Queering the ED: Lesbian, Gay, Bisexual, and Queer Health in Emergency Medicine

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Key Points

- A history of discrimination from the medical community and beyond often precedes a patient's emergency department (ED) visit. EPs and staff should be mindful of their own potential implicit or explicit biases.
- A simple way for EPs to establish trust is to use gender neutral and inclusive language.
- Sexual identity is not a proxy for sexual practices. If relevant to the chief complaint, EPs need to ask about sexual practice.
- Healthcare systems should incorporate gender identity and sexual orientation into institutional frameworks (such as electronic medical records, mission statements).

Foundations

Background

Our task of "queering" the ED is to critically examine the ways in which gender and sexuality enter into the practice of emergency medicine and how we can challenge our current beliefs and practices with the goal of providing better care to our LGBQ patients. In this chapter, we use the acronym "LGBQ" as an umbrella term meant to encompass patients who identify as lesbian, gay, bisexual, or queer. We

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recognize that there has been, and will continue to be, evolving terminology as we strive for representation and inclusivity. In clinical practice, an individual patient's preferred terminology should always be elicited, respected, and used preferentially during the patient encounter [1]. While it may be convenient to collapse subgroups together based on the nature of the structural violence and systemic oppression they face, it can create a problematic perception that the group is homogenous. On the contrary, the subpopulations represented by "LGBQ" are diverse and face their own unique struggles with health and within the healthcare system. Sexual identities also intersect with other differences—such as race, ethnicity, socioeconomic status, religion, and geography—creating complex and textured lived experiences.

Sexual orientation and gender identity have purposefully been separated in this textbook. While there is certainly intersectionality and shared cultural experiences, sexual orientation is distinct from gender identity. Sexual orientation refers to sexual or romantic feelings that a person might have for people of the same gender, a different gender, or more than one gender. Gender identity refers to one's concept of self as male, female, a combination of both, or neither; and can be the same or different from the assigned sex at birth. A transgender or gender nonconforming individual may be gay, straight, bisexual, or asexual. It is important to not sexualize gender by making assumptions about sexual orientation based on a person's gender identity or expression. Nonetheless, much of the health and healthcare disparities literature consolidates data on sexual orientation and gender identity ("LGBTQ", where T represents transgender). Whenever literature is cited in this chapter, we will report the language used in the original source to most accurately reflect the research. Although there are obstacles to accurate measurement, the current estimate is approximately 3.5% of adults in the US identify as LGBQ—just over eight million people. Furthermore, 8.2% of adults report same-sex behavior and 11% report same-sex attraction [2].

While a comprehensive historical review is beyond the scope of this chapter, a basic knowledge of the history of oppression, discrimination, and violence faced by the LGBQ community within the healthcare system is essential to understanding current LGBQ health disparities. Figure 6.1 presents an (incomplete) timeline of important events related to LGBQ health over the past 75 years. First, it is valuable to recognize that there is evidence of same-sex love and attraction in almost every documented culture and recorded as far back as Ancient Greece and Egypt [3]. However, the word "homosexual" was not coined until 1869 by Hungarian writer and journalist Karl Kertbeny. The American Psychiatric Association's (APA) first *Diagnostic and Statistical Manual of Mental Disorders* (DSM-1), published in 1952, designated homosexuality as a "sociopathic personality disturbance" [3]. Twenty years later in 1973, after persistent organizing efforts and educational campaigns led by the LGBQ community, homosexuality was removed as a pathology in DSM-II. It was not until 2000 that the APA took an official stance against reparative therapies [4]. Despite this apparent advance, conversion therapy and other "reparative" treatments continue to be recommended or provided by healthcare professionals.

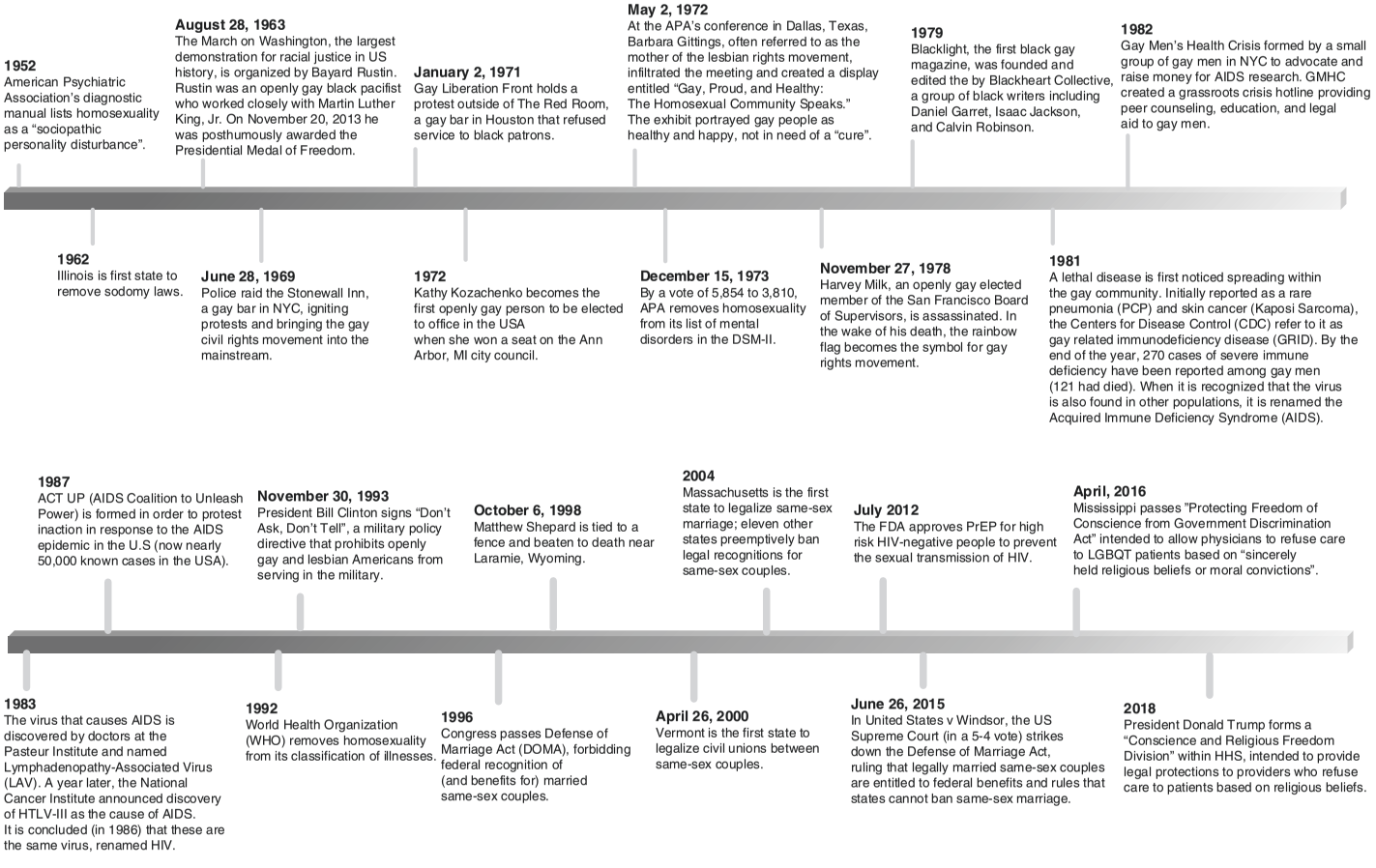

Fig. 6.1 An Incomplete Timeline of Modern US LGBQ History

Throughout the 1980s and 1990s, the AIDS crisis exacerbated the longstanding homophobia in healthcare [1]. While many demographics were affected by AIDS, the community of men who have sex with men (MSM) was the hardest hit. The Centers for Disease Control and Prevention (CDC) began tracking HIV/AIDS cases and deaths in 1981; by the end of 2000 over 750,000 people in the US had been diagnosed with AIDS, of whom almost 500,000 had died [5]. There was widespread discrimination within the healthcare system and by healthcare providers towards patients with HIV [1, 5]. The governmental response to the crisis in terms of research investment was viewed by many as inadequate, leading to a delay in appropriate treatment, prevention, and education [1, 5].

Throughout time, LGBQ people have demonstrated tremendous strength and resilience in the face of structural, physical, and sexual violence. The LGBQ community has led significant progress in breaking down structural barriers and educating the public and healthcare community. However, disparities in health and healthcare persist.

Evidence Basis

The "minority stress model" provides a useful framework for understanding LGBQ health disparities. Beginning in youth, LGBQ people live with the daily stress of structural stigma, discrimination, and marginalization. Chronic exposure to these daily stressors accumulates over the life course, and the resulting "wear and tear" on the body ultimately manifests in poorer mental and physical health outcomes [6–10]. A robust literature on experiences of discrimination and health has documented the effects on multiple physiological levels, from cellular functioning and gene expression (e.g., DNA methylation and histone modifications) to neuroendocrine dysregulation (e.g., cortisol patterns) to a range of health behaviors and outcomes (e.g., cardiovascular disease, diabetes, depression, smoking, substance use/misuse, and medication nonadherence) [11–18].

Early experiences of shame, rejection, and isolation can begin at home. LGBQ youth who report high levels of family rejection are 8 times more likely to have attempted suicide, 6 times more likely to be depressed, and 3 times more likely to use illegal drugs compared to those LGBQ youth who reported no or low levels of family rejection [19]. Family rejection also increases the risk of homelessness. Approximately 40% of homeless youth identify as LGBTQ and it is estimated that as many as 80,000 LGBTQ youth experience homelessness each year [20, 21]. By contrast, family acceptance/support has been shown to be associated with positive self-esteem and good general health [22]. Research to date has supported the conclusion that the mental health disparities among LGBQ youth are not inherent to sexual identity but rather result from societal stigma and familial rejection.

LGBQ youth may also face significant challenges at school. Experiences of homophobic bullying are associated with lower educational achievement, depression, suicidality, social isolation, and substance use [23]. More recently, attention has focused on the potential protective factors that may mitigate the effects of

exposure to homophobic bullying. Positive influences from the family or home may work as a buffer against negative impacts of both homophobic bullying and aggression that a youth may experience in school [24].

Experiences of shame and rejection both at home and school can lead to social isolation and harmful coping behaviors. LGBT youth are more likely than straight youth to report misuse of prescription opioids and sedatives [17], and are less likely than straight youth to engage in physical activity or team sports [25]. One-third of LGB youth engage in hazardous weight control behaviors, such as fasting more than 24 hours, using diet pills, or vomiting or using laxatives [26]. LGBT youth are twice as likely to have suicidal ideation and four times more likely to make a serious suicide attempt compared to heterosexual youth [27]. This last number is almost certainly an underestimate, as the sexual orientation of youth who complete suicide is often unknown.

The local sociopolitical environment also may be related to the health of LGBQ individuals. In a recent national study, health disparities among LGBQ people were greatest in communities with low levels of approval of same-sex marriage [28]. A study of same-sex couples prior to the Supreme Court ruling affirming same-sex marriage found that couples living in states with legally sanctioned marriage reported higher levels of self-rated health compared to those living in states with constitutional amendments against same-sex marriage [29]. It has also been shown that LGBQ adults who were raised in highly stigmatizing communities (as measured by LGBQ representation in local government, employment and nondiscrimination policies, and public opinion) exhibited blunted cortisol responses to a laboratory stressor [30].

LGBTQ individuals have a high lifetime risk of being a victim of a violent crime; 38% of gay men and 13% of lesbian women report hate crimes against their person or property [31]. In a recent national survey, 58% of LGBT respondents reported being subjected to jokes or slurs, 26% reported being threatened or physically attacked, and 21% reported being treated unfairly by an employer [32]. Over 80% of LBGT youth report experiencing verbal harassment at school, while 38% report having been physically assaulted [33]. Despite the long history of physical and sexual violence against the LGBQ community, it was not until 2009 that sexual orientation and gender identity were first included under federal "hate crimes" with the passage of the Matthew Shepard Act.

At the other end of the age spectrum, older LGBQ adults face unique challenges. Most came of age at a time of far less societal acceptance and with fewer available resources and role models. Of older LGBT individuals, 63–65% report experiencing physical violence related to their sexual identity at some point during their lifetime [34]. They experience high rates of internalized stigma, often leading to poorer mental health outcomes [35]. LGBT older adults are also more likely to be economically disadvantaged—a result of early and cumulative structural discrimination across the lifespan—exposing them to the higher overall mortality known to be associated with low socioeconomic status [36]. Older gay men living with HIV are more likely to live alone, have poor social support, and are at increased risk of depression [34].

Other subgroups of the LGBQ population also face unique health and healthcare needs. Men who have sex with men have an increased risk of HIV/AIDS, STIs, and anal cancers [37]. Lesbian and bisexual women have twice the risk of obesity compared to straight women as well as an increased risk of gynecological and breast cancers [14, 38, 39]. In addition to lower mammography rates, lesbian women on average have higher rates of some risk factors for breast cancer, including greater alcohol use and lower likelihood of childbearing [39]. Lesbian and bisexual women are also more likely to smoke and use illicit drugs compared to straight women [37].

Health disparities are compounded by unequal exposure to other well-documented adverse social determinants of health, such as low socioeconomic status. According to an analysis of the 2006–2010 National Survey of Family Growth, more than one-quarter (28%) of lesbian and bisexual women experience poverty, compared with 21% of straight women. Just over 1 in 5 gay and bisexual men (23%) experience poverty, compared to 15% of straight men [40].

LGBQ people of color are exposed to intersecting dynamics of discrimination that place them at greater risk of poor health outcomes. In one study, Latino men reported the highest number of negative family reactions related to their sexual orientation in adolescence [19]. Non-White lesbians report the poorest self-rated health compared to White lesbians, non-White straight women, and men [8]. The LGBQ community itself is not immune to ingroup racial discrimination and inequality. For example, lesbians of color were systematically marginalized and silenced within the feminist movement throughout the 60s and 70s, and continue to struggle for representation in the gay rights movement.

Emergency Department and Beyond

The healthcare system—historically and presently—is a significant contributing source of health disparities among the LGBQ community. Many LGBQ individuals report difficulty finding a healthcare environment in which they feel safe and respected; there remains a dearth of providers who are both welcoming and knowledgeable about the unique healthcare needs of LGBQ patients [3]. In a recent survey, 27% of medical students had observed judgmental attitudes and behaviors toward LGBQ patients from physicians [41]. Even in the absence of overt discrimination, physicians can deliver suboptimal care due to unconscious bias or simply a lack of knowledge and comfort with LGBQ-specific health issues. Negative interactions with(in) the healthcare system often lead LGBQ patients to delay care or even avoid care altogether [42].

Bedside

An emergency department (ED) encounter can be stressful under the best of circumstances, but this can be exacerbated by negative encounters with nurses, physicians, and other staff. Even before stepping foot in the ED, many patients are already

burdened with the cumulative weight of their prior negative healthcare experiences. Small microaggressions at the bedside can accumulate over time and can influence patient trust in providers. For example, this excerpt from a book on the experiences of queer and trans patients highlights how seemingly "harmless" assumptions made by providers can be isolating for patients.

> Finally, a middle-aged nurse with lime-green glasses comes over to offer me a heated blanket and, apparently, some comfort. "This must be really hard on you," she says, laying the blanket over my legs. "But at least your mom's here."
>
> For a fleeting moment, I actually feel embarrassed for her. Until I don't.
>
> "Uh, no. That's definitely not my mom."
>
> "What…?"
>
> "This is my wife. And she's five years older than I am."
>
> As the realization hits, her face falls. She scans her brain for a comeback. "It's.. it's just that you look so *young*," she says. "Which is *good*! You're lucky!"
>
> But my irritation has nothing to do with vanity and everything to do with her assumption: this is an ugly case of heteronormativity. Refusing to consider that we might be queer, this nurse reached into her brain for the closest heterosexual explanation for the intimacy between us, picking—for whatever reason—'mother and daughter'. We are clearly close in age and don't look alike, yet she'd stuffed us into a box that obviously didn't fit. Even in the era of same-sex marriage, rainbow families, and out-and-proud celebrities, it's still the case that everyone is presumed straight (innocent) until proven gay (guilty) [43].

When LGBQ patients present to the ED, the long history of institutional discrimination by the medical system precedes their arrival and may cloud the patient-clinician interaction. LGBQ patients may have had a negative experience with filling out registration forms or interacting with hospital staff before they reach the treating clinician [44–46]. Stories about patients who have experienced outright discrimination or whose families were denied hospital visitation because of their LGBQ relationship are well known in popular culture [47]. It is the responsibility of the treating clinician to establish trust in the patient encounter with the acknowledgement that creating that trust may be more difficult than with a typical patient encounter [48].

All emergency clinicians can use inclusive and gender-neutral language to establish trust with LGBQ patients. As it is often difficult to tell which patients are LGBQ, this language is useful when speaking with all patients. When first meeting a patient, refer to the patient by their full first and last name. Avoid using gendered titles like Mr. or Mrs. If a significant discrepancy between the documented name of the patient and the presenting gender of the patient exists, it is reasonable to confirm the last name and date of birth and ask, "What would you like to be called?" This allows patients a chance to take ownership of their title, as documented sex and gender identity/presentation may not correlate.

- When asking about patient's partner(s), avoid using gendered language. Instead, use terms such as "partner(s)" or "significant other(s)" until the patient clarifies the gender of their partner(s) and the nature of the relationship.
- When asking about visitors with a patient, avoid assuming the nature of the relationship. Ask open ended questions, such as "Who is here with you today?"

Avoid "Is this your mother/sister/wife?" Allow the patient or visitor to identify themselves and their relationship to the patient [48].

- Of the 650,000 same-sex couples in the US, 19% have children under the age of 18 [49]. Do not ask, unless medically relevant, which parent is the "real" or "biological" parent; treat both parents as equal caregivers.

These communication strategies can avoid many of the unintentional pitfalls clinicians experience when they accidentally misgender a patient or make the wrong assumptions about a patient's relationships. Assuming a bisexual woman has a male partner, or asking a gay man if his husband is his brother can further undermine the patient's trust in the clinical team and the healthcare system. Even with the best intentions, missteps may still occur. After making a mistake, the best approach is to acknowledge it directly, offer the patient a genuine apology for any harm caused, and move on with the clinical encounter. An example: "I apologize for using the wrong pronoun/name/terms. I did not mean to disrespect you" [50].

Sexual *identity* and sexual *practices* do not always align. While labels such as "gay" or "lesbian" can be heuristically useful, it is important to keep in mind that sexual identity may be distinct from sexual practices, and both may be dynamically fluid over the life course. Sexual identity should not be used as a proxy for behavioral risk factors (or lack thereof). It is important for healthcare providers to ask about both sexual orientation *and* sexual practices—if a patient's chief complaint warrants inquiry—in order to provide the most appropriate care. It is equally important to balance this care and necessary information gathering with respecting privacy. Especially in the ED, where due to limited resources, histories may be conducted in hallways or other less private areas, emergency practioners should be mindful about where, how, and why they are asking about sexual behavior and sexual history. While it may be tempting to ask questions out of curiosity to learn more about LGBQ people, LGBQ patients may want to keep their personal and medical histories private, just like everyone else. We must reflect on whether the questions being asked are to obtain necessary information to deliver care, or to satisfy a curiosity, and avoid asking unnecessary questions [50].

After moving the patient to a private space and determining that a focused sexual history is relevant to the ED visit, the questions below can help guide history taking for patients of any sexual orientation. As the sexual orientation of a patient is generally unknown prior to asking about their sexual practices, it is ideal to use gender neutral language initially and to specifically inquire about the gender of the patient's partner or partners. A sexual history should focus on the actual sexual behaviors of the patient, not only their stated sexual orientation. As many patients may have sexual partners that identify as transgender or gender nonbinary, the gender identity of a patient or their partner may not correlate with sexual anatomy. Discussions about risk for sexually transmitted infection and pregnancy need to be tailored to individual patient's sexual behaviors.

LGBQ Sexual History Questions:

Are you currently sexually active?
Have you ever been sexually active?
Tell me about the gender of your partner or partners.
When having sex, do you have vaginal, anal, and/or oral sex?
If relevant: do you use condoms or other barriers when having vaginal, anal, or oral sex? How often?
Do you and your partner(s) use any other protection against STIs? If no, Could you tell me the reason why not? If yes, what kind of protection do you use, how often? [51].
***If relevant and if the patient is sexually active with a partner or partners capable of producing pregnancy:*
Do you think you might like to have (more) children at some point?
If the patient is considering future parenthood: When do you think that might be?
How important is it to you to prevent pregnancy (until then)? [51]

Risk reduction strategies for STI and pregnancy prevention can be patient centered by focusing on the patient's goals and the patient's specific practices and partner(s). Regardless of gender or sexual identity, the clinically relevant information in a sexual history is what anatomy each person has, what sexual behaviors they engage in, and the level of individual agency present.

In addition to the sexual history, the family history may be a challenging part of the encounter for LGBQ patients. Often when conducting a family history, a clinician will ask about a patient's mother and father's health. Children from same-sex families are often conceived using sperm donors, egg donors, or gestational carriers. It may be more accurate to ask: "I'd like to learn more about your genetic risk factors for disease. Please tell me what you know about your genetic history."

Emergency clinicians are often champions of patient equality – treating any patient, any disease process, anytime, and proudly treating all patients as equals. In the context of health disparities and social emergency medicine, the framework for the individual encounter between clinicians and LGBQ patients must be one of **health equity**, not simply equality. Health equity is defined as "the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions" [52]. This may mean it requires more time and investment with LGBQ patients from the treating clinician to obtain the same level of trust as with non-LGBQ patients. By being open and flexible to patients' needs, clinicians can work to disrupt the effects of structural stigma and discrimination in a tangible way through the clinical encounter.

Through a commitment to justice and with proper research and education, emergency physicians can work to transform the healthcare encounter from a source of shame and rejection to a source of affirmation and empowerment. By becoming competent in the care of LGBQ patients, we can transform the doctor–patient relationship from a risk factor to a protective factor.

Hospital/Healthcare System

Cultural change within a profession begins with education. A survey of medical school deans at 176 allopathic and osteopathic medical schools found that the median reported time dedicated to teaching LGBT-related content in the medical curriculum was five hours. One-third of schools reported zero hours during clinical years, and 43.9% of institutions rated their curricular LGBT content as only "fair" [53]. In 2014, a survey of EM program directors characterized the prevalence of content and needs related to LGBT education, barriers to curricula, and program demographics associated with inclusion of LGBT educational material. Only 26% reported that a dedicated LGBT lecture had ever been presented, while 33% reported incorporating LGBT topics into other components of the didactic curriculum. The average amount of time spent on LGBT health was 45 minutes per year. Programs with LGBT faculty and residents expressed more support of inclusion of LGBT-focused material into training curricula compared to programs without LGBT faculty [54].

The Human Rights Campaign (HRC), a LGBTQ civil rights organization, has developed a "Healthcare Equality Index" (HEI) to score hospitals and other healthcare facilities on their compliance with best practices in LGBTQ health practices. In 2018, 626 facilities participated [55]. The HEI rates hospitals on nondiscrimination policies and staff training, patient services and support, employee benefits and policies, patient and community engagement, and responsible citizenship [56]. Similarly, The Association for American Medical Colleges (AAMC) has published best practices for developing a healthy institutional climate for LGBT faculty, students, residents, and administrators. In addition, they discuss the role of medical education in addressing health disparities and offer specific curricula for teaching core competencies related to LGBT health in medical schools [56]. The Gay and Lesbian Medical Association released a document outlining best practices for creating a climate of inclusion for LGBTQ health professionals and students [57]. These include LGBQ inclusion in mission statements, new employee orientations, and CME training requirements.

Recent research has established the utility and acceptability of routine collection and display of sexual orientation and gender identity in medical records. In qualitative interviews of patients and ED providers, LGBQ patients were much less likely to refuse to provide sexual orientation than ED providers expected [58]. Discordant views between providers and patients regarding collection of sexual orientation highlights the discomfort that many providers have in asking about sexual practices, in contrast to the willingness of the LGBQ community to be seen and normalized within the healthcare system. Gathering data on sexual orientation in clinical settings and in EHRs helps us better understand LGBQ health, including disparities in insurance coverage, access to care, diagnosis, and treatment [59]. Moreover, making sexual orientation and gender identity readily visible to providers in the EHR can mitigate misidentification and serve as a reminder of its importance in the healthcare encounter.

Societal Level

As illustrated above, the etiology of LBGQ health disparities can be traced to broader social, political, and economic conditions. As cultural changes have led to greater acceptance of LGBQ individuals and families, we are optimistic that reductions in health disparities will follow. Yet, disparities persist.

Over the past decade, there has been a long overdue recognition of the unmet healthcare needs of the LGBQ community accompanied by a renewed focus on research and action. In Healthy People 2020—the nation's roadmap for improving health over the next decade—the US committed for the first time to eliminating LGBT health disparities. Healthcare providers should "appropriately inquire about and be supportive of a patient's sexual orientation to enhance the patient–provider interaction and regular use of care" [60]. In 2016, the National Institutes of Health (NIH) designated sexual and gender minorities (SGM) as a health disparities population alongside racial/ethnic minorities, socioeconomically disadvantaged populations, and underserved rural populations for the purpose of research and grant funding [61, 62]: "In doing so, the NIH recognizes that more research in SGM health is critical to better understanding both the well-being of and the potentially undiscovered health disparities experienced by this population" [61].

A number of relatively recent legal changes have shaped access to and quality of health services for LGBQ Americans. In June 2013, the Supreme Court's ruling in United States v. Windsor overturned a portion of Defense of Marriage Act (DOMA) and required the federal government to recognize legal same-sex marriages for the first time. This decision has had ripple effects on LGBQ health, as marriage is tied to a range of federal benefits including tax deductions and access to health insurance [63]. The Affordable Care Act (ACA), passed in 2010, extended coverage to millions of uninsured persons through the expansion of Medicaid and the creation of new federally subsidized health insurance marketplaces in all states. It also included new federal regulations barring discrimination in insurance provision based on sexual orientation and gender identity. In addition, restrictions on coverage based on preexisting conditions (for example, HIV or mental illness) that historically disproportionately affected the LGBQ community, were eliminated. In 2010, the Department of Health and Human Services issued a policy stating that hospitals needed to allow patients to designate visitors regardless of sexual orientation, gender identity, or any other nonclinical factors. The Centers for Medicare and Medicaid Services also issued guidance noting that same-sex couples have the same rights as all patients to use an advanced directive to name a representative to make decisions on their behalf [64].

These changes have begun to narrow the longstanding disparities in insurance coverage for LGBQ individuals [65]. However, there have been recent setbacks as well. Beginning in 2019 the federal government attempted to expand the availability of specialized insurance plans that provide exemptions from key protections for sexual orientation and gender identity. "Conscience and religious" exemptions for healthcare providers have also been liberalized, which may limit access to care and

treatment for LGBT people, particularly in resource limited settings. A comprehensive approach to improving LGBQ health must include advocacy at the local, state, and national level to ensure equity in access to quality care.

Recommendations for Emergency Medicine Practice

Effective care for LGBQ patients in the ED requires an understanding not only of specific health risks but also of the larger sociopolitical context in which health disparities emerge. Moreover, providers need to be self-reflective and open to exploring personal biases (both explicit and implicit) in order to develop the skills needed for welcoming and respectful healthcare delivery. The following are concrete, tangible steps that EM providers can take to improve their clinical care of the LGBQ patient.

Basic

- Do not use sexual identity as a proxy for history taking. Ask the patient about sexual practices in ways which are nonjudgmental and affirming.
- Respect and reflect the terminology used by your patient. For example, if a male patient refers to the person accompanying him as his "husband," do not refer to him as the patient's "partner" or "friend." Try to stay current on evolving terminology. If you are not sure what language to use, ask the patient.
- When taking a history, avoid gender-specific language. For example, instead of asking "Do you have a wife or girlfriend?" you might ask "Are you in a relationship?"
- If you make a mistake, recognize it, apologize, and move on.

Intermediate

- Emergency providers can be allies to LGBQ patients by helping to create safe spaces by speaking up when they hear discriminatory language or witness discriminatory behavior.
- Bring up issues of biases in care when teaching residents, medical students, and staff. Encourage providers to reflect on personal biases that may be impacting the care they provide, and do so for your own care.
- Integrate LGBQ issues into resident conferences and simulations. This should be done on an ongoing basis to reflect the most current knowledge of health and healthcare needs as well as changes in terminology.
- Assess your own implicit bias. Take a free, evidence-based test at Project Implicit (https://implicit.harvard.edu/implicit/) [66]. Complete the free, self-guided case scenarios at the National LGBT Health Education Center titled "Learning to Address Implicit Bias Towards LGBTQ Patients" [67]. https://www.lgbthealtheducation.org/publication/learning-to-address-implicit-bias-towards-lgbtq-patients-case-scenarios/

Advanced

- Work with your hospital or healthcare organization to incorporate sexual orientation and gender identity into institutional frameworks. For example, advocate for LGBQ inclusion in mission statements, new employee orientations, and CME training requirements.
- Advocate for the implementation of EMR-based systems for identifying sexual orientation and gender identity. While there have been concerns about electronic identification leading to increased stigma or discrimination, studies show these datapoints are a catalyst for new provider trainings and improved cultural competence [59].
- Participate in community-level efforts to raise awareness and advocate for LGBQ rights.

Teaching Case

Clinical Case

Luis Garcia is a one and a half-year-old male presenting to the ED with a chief complaint of fever and cough. The nurse first assesses the patient and his family in triage. Vital signs show: temperature 38 C, HR 132, RR 32 and oxygen saturation of 94% on room air. The nurse's triage note documents scattered wheezing and mild retractions and reports that the history was given by the child's mother. The triage history notes that symptoms started yesterday and worsened today. He has never wheezed before.

You enter the exam room and find Luis sitting on a woman's lap. Another woman of similar age is also in the room. He is drinking a bottle when you enter the room and you notice mild subcostal retractions.

After introducing yourself, you inquire about the identity of Luis's caregivers by asking "Who is here today with Luis?" The woman holding Luis responds "We're Luis's parents." You shake his parents' hands and learn more about the history of this illness. You note that at 18 months, Luis is a little old for bronchiolitis, but also young to have a first episode of asthma or bronchospasm [68]. You are curious about Luis's birth history and familial genetic history of bronchospastic disease. You also know that as a family with same-sex parents, this family has likely experienced many intrusive questions about Luis's birth history and inquiries about which parent is his "real mom." You want to honor the equal role of both caregivers while obtaining important information about this child's health. You know that like any other child, Luis may have been conceived using either one of his parent's genetic material, donor egg and/or sperm, or been adopted.

You decide to explain your rationale and ask permission before going forward. "I notice that Luis is wheezing today. I'm concerned that this could be an early sign of asthma, but I'm not sure. I'd like to learn more about Luis's birth history and ask some more questions about his genetic family history. Would that be all right?" Both parents nod. You proceed to ask about his gestational age at birth and any complications. You ask about his genetic heritage and if there was any known history of asthma or atopic dermatitis. His parents note that he was conceived using a

known sperm donor and neither the donor nor the mother who carried him using her eggs have a history of asthma or atopic dermatitis.

You proceed to examine Luis. You decide to treat with supportive care for bronchiolitis with nasal suction, PO fluids, oxygen, fever management and close reassessment. You discuss your assessment and plan with his parents and answer their questions. After the visit, you document the history in the electronic health record, including that you spoke to both parents and inquired about Luis's genetic family history. You notice that the EHR template is not set up to make writing in this information easy, and you make a note to talk to your ED director to see if there's a better template available that's more inclusive for LGBQ families.

Teaching Points

1. Use open-ended questions to inquire about visitors with patients.
2. When asking history questions that may be perceived as invasive, first explain your rationale and how they relate to the goals of care for the patient. Ask permission to build trust.
3. LGBQ health encompasses much more than sexual health. As a clinician, it's essential to work to build trust and acknowledge the effects of minority stress and the systemic barriers these patients may face as part of their LGBQ experience.

Discussion Questions

1. Have you ever made a mistake when assuming the relationship of a patient and a visitor? What happened? How did you recover from it to continue the clinical encounter?
2. How do you approach obtaining a potentially sensitive patient history about a topic that may carry stigma, like sexual health, mental illness, or infertility?
3. What parts of this case and chapter overall affirmed your practice? What challenged your practice? Why?
4. How do you think an LGBQ-centered approach of not assuming family relationships, asking open-ended history questions and explaining the rationale for certain history questions would be received by non-LGBQ patients?

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