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Ending LGBT invisibility in health care: The first step in ensuring equitable care

ABSTRACT

Lesbian, gay, bisexual, and transgender (LGBT) individuals experience health care disparities that will be eliminated only if clinicians elicit information about sexual orientation and gender identity from their patients through thoughtful, nonjudgmental discussion and history-taking.

KEY POINTS

LGBT people are represented in most medical practices, and their health issues, including sexually transmitted diseases such as human immunodeficiency virus, can generally be managed in traditional health care settings rather than in special clinics.

Physicians need to become more comfortable asking patients about sexual health, identity, and behavior, and make such queries more routine.

Sexual behavior is not always congruent with routine understanding of sexual identity. For example, many men who do not identify themselves as gay occasionally have sex with men, as do many self-identified lesbians. It is important to know this to provide appropriate preventive screening and care.

IN SPEAKING ABOUT lesbian, gay, bisexual, and transgender (LGBT) health, it is not uncommon for me to be asked what is so unique about the health care needs of lesbians, gay men, bisexuals, and transgender individuals that it warrants focused attention in the training of health professionals and while providing care.¹ Although it is true that most health issues affecting LGBT individuals parallel those of the general population, people who are LGBT have been shown to have unique health needs and to experience disparities in care.

There is a growing if limited number of good studies of LGBT health. The Institute of Medicine² reported on lesbian health in 1999, concluding that enough evidence of disparities exists to support more research and to develop better methods of conducting the research. Healthy People 2020 actually recognizes significant health care disparities.³ Finally, the Institute of Medicine recently formed a committee on LGBT health issues to identify gaps in our knowledge and priorities for research. Their findings were expected to be published in late March 2011, after this article went to press.

MAKING A DIFFERENCE

While this article will not attempt to discuss all the disparities, the focus will be on how physicians can take the first critical step to helping LGBT individuals feel comfortable seeking care, ie, by being proactive in taking a history that includes discussion of sexual orientation and gender identity. Only by knowing this about patients will clinicians appro-

Medical Grand Rounds articles are based on edited transcripts from Medicine Grand Rounds presentations at Cleveland Clinic. They are approved by the author but are not peer-reviewed.

doi:10.3949/ccjm.78gr.10006

privately care for specific health needs, and will ensure patients feel comfortable discussing their concerns in clinical settings.

While some feel this is relevant only in select areas of the country, recent data show that the LGBT population is both spread throughout the country and diverse in how they might present themselves in clinical settings.^{1,4} In the United States, 1.4% to 4.1% of people identify themselves as lesbian, gay, or bisexual.⁵ About 3% of women and 4% of men say they have had a same-sex sexual contact in the last year, and 4% to 11% of women and 6% to 9% of men report having ever had one.

Everyone who practices clinical medicine needs to understand whether patients are LGBT and how to engage in conversation about sexual orientation and gender identity.

■ GETTING TO KNOW LGBT PATIENTS

What questions should a clinician ask to get this information? In thinking about what to ask, it helps to realize that patients generally do not mind being questioned about personal matters if the provider approaches the topic and the patient with genuine respect, empathy, and even curiosity.

On the other hand, providers often feel ill-prepared to discuss intimate issues, or feel uncomfortable doing so. Successfully achieving a change in clinical practice involves learning an approach to doing so and becoming comfortable with discussions that may follow. One question to consider is how you will feel and how you will follow up if a patient tells you that he or she is LGBT.

The core comprehensive history for LGBT patients is the same as for all patients, keeping in mind the unique LGBT health risks and issues. Clinicians may begin by getting to know each patient as a person (eg, ask about partners, children, and jobs). I like to begin a session with a patient who is otherwise in good health with an open-ended question such as “Tell me a bit about yourself.” This provides an opportunity for patients to raise a range of issues without any additional focused questions being asked. In this context, if a patient brings up issues regarding sexual orientation or gender identity, ask permission to include this information in the medical record and as-

sure the patient of its importance and that it will be confidential.

If these issues do not come up in response to general questions, they can be embedded in the sexual history, which should be more than a history of risk behaviors and should include a discussion of sexual health, sexual orientation (including identity, behavior, and desire), and gender identity. One can start by simply asking, “Do you have any concerns or questions about your sexuality, sexual orientation, or sexual desires?”

When it is necessary to ask more directed questions, it helps to provide some context so patients do not wonder why you are asking questions they may never have been asked by a physician before. It is best to explain that these are questions you ask all patients, as the information can be important in providing quality care. Patients should be told that discussion of sexual identity, behavior, and desire, as well as gender identity, is routine and confidential. For example, you might say: “I am going to ask you some questions about your sexual health and sexuality that I ask all my patients. The answers to these questions are important for me to know to help keep you healthy. Like the rest of this visit, this information is strictly confidential.”

One usually need not be too probing to get answers; people are often very forthcoming. During such conversations, patients often tell me that it is the first time a doctor has shown any interest in talking about these topics.

In having these conversations, initially it is best to use gender-neutral terms and pronouns when referring to partners until you know which to use: for example, “Do you have a partner or a spouse?” “Are you currently in a relationship?” “What do you call your partner?” Even if you make an incorrect assumption, and the patient corrects you, you can always apologize if a mistake is made and ask which term the patient prefers. Once you know it, use the pronoun that matches a person’s gender identity.

In order to get more information from the patient, the physician can engage in a series of questions, such as:

- Are you sexually active?
- When was the last time you had sex?
- When you have sex, do you do so with

Patients usually do not mind being asked about personal matters, if you approach the topic with respect

men, women, or both?

- How many sexual partners have you had during the last year?
- Do you have any desires regarding sexual intimacy that you would like to discuss?

In general, it is best to mirror the patient's language. If patients use the term "gay" or "lesbian" to describe themselves, it would be off-putting to the patient to use a more clinical term, such as homosexual, in response. Some patients may use terms such as "queer" to indicate that they do not choose to identify as gay or straight. If terms like this are unclear to you, you may simply ask what this term means to the patient.

■ ASSESS SEXUAL BEHAVIOR TO DETERMINE RISK

In taking a history, it is important to distinguish sexual identity from sexual behavior. Physicians need to discuss sexual behavior with patients regardless of their sexual identity in order to do a risk-assessment, ascertaining what activities they engage in and to learn what they do to prevent transmission of sexually transmitted disease. In a 2006 study of more than 4,000 men in New York City,⁴ 9.4% of those who identified themselves as straight had had sex with a man in the previous year. These men were more likely to be either foreign-born or from minority racial and ethnic groups with lower socioeconomic status. They were also less likely to have used a condom. A study of lesbians reported that 77% to 91% had at least one prior sexual experience with men, and 8% reported having had sex with a man in the previous year.⁶

Once you understand more about a patient's sexual behavior, it is important to ask how patients protect themselves from human immunodeficiency virus (HIV) and other sexually transmitted diseases. If they use condoms or latex dams, they should be asked whether they do so consistently. Many patients have the misconception that they are practicing safe sex by only engaging in oral sex and do not realize that although it is probably protective against HIV infection, it does not protect against gonorrhea, syphilis, and other sexually transmitted diseases. Although most sexually transmitted diseases are treatable, their pres-

ence increases the risk of transmission of HIV.

Counseling on safer sex should include behavioral risk-reduction approaches. Depending on what behaviors a patient already engages in and what counseling he or she would be willing to accept, one could counsel abstinence, monogamy with an uninfected partner, reducing the number of partners, low-risk sexual practices, consistent and correct use of barrier methods, ceasing to engage in at least one high-risk activity, and avoiding excessive substance abuse. Physicians should advise patients to have a proactive plan to protect themselves and their partners. Patients should also be counseled on the correct use of barrier protection and on what is available for prophylaxis in case of high-risk HIV exposure (eg, a condom breaking or postcoital HIV disclosure). Another important question is, "Do you use alcohol or drugs when you have sex, and does your partner?" because these behaviors are often associated with unsafe sexual practices.

A new dimension of care will be biomedical prevention. While there are many ongoing studies of vaginal and anal microbicides to prevent HIV infection, there are also ongoing studies of antiretroviral therapies to do so.

One important new study demonstrated the effectiveness a biomedical intervention using antiretroviral therapy to prevent HIV infection in high-risk individuals.⁷ The study showed that men who were assigned to take a combination antiretroviral medication orally on a daily basis decreased their HIV risk by almost half compared with those assigned to take a placebo. The therapy was given along with intensive behavioral counseling. While this study was done in men who have sex with men, it is a major breakthrough and suggests there will be many new approaches to preventing HIV in the future.

A guide for clinicians has not been published by any government agency at this point, but guidance for clinicians is available from the Fenway Institute at www.fenwayhealth.org.

■ ASSESS GENDER-IDENTITY ISSUES

One should also routinely ask about whether patients are transgender or have gender-identity concerns. Psychologists start the conver-

In general, it is best to mirror the patient's language in describing his or her sexual orientation

sation with the following example, which can also be used by general clinicians:

“Because so many people are impacted by gender issues, I have begun to ask everyone if they have any concerns about their gender. Anything you say about gender issues will be kept confidential. If this topic isn’t relevant to you, tell me and I’ll move on.”⁸

It is important to open the door to conversation, because many transgender people see a doctor for years and the topic never comes up. When they realize that they want to change their life, no one has ever helped them deal with the issues.

If appropriate, one can also say:

“Out of respect for my clients’ right to self-identify, I ask all clients what gender pronoun they’d prefer I use for them. What pronoun would you like me to use for you?”

Once these issues have been raised, it is important to support transgender people and help them explore a number of choices, including whether they wish to undergo hormone treatment, cosmetic surgery, and genital surgery. This may not be easy for many clinicians, so it will be important to learn about resources to care for transgender individuals in your community. Resources that can be very helpful for primary care clinicians include the following:

- The World Professional Association for Transgender Health (www.wpath.org) is the oldest and most traditional source for establishing standards of care.
- Vancouver Coastal Health published a series of monographs online (<http://transhealth.vch.ca>) that were developed by the University of British Columbia so that transgender people could be cared for in the community by primary care clinicians.
- The Endocrine Society in the United States published guidelines in 2009.⁹

■ PROVIDE SUPPORT FOR ‘COMING OUT’

We should also be understanding of people’s desires and support those who are “coming out.” The desire to reveal sexual orientation to others can happen at any age, including in childhood and among those who appear to have a traditional life because they are married and have children. Sometimes people do not know how to come out and would like to

discuss such issues with their doctor.

■ MENTAL HEALTH CONCERNS

Given the marginalization and stigma that LGBT people face throughout their lives, it is not surprising that mental health problems are more prevalent in this population than in the general population. Gay and bisexual men have more depression, panic attacks, suicidal ideation, psychological distress, and body image and eating disorders than do heterosexual men. Lesbian and bisexual women are at greater risk of generalized anxiety disorder, depression, antidepressant use, and psychological distress.¹⁰ Care providers should screen for mental health disorders, assess comfort with sexual identity, and ask about social support.

■ FAMILY LIFE

Gays and lesbians increasingly want to discuss commitment, marriage, having children, parenting, and legal issues. A lot of research is being conducted on the sexual orientation of children raised by gay parents, and evidence shows that they are not more likely to be gay or lesbian than children raised by straight parents.

Elderly same-sex couples face special difficulties. They are less likely to feel comfortable “out of the closet” than are younger people. Fewer family and community supports are available to them, and they are often unable to live together in an assisted living facility. They particularly need to have advanced directives because they do not have the legal protections of other couples.

■ JUST A BEGINNING

While the points made above are relatively straightforward, they will open the door for many patients to have more meaningful conversations about their lives with their health care providers. It may only be a first step, but it can make a world of difference helping LGBT people feel comfortable accessing health care and receiving appropriate preventive care and treatment. Beyond the interaction with clinicians, health care providers should consider their overall environment and ensure that it is welcoming to LGBT individuals who come there for care.¹¹ ■

Many men who describe themselves as straight have sex with other men

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LGBT INVISIBILITY

■ **RESOURCES**

Family Acceptance Project. familyproject.sfsu.edu

Gay & Lesbian Medical Association.
www.glma.org

Human Rights Campaign. HRC.org.

Parents, Families and Friends of Lesbians and
Gays. PFLAG.org

World Professional Association for Transgender
Health. www.wpath.org

Youth Resource (website by and for LGBT youth).
Youthresource.com

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