions through education is the first step to mitigating such microaggressions. The sexuality Implicit Association Test (IAT) measures antigay bias. It has been used in medical education as a needs assessment or pretest prior to an educational intervention.[31] The IAT measures attitudes and beliefs that people may

be unwilling or unable to report. An individual may gain insight about biases of which the individual was previously unaware.[32] The IAT may highlight the degree of bias in a work unit and need for implicit bias education.

Implications for education and training in EM

Recognition of the health care disparities faced by LGBTQIA+ patients is important for EPs to provide high-quality care to patients in the ED. The incorporation of education on these biases into emergency medicine education and training will contribute to improved and informed care and hopefully mitigation of the biases over time. Understanding about the LGBTQIA+ community through robust educational efforts will help decrease implicit and explicit biases held by EPs. As more EPs are educated, they can lead institutional changes to promote inclusive EHRs, facilities, and health care teams. Inclusive changes are needed to ensure welcoming care and begin to break down existing barriers, minimize disparities, and improve outcomes.

CONFLICT OF INTEREST

The authors have no potential conflicts to disclose.

AUTHOR CONTRIBUTIONS

All authors contributed to the concept, drafting and editing of the manuscript.

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