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Contact Hours: **2**

LGBTQ Cultural Competence Training approved for Washington, DC (as per a public health priorities education for nurses)

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LEARNING OUTCOME AND OBJECTIVES: Upon successful completion of this continuing education course, you will be prepared to provide effective and respectful care for patients identifying as LGBTQ+. Specific learning objectives to address potential learning gaps include:

- Describe terminology that is inclusive and respectful of the LGBTQ+ community.
- Summarize health disparities, health risk factors, and clinical implications specific to members of the LGBTQ+ community.
- Discuss legal issues associated with quality care for LGBTQ+ patients.
- Identify best practices regarding collecting and protecting patient information for LGBTQ+ patients.
- Discuss elements of culturally competent care for LGBTQ+ patients, including physical space, informational materials, patient communication, and staff training.
- Examine the intersection of oppression, discrimination, and cultural biases in order to provide nondiscriminatory care.

INTRODUCTION

It is not uncommon for a person who identifies as lesbian, gay, bisexual, transgender, or questioning/queer (LGBTQ) to have had negative experiences in the healthcare environment due

to discrimination and/or stigmatization based on their sexual orientation and/or gender identity. Such encounters may occur due to cultural bias or a lack of awareness and understanding by the provider of the healthcare needs and goals of such individuals.

For example:

- A gay man might be screened for HIV before being assessed for actual risk.
- A transgender man may be denied a mammogram because they transitioned from female to male.
- A lesbian visiting a new primary care provider might be asked if they would like a mental health referral to explore "abnormal" sexual feelings.
- A gender fluid person may not know how to respond to a healthcare form that only provides the options of male or female gender identity.

These sorts of negative encounters immediately affect the patient's trust of the healthcare system and marginalize their needs. Continuing stigma makes many patients reluctant to reveal their sexual orientation or gender identity to healthcare providers even though this information can be important to receiving individualized care.

From a historical perspective, it was not until 1973 that the American Psychological Association declared that homosexuality (now considered a marginalizing term) was not a mental illness (McHenry, 2022). This was a major milestone in the movement toward cultural awareness and in the fight for equal rights for people who identify as lesbian, gay, or bisexual. Similarly, being transgender was listed as "gender identity disorder" until 2013, when the DSM-5 changed it to "gender dysphoria," a more patient-centric term (Byne et al., 2020).

Over the past 20 years, the healthcare community has started to recognize and research the unique needs of these groups. One of the most significant reports includes the 2011 Institute of Medicine report titled "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding." This document outlined a research agenda for the future. The report also placed a focus on the needs of LGBT patients and described the uniqueness for each of the LGBT groups (IOM, 2011). Similarly, Healthy People 2030 includes a goal to improve the well-being, safety, and health of the LGBT patient population (ODPHP, n.d.).

Even though social acceptance has been increasing since that time and laws and policies are changing, LGBTQ+ individuals continue to face barriers, stigma, bias, and discrimination. Access to healthcare that is unbiased and culturally affirming remains a challenge in most parts of the United States.

People within the LGBTQ+ population are extraordinarily diverse, representing every social class and ethnicity in every geographical area and every profession (HRC, 2020). Healthcare professionals who practice cultural sensitivity in working with LGBTQ+ patients can have a

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positive impact and increase trust as they continue to understand the individual needs of their patients.

TERMINOLOGY

LGBTQ+ ACRONYM

The acronym *LGBTQ+* is an umbrella term used in this course to refer to the lesbian, gay, bisexual, transgender, and queer/questioning populations. The "+" designation is included to encompass additional populations (e.g., intersex [I], asexual [A], genderfluid, and others) that are not explicitly referred to by the acronym *LGBTQ* alone.

To better understand the LGBTQ+ population and their unique health concerns, it is important to define and clarify some basic concepts of gender identity and sexual orientation. Terms and definitions are ever-evolving, and clinicians must update their knowledge regularly to provide effective and respectful care for all patients. It is also important that clinicians have the comfort and sensitivity to ask their patients how they would like to be addressed in terms of identifiers of gender identity and sexual orientation in a respectful, honest, and open-minded manner.

Terminology described in this course is taken from recognized sources at the time the course was written. These terms may not reflect every individual's personal preference, may become outdated (even as they are mentioned in current clinical references), and may not reflect all local and regional variations.

Terms and Definitions

- **Anatomical sex:** The presence of certain female or male biologic anatomy (including genitals, chromosomes, hormones, etc.); also referred to as ***assigned sex at birth (ASAB)***
- **Asexual (A):** People with no or little sexual attraction to other people
- **Bisexual (B):** Men or women who are sexually attracted to people who are the same as and different than their own gender
- **Cisgender:** People whose gender identity aligns with the sex they were assigned at birth, i.e., the opposite of *transgender* or *gender diverse*
- **Gay (G):** A person who is attracted to someone of the same gender; historically, the term referred to men who are attracted to men, but it may also be used by women to refer to themselves
- **Gender expression:** The way a person presents their gender in society, through social roles, clothing, make-up, mannerisms, etc.
- **Gender identity:** A person's internal sense of being a male/man, female/woman, both, neither, or another gender

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- **Genderfluid or genderqueer (also called *nonbinary*):** People who do not strictly identify as male or female; a mix of male and female (genderqueer/genderfluid); neither male nor female (nonbinary); or no gender at all
- **Intersex (I):** People with an indeterminate mix of primary and secondary sex characteristics, such as a person born appearing to be female "outside" who has mostly male anatomy "inside," a person born with genitals that are a mix of male and female types (a female born with a large clitoris or without a vaginal opening, or a male born with a small penis or a divided scrotum that has formed like labia); may identify as either cisgender or gender diverse
- **Lesbian (L):** Women who are attracted to women
- **MSM:** Men who have sex with men
- **Queer:** An umbrella term for all who are not heterosexual or who are not 100% clear of their sexual orientation and/or gender identity
- **Questioning (Q):** A person who is in the process of discovery and exploration of their sexual orientation, gender identity, or gender expression
- **Sexual orientation:** How a person identifies their sexuality, including who they are physically and emotionally attracted to and with whom they choose to have sex; a person may not have a sexual attraction to others (asexual)
- **Transgender (T):** People with gender identities that do not align with their assigned sex at birth; some transgender individuals may alter their physical appearance and often undergo hormonal therapy or surgeries to affirm their gender identity. However, medical intervention is not required for a person to identify as transgender. Some transgender people do not undergo the medical transition process for a variety of reasons, including cost or other health concerns. Gender identity terms that may be used by transgender people to describe themselves include:
  - Demiboy: A person who feels their gender identity is partially male, regardless of assigned sex at birth
  - Demigirl: A person who feels their gender identity is partially female, regardless of assigned sex at birth
  - Transgender female/woman, trans woman: A transgender person who was assigned male at birth (AMAB) but who identifies as female; formerly referred to as *male-to-female (MTF)*
  - Transgender male/man, trans man: A transgender person who was assigned female at birth (AFAB) but who identifies as male; formerly referred to as *female-to-male (FTM)*
- **WSW:** Women who have sex with women
  (AECF, 2021; APA, 2022; PFLAG, 2022)

CULTURE AND TERMINOLOGY

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Terms for sexual orientation and gender identity vary according to culture. For example, *two spirit* is a non-Western term used by some Indigenous populations to describe gender identity, sexual identity, and/or spiritual identity. Some Indigenous languages do not have terms such as gay, lesbian, or bisexual and instead describe what people do rather than how they identify (Researching for LGBTQ2S+ Health, n.d.).

Terms and Concepts That May Be Marginalizing

Terms that marginalize and stigmatize people who are LGBTQ+ are still common. Also, some words previously used and accepted in the medical community may no longer be in common usage or considered acceptable/respectful today. Examples include:

- Homosexual
- Sexual preference
- Transvestite
- Male-to-female (MTF) transgender
- Female-to-male (FTM) transgender
(PFLAG, 2022; GLAAD, n.d.)

Examples of concepts that may contribute to societal stigmas for LGBTQ+ patients include:

- Heterosexism: The general presumption that everyone is straight or the belief that heterosexuality is a superior expression of sexuality
- Homophobia: Negative attitudes and feelings toward people with nonheterosexual sexualities; may include discomfort with expressions of sexuality that do not conform to heterosexual norms
- Internalized oppression: The belief that straight and cisgender people are "normal" or better than LGBTQ+ people, as well as the often-unconscious belief that negative stereotypes about LGBTQ+ people are true
- Transphobia: Negative attitudes and feelings toward transgender people or discomfort with people whose gender identity and/or gender expression do not align with traditionally accepted gender roles
(PFLAG, 2022; Ni, 2020)

Sexual Orientation, Gender Identity, and Gender Expression

Sexual orientation, gender identity, and gender expression are separate parts of a person's identity. *Sexual orientation* refers to a person's sexual attraction and sexuality. *Gender identity* refers to a person's innate sense of their own gender. *Gender expression* refers to the outward

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expression of one's gender. All of these terms fall along a spectrum, and a person can identify with more than one sexual or gender identity.

The terms *lesbian*, *gay*, and *bisexual* describe an individual's sexual orientation, attraction, or behavior and reflect the fact that sexuality is not exclusively heterosexual. In contrast, transgender people are defined according to their gender identity and presentation. This group is composed of individuals whose gender identity differs from the sex originally assigned to them at birth or whose gender expression varies significantly from what is traditional for that sex (i.e., people identified as male at birth who subsequently identify as female and people identified as female at birth who later identify as male).

Transgender individuals (and many others) may also reject traditional concepts of gender as being strictly binary in terms of the male-female dichotomy. The population is diverse in gender identity, expression, and sexual orientation. Transgender people can be any sexual orientation. Some lesbians, gay men, and bisexuals may be transgender (APA, 2022).

The gender-binary system is also important to understand in the context of the LGBTQ+ population. This system is based on the idea that society categorizes people as falling into one of two categories (man/woman, male/female, masculine/feminine), not recognizing gender is a spectrum. Individuals who identify as nonbinary or genderfluid often identify as being somewhere in the middle of this spectrum and may use gender-neutral pronouns such as "they/them/theirs." Therefore, it is important to address the question of pronouns with patients in each healthcare encounter.

LGBTQ+ POPULATION

It is difficult to accurately describe the demographics and statistics of the LGBTQ+ population. This may be due to the lack of appropriate survey questions on demographic questionnaires as well as a reluctance of individuals to respond for fear of stigma or discrimination. However, researchers have estimated that approximately 8% of adults in the United States identify as lesbian, gay, bisexual, and transgender and that more than 1% identify as transgender. An estimated 1 in 100 Americans is intersex. Among adults under 30 years of age, 2% identify as transgender, and 3% identify as nonbinary (Powell, 2021; Cleveland Clinic, 2022; Brown, 2022).

HEALTH DISPARITIES AND HEALTH RISK FACTORS

Ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location are all factors that contribute to an individual's ability to achieve good health. *Disparity* refers to a health outcome that is seen to a greater or lesser extent in one population relative to another population. *Risk factor* refers to a behavior or condition that increases a person's chance of developing a disease or health condition. This may include social and environmental factors (Medina-Martinez et al., 2021). The LGBTQ+ population is diverse in terms of race, ethnicity,

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disability, and socioeconomic status. Therefore, risk factors and disparities in each patient will vary depending on these individual factors. (See discussion below on specific population groups.)

Research has uncovered that LGBTQ+ individuals often face health disparities related to societal stigma, discrimination, and denial of civil and human rights in some manner. Discrimination has been linked to higher rates of psychiatric disorders, substance abuse disorders, and suicide. Violence and victimization are also more common and have life-long consequences to the individual and the community as a whole. Personal, family, and social acceptance of an individual's sexual orientation and gender identity often affects these individuals' mental health and personal safety (Medina-Martinez et al., 2021).

Individuals who identify as LGBTQ+ may also experience minority stress. Minority stress theory connects health disparities among individuals to stressors induced by a hostile, homophobic culture in society as a whole. This often results in experiences of prejudice, internal expectations of rejection, and internalized homophobia. Aspects of minority stress, including the perception of prejudice, stigma, or rejection, are associated with higher rates of depression and dysfunctional coping strategies (Hoy-Ellis, 2021).

LGBTQ+ populations experience a greater prevalence of mental health distress and diagnosis, such as:

- Anxiety and depression
- Suicidal ideation and attempts
- Other forms of emotional, physical, and sexual trauma (such as intimate partner violence) (Hoy-Ellis, 2021; Coleman et al., 2022)

Gay, lesbian, and bisexual adolescents and young adults have higher rates of tobacco and alcohol use, substance abuse, eating disorders, and risky sexual behaviors. This may be due to a higher level of psychological distress (CDC, 2022d; The Trevor Project, 2020, 2022).

Men Who Have Sex with Men (MSM)

The most researched health disparity among MSM is HIV/AIDS incidence and prevalence. In 2018, 81% of new HIV cases among men occurred in men who had sex with men (CDC, 2020). Gay, bisexual, and men who have sex with men have also been found to be at increased risk of other sexually transmitted infections (STIs) (CDC, 2022a), including:

- Syphilis
- Gonorrhea
- Chlamydia
- Human papillomavirus (HPV)
- Hepatitis A and B

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Gay men are also at an increased risk of cancers, including prostate, testicular, anal, and colon, which may be related to limited cancer screening and prevention services for this population (Domogauer et al., 2022). Moreover, men who have sex with men are also at higher risk for tobacco and drug use and depression (CDC, 2022b).

CLINICAL IMPLICATIONS

When providing care for men who have sex with men, clinicians and case managers should not assume that the individual is engaged in actions that increase the risk for certain disorders; a history should first be performed to understand the individual's risk (HEC, 2021). Understanding the risk factors and health disparities for MSM, it is important to address the unique clinical concerns for this population through:

- Regular assessment and screening for STIs and HIV
- Routine vaccination for hepatitis A, hepatitis B, and HPV
- Prevention and screening for prostate, testicular, anal, oral (head and neck), and colon cancers
  (CDC, 2022a)

Women Who Have Sex with Women (WSW)

Lesbian and bisexual women are more likely to be obese and to use tobacco and alcohol than heterosexual women. Stress may be a contributing factor to the increased substance use or abuse in this population. WSW are also at increased risk for depression and anxiety disorders and are less likely to receive routine reproductive care. Lesbian women are also less likely to access cancer screening and prevention services (Office on Women's Health, 2020; Open Access Government, 2020; ACS, 2021).

Lesbian women may be at a higher risk for uterine, breast, cervical, endometrial, and ovarian cancers for some of the factors listed above (ACS, 2021). Also, lesbians have traditionally been less likely to bear children, and hormones released during pregnancy and breastfeeding are believed to protect women against breast, endometrial, and ovarian cancers (WebMD, 2020).

CLINICAL IMPLICATIONS

Clinicians and case managers working with women who have sex with women should carefully assess and address the multiple risks that this population faces by providing:

- Preventive and wellness care to prevent or treat tobacco use/abuse and alcohol use/abuse
- Screening and early identification of behavioral health concerns such as depression or anxiety
- Regular preventive care and screening for uterine, breast, cervical, endometrial, and ovarian cancers

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- Programs for healthy weight and exercise
  (WebMD, 2020)

Transgender and Gender Diverse

Transgender individuals often face victimization, violence, and minority stress, and they are less likely to have access to health insurance for a variety of reasons. Transgender individuals have a higher prevalence of:

- HIV
- Sexually transmitted infections (STIs)
- Behavioral health disorders
- Suicide
  (CDC, 2022c; CDC, 2021; NAMI, 2022)

CLINICAL IMPLICATIONS

Caring for transgender patients therefore includes screening for the following risks, as appropriate:

- Access to appropriate health insurance
- Violence
- Minority stress
- HIV
- STIs
- Suicide
- Behavioral health disorders
  (Caughey et al., 2021; Eder et al., 2021; Goldsmith & Bell, 2022)

GENDER-AFFIRMING MEDICAL INTERVENTIONS

Some transgender individuals desire to undergo medical interventions to alter their outward appearance and secondary sex characteristics in order to feel aligned in their body with their gender, while others do not desire this intervention. It is important to recognize the unique needs of these patients as they make decisions about transition-related care and treatment.

Some surgical treatments can take years, with multiple procedures needed to complete a gender-affirming transition. Education on preparation, treatment, supportive care, and follow-up care are essential to support transgender patients in this process. In many cases, gender-affirming surgeries are done at specialty centers, so it is important to understand where this

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care can be obtained and how to refer patients to these services, while also tending to their healthcare needs before, during, and after treatment for transition (Coleman et al., 2022).

Adolescents and Young Adults

Many concerns may impact the health and well-being of an LGBTQ+ individual. This is especially true for adolescents, who are in the process of navigating developmental milestones along with sexual orientation and gender identity.

Young adults who "come out" may be faced with bullying from their peers or family rejection. LGBTQ+ youth have a high rate of substance abuse, STIs, and homelessness (Hao et al., 2021). They are more prone to have an increased risk of depression, suicidal ideation, and substance use, including tobacco, alcohol, cannabis, cocaine, ecstasy, and heroin (The Trevor Project, 2020, 2021).

Research has shown that LGBTQ+ adolescents and young adults with family acceptance have greater self-esteem, more social support, and better health outcomes. This acceptance also reduces the risk of substance abuse, depression, and suicide (Delphin-Rittmon, 2022).

CLINICAL IMPLICATIONS

Clinicians and case managers working with this population should pay careful attention to subtle clues and risk factors of each individual, as adolescents and young adults may be especially reticent to discuss their concerns. Careful assessment focuses on:

- Evidence or risk of bullying
- Dysfunctional family dynamics
- Substance abuse risks
- Depression screening
- Suicide risks
- STIs screening
- HPV vaccination
- Home living conditions
  (Hao et al., 2021; Eder et al., 2021)

CASE

Mark is a 38-year-old presenting to the urgent care clinic with UTI symptoms. The nurse practitioner, Jocelyn (she/her), asks Mark about pronouns, and Mark responds with "they/them." Mark describes to Jocelyn their concern about having three UTIs in the past three months.

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According to the medical record, Mark is male and currently taking testosterone and bupropion. The nurse practitioner confirms this information, stating "I see on your intake form that you marked your gender identity as trans man. Is that correct?" Mark nods and replies, "Thank you for acknowledging this. Most providers ignore my gender identity." Jocelyn then asks about sexual orientation, and Mark responds, "I am gay and have a male partner." She documents Mark's responses so that the medical record accurately reflects sexual orientation and gender identity.

It could be easy to assume that Mark's genitals and organs match their outward male appearance and gender identity. But due to Mark's medication history and in order to clarify, Jocelyn asks which organs Mark has. She explains that asking Mark about their organs is important to determine whether there may be another medical reason Mark is having repeated UTIs. Mark reports having ovaries, a uterus, and a vagina. Jocelyn then explains to Mark that UTIs are common in people with frontal genital openings or vaginas.

Aware that using public restrooms can be uncomfortable or unsafe for some transgender people, Jocelyn asks if Mark is always able to empty their bladder when it is full or if there are times or situations where they are not able to do this. Mark responds that they are able to empty their bladder now but that prior to top surgery (6 months ago), they did not feel comfortable or safe using either female or male public restrooms due to a large chest.

Ruling this out as an issue that might be contributing to Mark's UTIs, Jocelyn explains how testosterone can lead to vaginal atrophy and that the urethra is estrogen responsive. Since Mark is having repeated UTIs, it may be helpful to treat them with a course of vaginal estrogen.

Since Jocelyn has normalized the discussion of Mark's UTIs and gender identity, Mark leaves the office not only feeling very affirmed in their gender, but also relieved to understand that there is a medical reason for their continued infections.

LAWS RELATED TO LGBTQ+ HEALTHCARE

LGBTQ+ individuals continue to face unique legal challenges due to their frequent inability to be recognized as their identified gender and/or to formalize their relationships. This can leave many individuals and families feeling invisible in healthcare settings. In order to provide effective care and to keep up to date with changing laws and policies, healthcare professionals should educate themselves about such laws, policies, and requirements needed to protect and ensure quality care for LGBTQ+ patients.

Expanded Health Insurance Laws

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The federal Affordable Care Act (ACA), passed in 2015, contained certain provisions important for LGBTQ+ patients and their families, such as:

- Health insurance plans may not exclude transition-related care for transgender patients.
- Coverage may not be denied based on pre-existing conditions (important, for instance, for patients with a pre-existing HIV/AIDs diagnosis).
- Insurance coverage must be made available regardless of employment status (important since protection from employment discrimination is not guaranteed for LGBTQ+ individuals).
- Expanded coverage is available (in most states) for LGBTQ+ partners and children (depending on the state's definition of "family members").
- Certain coverages are mandated for preventive services and screening, mental health, and substance abuse treatment.
- Protection is provided against discrimination based on sexual orientation and gender identity.
(Medina & Mahowald, 2020)

Healthcare providers must stay current on changes to the ACA and other healthcare laws and policies affecting the healthcare rights of their LGBTQ+ patients. Clinicians and providers can also assist in advocating for quality care by supporting policies that protect LGBTQ+ rights and referring patients who have questions about care or health insurance coverage to a social worker or case manager. (See "Resources" at the end of this course for more on state laws and policies.)

LGBTQ+ Cultural Competency

In 2015, the D.C. Council Committee on Health and Human Services voted unanimously to approve the LGBTQ Cultural Competency Continuing Education Amendment Act of 2015. This act requires all healthcare providers to complete cultural competency training on the unique culture and healthcare needs of LGBTQ+ patients. Some U.S. states have mandated similar measures (University of Wisconsin Public Health Institute, 2020).

Professional Association Policies and Position Statements

In order to protect the rights of LGBTQ+ patients, various professional and oversight organizations have also adopted policies, position statements, and/or requirements. Some of these are included below.

AMERICAN NURSES ASSOCIATION (ANA)

The ANA (2018) published the following position statement:

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> The ANA condemns discrimination based on sexual orientation, gender identity, and/or expression in healthcare and recognizes that it continues to be an issue despite the increasing recognition and acceptance of LGBTQ+ populations. Many LGBTQ+ individuals have reported experiencing some form of discrimination or bias when accessing healthcare services. Persistent societal stigma, ongoing discrimination, and denial of civil and human rights impede individuals' self-determination and access to needed healthcare services, leading to negative health outcomes including increased morbidity and mortality. Nurses must deliver culturally congruent, safe care and advocate for LGBTQ+ populations.

AMERICAN PHYSICAL THERAPY ASSOCIATION (APTA)

The APTA (2019) published the following nondiscrimination statement:

> The American Physical Therapy Association opposes discrimination on the basis of race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA)

The AOTA's vision statement (2021) affirms its commitment to diversity, equity, and inclusion, as follows:

> AOTA is committed to creating an environment where all people within our professional community are valued and able to give their best in the communities where they live and work. AOTA strives to recognize and uplift the diversity of our profession and is committed to creating opportunities to foster inclusivity, participation, and representation. We will act with intention and live our values to be inclusive, equitable, just, and accountable in this work.

THE JOINT COMMISSION (TJC)

The Joint Commission ambulatory care standards address discrimination and a patient's right to have an advocate: "As a patient, you have the right to be informed about and make decisions regarding your care. You also have the right to care that is free from discrimination as well as the right to have a patient advocate" (TJC, 2019).

In addition, The Joint Commission (2011) earlier published an extensive field guide for hospitals to meet the needs of LGBT patients. This field guide points out potential barriers to care that LGBT individuals might face in the hospital setting, such as:

- Refusal of care
- Delayed or substandard care
- Mistreatment
- Inequitable policies and practices

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- Little or no inclusion in health outreach or education
- Inappropriate restrictions or limits on visitation

These guidelines have created awareness to the needs of LGBTQ+ patients and outlined a roadmap for healthcare organizations to follow as they create and implement new policies and make change for a more inclusive healthcare environment for all patients. The Joint Commission does acknowledge, however, that their 2011 *Field Guide* refers to some regulations and includes some definitions and terms that have since become outdated (Cordero & Tschurtz, 2022).

THE JOINT COMMISSION FIELD GUIDE RECOMMENDATIONS

- Hospitals must prohibit discrimination based on sexual orientation and gender identity or expression, and this requirement applies regardless of local law.
- Hospitals may not refuse care because of sexual orientation or gender identity or expression.
- Hospitals should recognize same-sex partners as the patient's family, including recognizing same-sex marriages, even if not recognized by the law of the state in which the hospital is located.
- Patients may designate same-sex partners as surrogate decision-makers, including in advance directives.
- Hospitals should involve same-sex parents in their children's care, even those parents who lack legal custody.
- Hospitals should not permit a patient's parents who disapprove of the patient's same-sex relationship from excluding the patient's partner against the patient's wishes.
- A patient may designate a same-sex partner as family for visitation and other purposes.
- Healthcare providers should use neutral language when taking sexual histories.
- Hospitals should use a transgender patient's preferred name even if not the legal name.
- Hospitals should refer LGBT patients to welcoming healthcare providers for follow-up.
- Hospitals should maintain the confidentiality of information about sexual orientation and gender identity or expression.
- Hospitals should use available research data to understand LGBT community needs.
- Hospitals should consider modifying data systems to permit the capture of sexual orientation and gender identity or expression information in electronic medical records.
- Intake forms should be inclusive of LGBT patients.
- Hospitals should create a welcoming environment for LGBT staff and patients.
- LGBT hospital staff should be protected from discrimination.

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- Key terms, such as *family, gender expression, gender identity,* and *sexual orientation,* are defined in ways affirming to LGBT people, and the LGBT community's preferred and expansive phraseology important for transgender people—"gender identity or expression"—is adopted throughout.
(TJC, 2011)

Other Legal Concerns of LGBTQ+ Patients

While not all jurisdictions provide specific legal protections for LGBTQ+ individuals, healthcare professionals and institutions can discuss and address various legal issues with patients.

LIVING WILL AND MEDICAL DIRECTIVES

LGBTQ+ individuals, as with all patients, should file documents outlining their wishes concerning life-sustaining medical care, funeral arrangements, and organ donation. This is especially important as they grow older. Each state may have different document names or requirements. Documents may be called:

- Living will
- Medical directive
- Healthcare directive
- Directive to physicians
- Declaration regarding healthcare

The **"District of Columbia Declaration"** is the District of Columbia's living will. It allows individuals to state their wishes about medical care in the event that they develop a terminal condition and can no longer make their own medical decisions. The declaration goes into effect when a patient's physician and one other physician certify that the patient has an incurable condition that will lead to their death, with or without the use of life sustaining medical care, and that life-sustaining procedures would serve only to postpone their death.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

A durable power of attorney for healthcare (or healthcare proxy) is a legal document that allows a designated person to make medical decisions for another person in the event they are unable to do so themselves. For an LGBTQ+ patient, this is a very important document that can protect their wishes at a time when they may not be able to speak for themselves. Same-sex partners should file these documents and make their wishes known to their family members as well. This is a legal document that should be kept on file with the healthcare facility and with the person who is named as the healthcare proxy.

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In the **District of Columbia**, specific forms are available to create and notarize a durable power of attorney to keep on file as a legal document. (See "Resources" at the end of this course.)

HOSPITAL VISITATION AUTHORIZATION

A hospital visitation authorization allows a patient to name specific individuals they wish to visit them in the event that they are no longer able to communicate their wishes.

For participating hospitals, a Centers for Medicare and Medicaid Services rule ensures visitation rights for family members, partners, and spouses of all patients, including LGBTQ+ individuals. Hospitals are required to inform each patient (or support person, where appropriate) that they may receive the visitors they designate, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend (CMS, 2010).

The Joint Commission (Cordero & Tschurtz, 2022) also supports visitation policies that give patients the right to choose who may visit them. This includes family members, spouses, domestic partners, or other visitors of the patient's choosing.

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF A MINOR

Medical treatment of a minor requires authorization from the legal parents. In states that do not recognize both parents in a same-sex couple as legal parents, it is critical to file the appropriate state form to address this issue. Such a form may be helpful in times when emergency care for a child of a same-sex couple is needed. For couples who are planning to have children, this document should be completed before the birth mother goes into the hospital. Most hospitals honor this authorization.

In the **District of Columbia**, the law reads:

> A parent, legal guardian, or legal custodian may authorize an adult person, in whose care a minor has been entrusted, to consent to any medical, surgical, dental, developmental screening, and/or mental health examination or treatment, including immunization, to be rendered to the minor under the supervision or upon the advice of a physician, nurse, dentist or mental health professional licensed to practice in the District of Columbia, provided there is no prior order of any court in any jurisdiction currently in effect which would prohibit the parent, legal guardian, or legal custodian from exercising the power that they seek to convey to another person. Medical, surgical, and dental treatment or examination may include any X-ray or anesthetic required for diagnosis or treatment (Council of the District of Columbia, 2022).

DURABLE POWER OF ATTORNEY FOR FINANCES

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A durable power of attorney for finances designates another person (agent) to take care of finances when a person is not able to do so for themself. This may include paying medical bills, cashing checks, and receiving benefits.

WILL

A will is a legal document that allows a person to designate who will receive any property when they die. If a person dies without a will, their property is automatically distributed to their legal heirs. A will is important for anyone to have, but especially important for same-sex partners, since they may not be recognized as a legal heir in all states.

"KNOW YOUR RIGHTS" IN WASHINGTON, DC

In the District of Columbia, specific laws and regulations may apply to the LGBTQ+ community, including these sections of the DC Code:

- 1-529, Spouse equity
- 1-612.31 and 32(b), Voluntary leave transfer program
- 1-621-07, 623.10 and 33, Health benefit coverage
- 2-1401, Human rights definitions
- 4-201.01, 205.22, 213.01, 218.01, 1301.02, Public assistance support actions
- 7-231-08, 18, 24, Vital records—Birth and marriage registration
- 7-1601, AIDS health care definitions
- 16-1001, Intrafamily proceedings definitions
- 16-2345, Changes to new birth record upon marriage or determination of natural parents
- 16-2501, Change of name or gender
- 21-2113, Uniform general power of attorney, related to personal and family maintenance
- 21-2202, Health-care decisions
- 22-501, Criminal offenses and penalties concerning bigamy
- 22-3701, Bias-related crime definitions
- 23-154, Care for LGBT seniors and seniors with HIV Amendment Act of 2020
- 31-3303.07, Group health insurance
- 32-501, Family and medical leave
- 32-701, 702(i), 704, 705, 706, Health care benefits expansion
- 32-1201, Parental leave definitions

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- 32-1501, Worker's compensation definitions
- 46-405, Illegal marriages entered into in another jurisdiction
- 50-1501.02(e)(4), Adding joint ownership to registration of motor vehicles

Specific acts and amendments to acts include:

- Bias-Related Crime Act of 1989
- Omnibus Domestic Partnership Equality Amendment Act of 2008 (Law 17-231)
- Jury and Marriage Amendment Act of 2009
- Religious Freedom and Civil Marriage Equality Amendment Act of 2009

(Council of the District of Columbia, 2022)

BEST PRACTICES REGARDING PATIENT INFORMATION

The process of collecting, storing, using, and keeping confidential information regarding sexual orientation and gender identity is evolving at most healthcare institutions. In 2011, the Institute of Medicine recommended that all healthcare institutions integrate data related to sexual orientation and gender identity into medical records. Appropriate data collection and privacy policies can lead to improved access, quality of care, and outcomes (Medina & Mahowald, 2022; GLMA, n.d.).

Inclusive Data Collection

Data collection on intake and other forms should allow for appropriate responses that are inclusive of LGBTQ+ patients. Best practices when collecting data include asking questions about gender first, then sexual orientation, followed by relationship status. Examples of inclusive data collection are indicated below.

Name

- Legal name:__________________________
- Name you use:__________________________

Gender Identity

- What was your assigned sex at birth (ASAB)?
  [ ] Male
  [ ] Female
  [ ] Other ASAB not listed here
  [ ] Do not wish to disclose

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- What is your gender identity? (check all that apply)
  [ ] Male
  [ ] Female
  [ ] Transgender Male
  [ ] Transgender Female
  [ ] Queer
  [ ] Nonbinary
  [ ] Cis-male
  [ ] Cis-female
  [ ] Gender identity not listed above__________________
  [ ] Do not wish to disclose

- What are your pronouns (check all that apply)?
  [ ] He/him
  [ ] She/her
  [ ] They/them
  [ ] Your name
  [ ] Pronouns not listed above__________________

Sexual Identity

[ ] Straight
[ ] Gay
[ ] Lesbian
[ ] Bisexual
[ ] Queer
[ ] Questioning
[ ] Don't know
[ ] Sexual identity not listed above__________________
[ ] Do not wish to disclose

Relationship Status

[ ] Single
[ ] Married
[ ] Partnered/long-term or domestic partnership
[ ] Divorced/separated
[ ] Widowed
[ ] Do not wish to disclose

(Grasso et al., 2021; National LGBT HEC, 2022)

Privacy Policies

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It is important to assure all patients that any information collected is considered confidential. Confidential information may include patient-provider conversations and any data collected and stored in the medical record. Assurance of patient privacy may help LGBTQ+ patients feel more comfortable disclosing information within a healthcare setting knowing that it is protected. A confidentiality and privacy policy should be available in written format and readily available for patients to read and understand.

Elements to include in a privacy policy include:

- What information is covered by the policy
- Who has access to the medical record
- How test results remain confidential
- How information is shared with their insurance provider
- Any instances when maintaining confidentially is not possible
  (GLMA, n.d.)

BEST PRACTICES FOR CULTURALLY COMPETENT CARE

LGBTQ+ patients, particularly those who identify as transgender or nonbinary, often face barriers to accessing healthcare services due to the lack of provider understanding of their gender identities. Providing high-quality, culturally competent, patient-centered care is a complex process that requires ongoing learning and awareness of the various factors that affect the LGBTQ+ population.

Even healthcare organizations that have taken positive steps toward improving cultural competency for LGBTQ+ patients will find new ways to address barriers to care and engage staff in improvement initiatives. Improving skills and knowledge among healthcare leaders, providers, and staff should be looked at as opportunities rather than as organizational or individual weaknesses.

Physical Space

Best practices start at the front door and extend into the provider's office and treatment areas. Everything from the hospital website to the front desk and waiting areas should reflect a healthcare setting that is welcoming, open, and inclusive.

- Include gender-neutral restrooms and signage.
- Post signage to affirm nondiscrimination policies that include sexual orientation, gender identity, and gender expression.
- Evaluate environmental factors of potential concerns for LGBTQ+ patients and families, such as bathroom designations, artwork, posters, educational brochures, etc.
  (Reynolds, 2020; GLMA, n.d.)

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Internet and Website

Informational, educational, and support materials should be designed to help LGBTQ+ patients feel comfortable and supported in the healthcare setting.

- Include inclusive language on any websites and marketing materials that describes a commitment to high-quality, culturally competent, patient-centered care.
- Ensure that marketing, advertising, and informational materials reflect diverse populations, including same-sex couples and families.
- Create a separate webpage or portal for information and resources related to LGBTQ+ care.
(National LGBTQIA+ HEC, 2021; GLMA, n.d.)

Supportive Communication

An individual may delay or avoid accessing care due to the fear that their provider may not take their gender identity and pronouns seriously or be entirely dismissive of them, causing them to feel "invisible." There are many ways that a healthcare provider and support staff can communicate with patients to help them feel respected and comfortable.

- Avoid the use of gendered titles such as "Sir" or "Ma'am." Instead of Mr. or Ms., patients may also wish to be addressed as Mx. (pronounced with a "ks" or "x" sound at the end).
- Introduce yourself with your pronouns. Ask patients for information such as their pronouns, preferred name, and gender identity. Pronouns may include: he/his/him, she/hers/her, or a range of options for nonbinary transgender patients, such as they/their/them, ze, sie, hir, co, and ey. Always respect the patient's pronouns and apologize if the wrong pronouns are used by mistake.
- Always ask for clarification when not clear what a patient would like to be called or how the patient would like to be addressed. Apologize if you refer to a patient in a way that seemed offensive.
- Ask patients what terms they use to refer to their anatomy, and mirror those terms during the patient interaction. Transgender patients may experience gender dysphoria and/or may not be comfortable with traditional terms for body parts.
- Ask the patient to clarify any terms or behaviors that are unfamiliar, or repeat a patient's term with your own understanding of its meaning to make sure you have a good understanding of what it means to them.
- Do not make assumptions about patients' sexual orientations, gender identities, beliefs, or concerns based on physical characteristics such as clothing, tone of voice, perceived femininity/masculinity, etc.

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- Do not be afraid to tell a patient about one's own inexperience working with LGBTQ+ patients. Honesty and openness will often stand out to a patient from their previous healthcare experiences.
- Do not ask patients questions about sexual orientation or gender identity that are not material to their care or treatment.
- Do not disclose patients' sexual orientations or gender identities to individuals who do not explicitly need the information as part of the patients' care.
- Keep in mind that sexual orientation and gender identity are only two factors that contribute to a patient's overall identity and experience. Other factors—including race, ethnicity, religion, socioeconomic status, education level, and income—also contribute to the patient's experiences, perceptions, and potential barriers to healthcare.

  (TJC, 2011; Reynolds, 2020; GLMA, n.d.; LGBTQ+ Resource Center, n.d.; Garrett, 2022.)

CASE

James is a 23-year-old patient brought to the emergency department by a close friend who is concerned about James's symptoms of depression and a statement James made about "wishing I were dead." James has no significant medical or mental health history according to the medical record.

The clinician enters the room and greets the patient, saying, "Hello, I am Tonya. My pronouns are she/her. I am a nurse and will be taking care of you today. May I ask what name and pronouns you use?" James doesn't respond right away, and Tonya notices James looking at her name badge, indicating her own pronouns, and also staring at the rainbow flag hanging on the wall of the exam room.

After a moment of silence, James quietly tells Tonya her name is Jenna and her pronouns are "she/her." Jenna then breaks down in tears and says she has never shared her preferred name with a "stranger" before. She says that she sometimes just wants to die because she feels like she is supposed to be a woman but is afraid this will never be a reality or possibility. Jenna worries about how her family will react and about losing her job and healthcare coverage if she comes out to others with her true gender identity.

Tonya responds with understanding and stresses that the most important thing now is to make sure that Jenna is safe and has the support she needs. Tonya brings in the social worker to complete a behavioral health assessment and to address the possible risk of imminent self-harm. The social worker also documents Jenna's preferred name and pronouns in the medical record and then provides Jenna with a national suicide hotline number for transgender people, a list of local support groups, the name of a psychologist who specializes in gender issues, and an insurance contact to review her benefits related to gender care.

Jenna states that she was previously unaware of all these support resources. She adds that she feels more hopeful than she has in a long time and that she had never been able to express her feelings so freely before.

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Institutional Policies and Practices

In order to provide culturally competent care, institutions must assess current organizational practices and identify gaps in policies and services related to care and services for LGBTQ+ patients. This also includes ensuring that policies comply with all federal and state regulations (see "The Joint Commission Field Guide" earlier in this course).

Recommendations to build awareness within an organization about the LGBTQ+ community include:

- Hold an open discussion with healthcare professionals and staff about the difference between sexual orientation (lesbian, gay, bisexual, etc.) and gender identity (transgender, nonbinary, intersex, etc.), since this can be confusing to those who are not familiar with such concepts
- If not already in place, establish a point person, office, or advisory group to oversee LGBTQ-related policies and concerns, ideally including members representing the LGBTQ+ community
- For inpatient facilities, review visitation policies to empower patients to decide who can visit them and act on their behalf (see also "Legal Issues" earlier in this course)
- Review codes of conduct and ethics to ensure they include expectations for respectful communication with all patients, visitors, and staff members and that they specify consequences for code violations
- Provide training and orientation on a regular basis to professionals and staff on culturally competent care and organizational policies related to conduct, ethics, privacy, nondiscrimination, and antiharassment policies
  (GLMA, n.d.; National LGBTQIA+ HEC, 2021)

OPPRESSION, DISCRIMINATION, AND CULTURAL BIAS IN HEALTHCARE

While a person may define themselves largely by their sexual orientation and/or gender identity, one's experience is also influenced by the intersection of sex, race, ethnicity, socioeconomic status, ability, and other social determinants. All these factors have an impact on a patient's access to healthcare, health risks, and health outcomes. Any past and present discrimination, oppression, or fear related to these factors can greatly influence an individual's actions to actively seek care when needed or, conversely, to defer their healthcare needs until a crisis occurs (Medina-Martinez et al., 2021).

An Intersectionality Perspective

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Providing whole-person, patient-centered care requires proactively considering how the intersection of each person's diverse identities and broader cultural factors can affect their health risks, healthcare experiences, and health outcomes. Such an "intersectionality" perspective should not lead to assumptions about an individual based on the minority groups with which they identify but should inform the clinical experience in a positive manner in order to respect and address each person's unique needs (Medina-Martinez et al., 2021).

Cultural Bias and the Provision of Care

When working with LGBTQ+ patients, it is especially important for clinicians and case managers to build a positive rapport as a way to counteract the exclusion, discrimination, and stigma their patients may have experienced previously in the healthcare environment. However, despite their best intentions, healthcare professionals may hold internalized cultural biases that affect their interaction with patients. For example, a clinician, case manager, or other staff member may say something or use body language that communicates a stereotype or negative message about LGBTQ+ people.

These biases can lead to unequal care and affect a patient's decision to follow medical advice or return for follow-up care. Negative messages can also become internalized in the patient, adding to an LGBTQ+ person's stress and contributing to negative mental and physical health outcomes (Medina-Martinez et al., 2021).

Studies have shown that no matter how individuals may feel about prejudiced behavior, everyone is susceptible to biases based on cultural values and stereotypes that were embedded in their belief systems from a young age. To increase one's own awareness of internal bias, it is helpful to notice times when biased attitudes and beliefs may arise. Such internal awareness is the first step in making changes. Internal questions to ask may include:

- How do my current beliefs help me?
- What might I lose if I change my beliefs?
- How might my current beliefs harm others?
- How might it benefit me and others to change my beliefs?
  (NCCC, n.d.)

It is important for clinicians and case managers to focus on remaining open and compassionate by consciously intending to set aside assumptions and get to know a patient as an individual. For example, when first meeting a new patient who is a transgender man, the clinician can imagine what it might be like for this person to see a new provider for the first time. Instead of focusing on the patient's gender identity and when or if he has transitioned, the clinician or case manager can focus on getting to know him as a person, such as understanding where he lives and works and more about his family support.

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CONCLUSION

Providing high-quality, culturally competent care to all patients involves understanding the cultural contexts of each individual. In the case of LGBTQ+ patients, it is important to educate oneself on issues related to sexual orientation and gender identity in order to address and understand the spectrum of these patients' health concerns. This may include addressing any health risks or disparities, with careful attention to any behavioral health needs and transgender care.

When considering best practices for providing culturally competent care, healthcare professionals should carefully evaluate their practice environment; examine, advocate for, and modify practice policies when needed; take detailed and nonjudgmental histories; educate themselves and/or update their knowledge on the health issues of LGBTQ patients; and reflect on any personal attitudes or bias that may prevent them from providing the highest level of care to their patients. By taking these positive steps, healthcare providers can ensure that all patients they care for achieve the best possible health outcomes.

RESOURCES

GLMA: Health Professionals Advancing LGBTQ Equality
https://www.glma.org/

Human Rights Campaign
https://www.hrc.org/

Lesbian, gay, bisexual, and transgender health (Centers for Disease Control and Prevention)
https://www.cdc.gov/lgbthealth/index.htm

LGBTQ healthcare laws and policies map
https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies

Mayor's Office of Lesbian, Gay, Bisexual, Transgender and Questioning Affairs (Washington, DC)
https://communityaffairs.dc.gov/molgbtqa

National Center for Transgender Equality

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https://transequality.org/know-your-rights/health-care

National Coalition for LGBTQ Health
https://healthlgbtq.org/

National LGBT Health Education Center (Fenway Institute)
https://www.lgbthealtheducation.org/

National LGBTQ Task Force
https://www.thetaskforce.org/

PFLAG
https://pflag.org/

Washington, DC, advance directive form (National Hospice and Palliative Care Organization)
https://www.nhpco.org/wp-content/uploads/DistrictofColumbia.pdf

WPATH (World Professional Association for Transgender Health)
https://wpath.org/

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TEST

[Take the test online at wildirismedicaleducation.com]

1. Which statement defines a transgender person?

a. A man who is primarily attracted to men
b. A person who has a gender identity that does not match their assigned sex at birth
c. A woman who is primarily attracted to women
d. A person who is attracted to someone on the basis of their characteristics rather than their gender

2. Which term is no longer considered acceptable usage today?

a. Transgender
b. Queer
c. Homosexual
d. Gay

3. Which condition is an individual who identifies as a lesbian at increased risk for acquiring?

a. Gonorrhea infection
b. Hepatitis infection
c. Depression
d. Colon cancer

4. For which condition should an adolescent who is teased by peers for being transgender be assessed?

a. Obsessive compulsive disorder
b. Attention deficit disorder
c. Bipolar disorder
d. Suicide ideation

5. Which institutional policy should be changed in order to meet the Joint Commission standards for appropriate care of LGBT patients?

a. LGBT hospital staff may not be discriminated against in the workplace due to their sexual orientation.
b. Information related to sexual orientation and gender expression is protected as confidential.
c. Same-sex partners are not considered “family” for visitation purposes unless required by state law.
d. The hospital intake form shall include questions about sexual orientation, gender identity, and relationships.

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6. Which document should a patient with a same-sex partner be encouraged to obtain in order to protect their wishes for care?

a. Durable power of attorney for healthcare
b. Marriage certificate
c. Health insurance policy
d. Life insurance policy

7. Which action should the clinician take when conducting an intake interview with a patient being admitted to the hospital?

a. Document the gender identity that matches the patient's outward appearance
b. Enter sexual orientation into the medical record
c. Omit relationship status because it is not part of an admission interview
d. Enter only the patient's legal name into the medical record

8. Which action should a healthcare facility take to support a culturally appropriate physical environment for LGBTQ+ patients?

a. Place male and female restrooms in separate areas of the building
b. Avoid images of same-sex couples on posters
c. Post nondiscrimination policies discreetly in private areas
d. Provide gender-neutral restrooms for all patients

9. Which action should be taken when a newly admitted patient has the legal first name "Karl"?

a. Show the patient the men's restroom when orienting them to the clinic facilities
b. Refer to the patient as "sir" until a more relaxed relationship has been established
c. Ask the patient the name they use and their pronouns
d. Inquire if the patient is married in the event they will need help at home during recovery

10. Which action would a healthcare professional take to reduce their personal cultural bias?

a. Answer the question, "Is my current belief wrong or right?"
b. Take a test on knowledge of LGBTQ+ terminology
c. Answer the question, "How might my current beliefs harm others?"
d. Debate personal beliefs on LGBTQ+ issues with other clinicians

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