Title
Block by block: Building on our knowledge to better care for LGBTQIA+ patients

Journal
AEM Education and Training, 6(Suppl 1)

ISSN
2472-5390

Authors
Driver, Lachlan
Egan, Daniel J
Hsiang, Elaine
et al.

Publication Date
2022-06-01

DOI
10.1002/aet2.10755

PennState Health
Emergency Medicine
Residency Program Director

Penn State Health Milton S. Hershey Medical Center is seeking an Emergency Medicine Residency Program Director to join our exceptional academic team located in Hershey, PA. This is an excellent opportunity to join an outstanding academic program with a national reputation and inpact the lives of our future Emergency Medicine physicians.

What We're Offering:

- Competitive salary and benefits
- Sign-On Bonus
- Relocation Assistance
- Leadership for Emergency Medicine Residency Program
- Comprehensive benefit and retirement options

What We're Seeking:

- MD, DO, or foreign equivalent
- BC/BE by ABEM or ABOEM
- Leadership experience
- Outstanding patient care qualities
- Ability to work collaboratively within a diverse academic and clinical environment

FOR MORE INFORMATION PLEASE CONTACT:

Heather Peffley, PHR CPRP
Physician Recruiter
Penn State Health

Email: hpeffley@pennstatehealth.psu.edu
Website: careers.pennstatehealth.org

What the Area Offers:

Located in a safe family-friendly setting, Hershey, PA, our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Known as the home of the Hershey chocolate bar, Hershey's community is rich in history and offers an abundant range of outdoor activities, arts, and diverse experiences. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

Received: 6 October 2021 | Revised: 4 February 2022 | Accepted: 15 February 2022

DOI: 10.1002/aet2.10755

CONCEPT PAPER (SPECIAL ISSUE ONLY)

Block by block: Building on our knowledge to better care for LGBTQIA+ patients

Lachlan Driver MD[1] | Daniel J. Egan MD[1] | Elaine Hsiang MD[2] | Michelle D. Lall MD, MHS[3] | Joel Moll MD[4] | Amanda M. Ritchie MD[5] | Brandon J. Sonn PhD, MS[6] | Vicken Y. Totten MD, MS[7] | Dustin B. Williams MD[8] | Alyson J. McGregor MD, MA[9]

[1]Department of Emergency Medicine, Harvard Affiliated Emergency Medicine Residency, Mass General Brigham, Boston, Massachusetts, USA

[2]Department of Emergency Medicine, University of California, San Francisco, California, USA

[3]Department of Emergency Medicine, Emory University School of Medicine, Atlanta, Georgia, USA

[4]Department of Emergency Medicine, VCU School of Medicine, VCU Health, Richmond, Virginia, USA

[5]Departments of Emergency Medicine and Internal Medicine, Louisiana State University, New Orleans, Louisiana, USA

[6]Department of Emergency Medicine, University of Colorado Anschutz Medical Campus, Aurora, Colorado, USA

[7]Emergency Medicine, Kaweah Delta Health Systems, Visalia, California, USA

[8]Department of Emergency Medicine, UT-Southwestern Medical Center, Dallas, Texas, USA

[9]Department of Emergency Medicine, Division of Sex and Gender in Emergency Medicine, Warren Alpert Medical School of Brown University, Providence, Rhode Island, USA

Correspondence
Lachlan Driver, Department of Emergency Medicine, Harvard Affiliated Emergency Medicine Residency, Mass General Brigham, Boston, MA 02199, USA.
Email: lachlandriver2@gmail.com

Abstract

Background: Emergency physicians need to recognize the diversity of identities held by sexual and gender minorities, as well as the health implications and inequities experienced by these communities. Identities such as lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, aromantic, and many others fall under the LGBTQIA+ acronym. This wide spectrum is seldom discussed in emergency medicine but nonetheless impacts both patient care and patient experience in acute and critical care settings.

Aims: This commentary aims to provide a brief but nonexhaustive review of LGBTQIA+ identities and supply a critical framework for applying this understanding to patient encounters in the emergency department, as well as describe the challenges and educational aims at the level of medical school, residency, and postresidency.

Materials and Methods: The commonly used and widely accepted definitions of LGBTQIA+ terms are described, as well as implications for patient care and emergency physician education. The authors of this writing group represent the Society for Academic Emergency Medicine, LGBTQ Task Force of the Academy of Diversity Inclusion in Medicine.

Results: LGB terms are addressed, with LGBTQIA+ adding "intersex," "asexual," and "+," to include other gender identities and sexual orientations which are not already included. This paper also addresses the terms "transition," "nonbinary," "polyamorous." "two-spirit," "queer," and others. These acronyms and terms continually expand and evolve in the pursuit of inclusivity. Additionally, with some health issues potentially related to medications, hormones, surgery, or to internal or external genitalia, important EM physician tools include gathering an "organ inventory," asking about sexual history, and conducting a physical exam.

Discussion: Most persons have congruent biological sex, gender identity, and attraction to the "opposite" gender. However, humans can have every imaginable variation and configuration of chromosomes, genitalia, gender identities, sexual attractions, and

Special Issue: Proceedings from the SAEM 2021 Annual Meeting.

Supervising Editor: Dr. Susan Promes

sexual behaviors. Terms and definitions are constantly changing and adapting; they may also vary by local culture. Obtaining relevant medical history, conducting an "organ inventory," asking about sexual history in a nonjudgmental way, and conducting a physical exam when warranted can all be important in delivering best possible medical care. Although there has been increased focus on education at the medical school, residency, and faculty level on LGBTQIA+ patient care in the ED, much work remains to be done.

Conclusion: Emergency physicians should feel confident in providing a model of care that affirms the sexual and gender identities of all the patient populations we serve. Optimal patient-centric care requires a deeper understanding of the patient's biology, gender identity, and sexual behavior encapsulated into the ever-growing acronym LGBTQIA+.

INTRODUCTION

Emergency physicians need to recognize the diversity of identities held by sexual and gender minorities as well as the health implications and inequities experienced by these communities. Identities such as lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, aromantic, and many others fall under the LGBTQIA+ acronym. This wide spectrum is seldom discussed in emergency medicine but nonetheless impacts both patient care and patient experience in acute and critical care settings. These individuals may therefore frequently fail to access needed care and in general have worse health outcomes.[1-5] Additionally, while many physicians understand the nuances of the LGBTQIA+ acronym, there is likely a large variation in levels of knowledge complicated by a rapidly changing vernacular over time. This commentary will provide a brief but nonexhaustive review of LGBTQIA+ identities and supply a critical framework for applying this understanding to patient encounters in the emergency department (ED). The authors of this writing group represent the Society for Academic Emergency Medicine, LGBTQ Task Force of the Academy for Diversity & Inclusion in Emergency Medicine (ADIEM).

Basic concepts

Biological sex (sometimes referred as genetic gender or genotype) refers to the sex chromosomal complement: male (XY) and female (XX) along with variants that range from XO to multiple Xs and multiple Ys. There are no viable humans who do not have at least one X. Most infants are born with obvious external genitalia; however, sometimes genitalia can be ambiguous. In those cases, gender is usually assigned based on chromosomes. Assigned female at birth (AFAB) and assigned male at birth (AMAB) are terms used in describing biological sex and its gender counterpart, with their corresponding pronouns.

Sexual orientation describes personal sexual interest, while gender identity includes a person's place and role in their family and culture. The Human Rights Campaign describes sexual orientation as: "An inherent or immutable enduring emotional, romantic or sexual attraction to other people […] independent of their gender identity," whereas gender identity is "One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves."[6] Cultural roles and norms contribute to gender-specific social expectations, which can significantly impact health and disease. The terminology addressed in this paper is ultimately derived from the nuanced history of the LGBTQIA+ community, with some of the vernacular formerly used in a disparaging manner now being reclaimed by the community, though much terminology remains offensive and should never be used.[7]

Most persons have congruent biological sex, gender identity, and attraction to the "opposite" gender. This constellation and alignment are called "heteronormative." However, humans can have every imaginable variation and configuration of chromosomes, genitalia, gender identities, sexual attractions, and sexual behaviors. Terms and definitions, especially in the nonheteronormative world, are constantly changing and adapting and may vary by local culture.

"Gender-nonconforming" is sometimes used as an umbrella term for gender expression that does not conform to traditional gender norms. The term "nonbinary" is also used for these individuals with gender identities outside of, or between, the man–woman binary.

Block by block: building on our knowledge

The following definitions of terms are derived as a summary from the Merriam-Webster dictionary, as well as being commonly used and widely accepted.[8]

L is for lesbian

A "lesbian" is a person whose gender identity is "woman" and who is sexually and/or romantically oriented toward other individuals who identify as women. This includes AMAB individuals who identify as women who are sexually or romantically attracted to other women.

G is for gay

"Gay," like many terms, has a specific and a more universal meaning. It traditionally refers to a person whose gender identity is man and is sexually and/or romantically attracted toward other men. It has grown to encompass women who are sexually or romantically oriented to other women and nonbinary individuals who do not identify with heteronormative sex and gender roles or relationships.

B is for bisexual

A "bisexual" person is sexually or romantically interested in people regardless of gender, occasionally used interchangeably with pansexual. Bisexual and pansexual individuals can be attracted in varying degrees to different genders. The term LGB has added letters since its inception in the 1990s, as the nomenclature incorporates more human variation.

T is for transgender

A "transgender" person is someone whose biological sex and gender identity are discordant. In other words, these are individuals whose gender identities and/or gender roles do not conform to their sex assigned at birth (AFAB or AMAB). Such persons were formerly referred to as "transsexual." Gender differs from physiological sex traits and is not defined by external genitalia. Rather, gender is a cultural and individual construct of one's own identity.

"Transmasculine" is an umbrella term for transgender people (generally ones who were AFAB), who express themselves in a masculine way, including transgender men, but can include nonbinary individuals. "Transfeminine" is an umbrella term for transgender people (generally ones who were AMAB), who express themselves in a feminine way, including transgender women, but can include nonbinary individuals.

Recent estimates report that 1.4 million or more individuals in the United States identify as transgender, accounting for around 0.6%–2.7% of the population.[1,9] However, the true number is likely to be higher, due to both limited data and the social stigma causing "closeting." There is significant variation in studies estimating the transgender population due to difference in definition, geography, and small sample sizes.[10,11]

N is for nonbinary (also known as NB or Enby)

Out of all the LGBTQIA+ individuals in the United States, 11% identify as nonbinary, and many of these individuals also consider themselves to fall under the transgender umbrella.[12] A large percentage of these persons are in young adulthood, with 76% being between the ages of 18 and 29.[12] Nonbinary individuals are usually born with bodies that may fit typical definitions of male or female, but their innate gender identity is something other than exclusively man or woman. These individuals may identify as both, as being in-between genders, or as outside the gender spectrum—not having a gender identity at all.

Some individuals who are transgender also use "queer" or "genderqueer" to describe their gender identity and may see themselves outside of, or in-between, the gender binary or may simply feel restricted by gender labels. Queer/genderqueer/nonbinary individuals often use gender-neutral pronouns, such as "they/them/their" or the neopronouns "ze/hir" or "ze/zir." Some people use multiple terms or use them interchangeably and prior to labeling a patient, the emergency physician should ask which pronouns the patient uses.

T is also for transition

The word "transition" refers to one or more processes that transgender or other gender-nonconforming individuals undergo to align themselves more closely with their gender identity. Possibilities include social, hormonal, and/or surgical transitions. Any one transgender individual may undergo any, all, or none of these. It is a misconception that transitioning is either required or linear. Social transition can include changing one's name, style of dressing, and pronouns. Frequently these elements of a transition are done to feel more comfortable in one's body, to align internal identity more closely to external presentation, to experience gender euphoria, and/or simply to decrease gender dysphoria.[13] It should be noted that infrequently transgender individuals who pursue gender affirmation, or transition, subsequently "detransition"—reverting to living as their sex assigned at birth.[14,15] Specifically, Turban et al.[14] found in a 2021 study that of 17,151 transgender and gender-nonconforming participants who pursued gender affirmation, only 13.1% reported a history of detransition, with 82.5% of those detransitioning reporting one or more external driving factors. These external driving factors include social stigma, family pressures, verbal/physical harassment, and others.[14,15] Thus, in addition to "detransitioning" being infrequent, for the vast majority of those who undergo the process, it is primarily secondary to external pressures, as opposed to an internal factor, such as uncertainty of one's gender identity.[14,15]

Inclusivity of a spectrum/beyond the binary

In recent years, a string of letters has been added to the older terms of LGB. Some common variants include LGBT+ and LGBTQ (questioning and queer); LGBTQIA+ adds "intersex," "asexual," and "+" to include other gender identities and sexual orientations that are not already included. These acronyms continue to expand and evolve in the pursuit of inclusivity.

Q is for queer

The term "queer" was a historically pejorative term used to describe members of the LGBTQIA+ community and has since been reclaimed as an increasingly common identity. Despite this, the term "queer" should be approached cautiously by providers due to the historical negative connotations of the word.

"Queer" is a multifaceted word for sexual and gender minorities, not exclusively heterosexual or cisgender. This could refer to a person attracted to people of multiple genders, people who do not conform to traditional gender norms, or an umbrella term referring to LGBTQIA+ people (please see the "Transgender" section above for a discussion on the usage of "queer" in reference to gender identity).

Q is also for questioning

A person who is questioning may be in the process of defining, redefining, or exploring their sexual orientation, gender identity, and/or gender expression. This can occur irrespective of whether someone has come "out" regarding their identities.

I is for intersex

"Intersex" persons have anatomy or genes that do not fit typical definitions of male and female. Most intersex people do identify as either men or women. Intersex is related to biological sex and is not the same as being nonbinary or transgender, which are terms related to gender identity, although some intersex persons may also identify as transgender and/or nonbinary. "Hermaphrodite" is an outdated and offensive term for this group of individuals and thus is no longer used.

A is for asexual or aromantic

Despite the prevalence of sexual desire and sexual activity among humans, asexual and/or aromantic individuals have little to no sexual and/or romantic interest, respectively. It is still necessary to address sexual history in these patients as some may still engage in sexual relationships despite lack of interest.

+ is for all the important other letter designations that could fall under the umbrella, including but not limited to

D is for demisexual, "demi" means half: those individuals who only feel sexually attracted to a person after forming an emotional bond with them. They can be lesbian, gay, straight, bisexual/pansexual, or none of the above and may have any gender identity.[8]

P is for "polyamorous," or ethically nonmonogamous, individuals with multiple romantic and possibly sexual relationships, all of which they may consider partnerships, and can sometimes live as a family unit and parent children together. Not to be confused with polygamy, this relationship style focuses on open communication and trust between multiple consenting adults and can look like a "V" with one person dating/partnered with two, a triangle, or a longer configuration commonly called a "polycule."

T is for "two-spirit," an indigenous term that refers to a person whose identity encompasses the spirit of both masculine and feminine. This can also refer to these individuals' sexual, gender, and/or spiritual identity. It has been reappropriated more recently by individuals who are not part of an indigenous culture. An example of the concept of societies having three or more genders is found in traditional Hindu culture where castrated males were considered a third gender, as well as the "Kathoey" identity in Thailand, and the term "mahu" is used in Hawaiian and other Polynesian cultures. This idea of a third gender is more common than many western-minded people realize.[16-19]

F is for "fluid," which encompasses gender and sexual fluidity, which can change even daily. Per the Human Rights Campaign, the definition is: "A person who does not identify with a single fixed gender or has a fluid or unfixed gender identity."[6]

Organ Inventory

Although many patients' chief concerns can be unrelated to their reproductive organs, many health issues could potentially be related to medications, hormones, surgery, or internal or external genitalia, which would make gathering an organ inventory a critical part of the review of systems. Additionally, this organ inventory may alter the diagnostic testing we do as emergency medicine physicians (e.g., pregnancy test on a transmasculine person with a uterus and ovaries).

An organ inventory considers the organs that a patient may or may not have in a nonjudgmental way, and it typically excludes the organs that all individuals have in common. Some of the questions to ask, if pertinent, are:

- "What words do you use for your internal and external genitals?"
- Specific to AFAB: "Do you have a uterus? Ovaries? Fallopian tubes? Cervix or vagina?"
- Specific to AMAB: "Do you have a penis? Testicles?"
- For all patients: "What surgeries have you had? Top surgery and/or bottom surgery? Were you assigned male or female at birth?"

Sexual history

When relevant to the ED presentation, a nonjudgmental, tailored, and considerate sexual history is important to provide accurate and inclusive care. Most of us learned in medical school to ask: "Do you

have sex with men, women, or both?" However, there has been a large shift away from this as a general screening question. As an alternative, some of the questions to ask, if pertinent, are:

- "Do you have one or more sexual partners? Do they have any additional sexual partners?"
- "Do you engage in genital sex? If insertive sex occurs, do you use barrier protection? Sometimes or all the time?"
- "Do you or any of your partners produce sperm?"
- "When you have sex, is it ever oral receptive or insertive with a penis or object? Anal receptive or insertive with a penis or object? Vaginal receptive or insertive with penis or object?"

It is important to ensure the information is medically relevant and to explain to the patient why the health care team needs to know and how the answer will change their clinical management before asking.

Physical exam

As with all physical exams performed in the ED, the exam of the gender or sexual minority patient should be focused, relevant, and based on patient anatomy. Additionally, there should always be someone else in the room for genital portions of an exam, although it is wise to avoid unnecessary observers when possible. Providers should describe the steps they plan to take during the exam and try to use the words for the patient's genitals that they use, which must be discussed while the patient is still dressed.

Specific considerations include being cautious of a smaller neovaginal opening in postoperative transfeminine patients and a smaller vaginal opening in postoperative transmasculine patients. One may consider using the smallest possible speculum or even an anoscope if explicitly indicated.[20] Finally, it is crucial to be cognizant of the social, emotional, and medical challenges these patients face.[21-23]

Implications for EM physician training

Students

There is now an increasing focus on incorporating LGBTQIA+ topics in medical school as more medical students are openly identifying as LGBTQIA+ and are interested in improving the care of sexual- and gender-minority patients,[24] with several medical student organizing efforts around this topic.[25,26] A significant number of medical students across multiple studies have reported insufficient curricular preparation to achieve the competencies necessary to care for this population.[27-29] In 2014, the AAMC released guidelines and educational materials specific to caring for LGBTQIA+ patients, although further curriculum development and implementation is needed to incorporate these recommendations into medical school curricula.[29,30]

Residents

Recognizing gaps in medical school curricula, and the need for additional specialty-specific content, education on LGBTQIA+ topics must continue during residency. Developing standard and consistent curricula throughout training will help improve knowledge, decrease bias, and address the particularly vulnerable position of these patients in the ED. A 2014 study reported a median of 45 min of LGBTQIA+ content in EM didactics, and a related study in 2018 found that a significant proportion of EM residents felt less comfortable caring for LGBTQIA+ patients when compared to cisgender and heterosexual patients.[9] Additionally, a substantial amount of LGBTQIA+ residents experience discrimination and mistreatment from both patients and other health care providers, highlighting a critical structural need to boost diversity, equity, and inclusion.[31-33] Although most program directors desire inclusion of sexual and gender minority–adjacent curricula, few emergency medicine residencies have incorporated LGBTQIA+ health into their conference and didactic curricula.[9]

Faculty

Given the minimal curricula in current undergraduate and graduate medical education, faculty members also have knowledge deficits in this space unless they have pursued self-directed learning. According to one pilot study, attending physicians were more in agreement with the statement "There should be educational events at my hospital about LGBT+ health needs" than to "I am well informed on the health needs of the LGBT patients" and that there was a need for further education on this topic at the faculty/attending level as well as the medical school level.[39] Additionally, it is challenging to teach residents and students when faculty do not feel well informed on the health needs of LGBTQIA+ patients. A growing number of resources are being developed to address this knowledge gap.[40,41]

CONCLUSION

Emergency physicians should feel confident in providing a model of care that affirms the sexual and gender identities of all the patient populations we serve.[34] From the health care provider perspective, embracing the constant evolution in the definitions of various LGBTQIA+ identities and celebrating the diversity within these communities will ultimately provide a deeper understanding of our own human nature—in health and illness—as well as offering optimal care for all our patients.

All patients should be approached with neutral and unassuming language. However, providers and medical systems hold societal biases toward heteronormative assumptions that they must mitigate for the provision of equitable care. We therefore recommend universally asking patients for their pronouns, offering our own, and communicating this information to the rest of the care team.

Additionally, determining a patient's sex assigned at birth and gender identity may be relevant as we aim to deliver the optimal care possible to all our patients. It is critical to be specific when asking these questions, keeping in mind using the simplest, nonmedical language as appropriate.[35] It is also important to explain why these questions are being asked.

Everyone, including LGBTQIA+ individuals, makes unintended mistakes including those concerning pronouns, misunderstanding current queer terminology, and other aspects addressed in this paper. However, being aware, open-minded, and willing to learn is the key to making the connection you need to deliver the best medical care possible. The most important steps include working to practice individually or with others on using discordant or neopronouns to feel more comfortable, avoiding taking corrections (or mistakes) personally, and not dwelling on the errors to the detriment of the other person (e.g., profuse, drawn out apology to the other party instead of a quick apology and moving on).[36] Finally, it is critical to never shame or mock individuals who use the wrong terminology or wrong pronouns, who ask questions, or who frankly seem lost. As a specialty, we need to evolve together for the sake of inclusivity and understanding.

As for our own implicit biases, it s important to acknowledge that we are all susceptible to biases and may not always be aware of them or how they contribute to the microaggressions our patients face. Having workplace training to address these issues can be paramount. Having an electronic health record that is inclusive and allows for insertion of a patient's gender, sex, name used, pronouns, and sexuality would go a long way to reducing the daily microaggressions faced by this population.[37,38] Optimal patient-centric care requires a deeper understanding of the patient's biology, gender identity, and sexual behavior encapsulated into the ever-growing acronym LGBTQIA+ .

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. Lachlan Driver and Alyson J. McGregor led to the procurement and interpretation of data and critical revisions of the manuscript. All authors other than Lachlan Driver and Alyson J. McGregor are listed in alphabetical order by last name.

ORCID

Lachlan Driver https://orcid.org/0000-0001-6549-7386
Daniel J. Egan https://orcid.org/0000-0002-2009-7984
Michelle D. Lall https://orcid.org/0000-0002-5622-1705
Joel Moll https://orcid.org/0000-0002-7169-8923

REFERENCES

1. Nolan IT, Kuhner CJ, Dy GW, et al. Demographic and temporal trends in transgender identities and gender confirming surgery. *Transl Androl Urol*. 2019;8(3):184-190.
2. Samuels EA, Tape C, Garber N, Bowman S, Choo EK. "Sometimes you feel like the freak show": a qualitative assessment of emergency care experiences among transgender and gender-nonconforming patients. *Ann Emerg Med*. 2018;71(2):170-182.
3. James SE, Herman JL, Rankin S, et al. *The Report of the 2015 U.S. Transgender Survey*. National Center for Transgender Equality; 2016.
4. Herman JL, Brown TNT, Haas AP. Suicide thoughts and attempts among transgender adults: findings from the 2015 U.S. transgender survey. Williams Institute UCLA. 2019. Accessed October 3, 2021. https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/
5. Caceres BA, Brody A, Luscombe RE, et al. A systematic review of cardiovascular disease in sexual minorities. *Am J Public Health*. 2017;107:e13-e21.
6. Glossary of terms. Human Rights Campaign. Accessed October 3, 2021. https://www.hrc.org/resources/glossary-of-terms
7. 21 words the queer community has reclaimed (and some we haven't). OUT. TheAdvocateMag. 2017. Accessed January 25, 2022. https://www.advocate.com/arts-entertainment/2017/8/02/21-words-queer-community-has-reclaimed-and-some-we-havent#-media-gallery-media-1
8. Demisexual. Merriam-Webster Dictionary. Accessed September 16, 2021. https://www.merriam-webster.com/dictionary/
9. Moll J, Krieger P, Moreno-Walton L, et al. The prevalence of lesbian, gay, bisexual, and transgender health education and training in emergency medicine residency programs: what do we know? *Acad Emerg Med*. 2014;21(5):608-611.
10. Abeln B, Love R. Considerations for the care of transgender individuals. *Nurs Clin North Am*. 2019;54(4):551-559.
11. Goodman M, Adams N, Corneil T, Kreukels B, Motmans J, Coleman E. Size and distribution of transgender and gender nonconforming populations: a narrative review. *Endocrinol Metab Clin North Am*. 2019;48(2):303-321.
12. Wilson BD, Meyer IH. *Nonbinary LGBTQ adults in the United States*. The Williams Institute. 2021. Accessed October 3, 2021. https://williamsinstitute.law.ucla.edu/publications/nonbinary-lgbtq-adults-us
13. Bockting W, Coleman E, Deutsch MB, et al. Adult development and quality of life of transgender and gender nonconforming people. *Curr Opin Endocrinol Diabetes Obes*. 2016;23(2):188-197.
14. Turban JL, Loo SS, Almazan AN, Keuroghlian AS. Factors leading to "detransition" among transgender and gender diverse people in the United States: a mixed-methods analysis. *LGBT Health*. 2021;8(4):273-280. doi:10.1089/lgbt.2020.0437
15. Landén M, Wålinder J, Hambert G, Lundström B. Factors predictive of regret in sex reassignment. *Acta Psychiatr Scand*. 1998;97:284-289. doi:10.1111/j.1600-0447.1998.tb10001.x
16. Trumbach R. London's Sapphists: from three sexes to four genders in the making of modern culture. In: Herdt G, ed. *Third Sex, Third Gender: Beyond Sexual Dimorphism in Culture and History*. Zone Books; 1994:111-136.
17. Fewster PH. Two-spirit community. Researching for LGBTQ Health. University of Toronto. c2022. Accessed September 20, 2021. https://www.lgbtqhealth.ca/community/two-spirit.php
18. Winter S. Thai transgenders in focus: demographics, transitions and identities. *Int J Transgend*. 2006;9(1):15-27.
19. Transgender, transsexual, gender identity, gender diversity. Polare 3: Like a Lady in Polynesia. The Gender Centre Inc. 2013. Accessed January 25, 2022. https://web.archive.org/web/20150924021528/http://www.gendercentre.org.au/resources/polare-archive/archived-articles/like-a-lady-in-polynesia.htm
20. Davis WD, Patel B, Thurmond JK. Emergency care considerations for the transgender patient: complications of gender-affirming treatments. *J Emerg Nurs*. 2021;47(1):33-39.

21. Gorton RN, Berdahl CT Improving the quality of emergency care for transgender patients. *Ann Emerg Med*. 2018;71(2):189-192.
22. Samuels EA, Tape C, Garber N, Choo E. "Sometimes you get to feel like the freak show": transgender and gender-non-conforming patient experiences and barriers to emergency care. *Ann Emerg Med*. 2015;66(4):S57.
23. Samuel L, Eve ZE. Communicating effectively with transgender patients. *Am Fam Physician*. 2008;78(5):648-650.
24. Tanner L. U.S. medical schools boost LGBTQ students, doctor training. AP NEWS. 2020. Accessed February 5, 2022. https://apnews.com/article/ky-state-wire-health-us-news-ap-top-news-medical-schools-985d50d0a7b1b593acd0dd791e8c3118
25. Medical Student Pride Alliance. Accessed February 5, 2022. https://www.medpride.org/
26. BNGAP. Accessed February 5, 2022. http://bngap.org/
27. Wittenberg A, Gerber J. Recommendations for improving sexual health curricula in medical schools: results from a two-arm study collecting data from patients and medical students. *J Sex Med*. 2009;6(2):362-368. doi:10.1111/j.1743-6109.2008.01046.x
28. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*. 2011;306(9):971-977. doi:10.1001/jama.2011.1255
29. Zelin NS, Hastings C, Beaulieu-Jones BR, et al. Sexual and gender minority health in medical curricula in New England: a pilot study of medical student comfort, competence and perception of curricula. *Med Educ Online*. 2018;23(1):1461513. doi:10.1080/10872981.2018.1461513
30. Hollenbach AD, Eckstrand KL, Dreger, AD. *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD: A Resource for Medical Educators*, 1st ed. Association of American Medical Colleges; 2014.
31. Heiderscheit EA, Schlick CJ, Ellis RJ, et al. Experiences of LGBTQ+ residents in US general surgery training programs. *JAMA Surg*. 2022;157(1):23-32. doi:10.1001/jamasurg.2021.5246
32. Hu YY, Ellis RJ, Hewitt DB, et al. Discrimination, abuse, harassment, and burnout in surgical residency training. *N Engl J Med*. 2019;381(18):1741-1752. doi:10.1056/NEJMsa1903759
33. Lall MD, Bilimoria KY, Lu DW, et al. Prevalence of discrimination, abuse, and harassment in emergency medicine residency training in the US. *JAMA Netw Open*. 2021;4(8):e2121706. doi:10.1001/jamanetworkopen.2021.21706
34. Counselman FL, Babu K, Edens MA, et al. The 2016 model of the clinical practice of emergency medicine. *J Emerg Med*. 2017;52(6):846-849.
35. Guss CE, Woolverton GA, Borus J, Austin SB, Reisner SL, Katz-Wise SL. Transgender adolescents' experiences in primary care: a qualitative study. *J Adolesc Health*. 2019;65(3):344-349.
36. Conrod K. Pronouns 102: how to stop messing up pronouns. Medium. 2020. Accessed January 25, 2022. https://kconrod.medium.com/pronouns-102-how-to-stop-messing-up-pronouns-9bd66911118
37. McDowell MJ, Berrahou IK. Learning to address implicit bias towards LGBTQ patients: case scenarios. National LGBT Health Education Center. 2018. Accessed October 3, 2021. https://www.lgbthealtheducation.org/publication/learning-to-address-implicit-bias-towards-lgbtq-patients-case-scenarios/
38. Waryold JM, Kornahrens A. Decreasing barriers to sexual health in the lesbian, gay, bisexual, transgender, and queer community. *Nurs Clin North Am*. 2020;55(3):393-402.
39. Driver L, Adams W, Dziedzic J. Attitudes, behavior & knowledge of emergency medicine healthcare providers regarding LGBT+ patient care. *West J Emerg Med*. 2019;20(6):viii.
40. Learning resources. Originally presented on 9 October 2021. (n.d.). National LGBTQIA+ Health Education Center of Fenway Health. Accessed February 2, 2022. https://www.lgbtqiahealtheducation.org/resources/
41. Teaching LGBTQ+ health. Stanford Medicine. c2021. Accessed February 4, 2022. https://mededucation.stanford.edu/courses/teaching-lgbtq-health/

How to cite this article: Driver L, Egan DJ, Hsiang E, et al. Block by block: Building on our knowledge to better care for LGBTQIA+ patients. *AEM Educ Train*. 2022;6(Suppl. 1): S57–S63. doi:10.1002/aet2.10755