LGBTQI+: Special considerations for reproductive health care

Creating a welcoming practice means inclusivity, and evaluating how you present yourself to patients to consider their gender expression and identity is part of contemporary practice

Beatrice Telzak, MD; Jessica Rose, MD; Gwendolyn Quinn, PhD; Steven R. Goldstein, MD, MSCP, CCD

IN THIS ARTICLE

CASE A new patient office visit

A new patient is waiting for you in the exam room. You review the chart and see the sex demographic field is blank, and the patient's name is Alex. As an ObGyn, most of your patients are female, but you have treated your patients' partners for sexually transmitted infections. As you enter the room, you see 2 androgynously dressed individuals; you introduce yourself and ask,

"What brings you in today, and who is your friend?"

"This is my partner Charlie, and we are worried I have an STD."

Estimates suggest that between 7% to 12% of the US population identifies as lesbian, gay, bisexual, transgender/non-binary, queer/questioning, intersex, or asexual (LGBTQI+).[1] If you practice in an urban area, the odds are quite high that you have encountered an LGBTQI+ person who openly identified as such; if you are in a rural area, you also likely have had an LGBTQI+ patient, but they may not have disclosed this about themselves.[2] Maybe you have had training in cultural relevance or are a member of this community and you feel confident in providing quality care to LGBTQI+ patients. Or maybe you think that, as a responsibly practicing health care clinician, you treat all patients the same, so whether or not you know their sexual orientation or gender identity does not impact the care you provide. As the proportion of US adults who identify as LGBTQI+ increases,[1] it becomes more important for health care clinicians to understand the challenges these patients face when trying to access health care. To start, let's review the meaning of LGBTQI+, the history of the community, what it means to be culturally relevant or humble, and how to create a welcoming and safe practice environment.

Dr. Telzak is Clinical Assistant Professor, New York University Grossman School of Medicine, New York, New York.

Dr. Rose is Clinical Associate Professor, New York University Grossman School of Medicine.

Dr. Quinn is Livia Wan Endowed Professor and Vice Chair of Research in the Department of Obstetrics and Gynecology, New York University Grossman School of Medicine.

Dr. Goldstein is Professor, Obstetrics and Gynecology, New York University Grossman School of Medicine. He serves on the OBG MANAGEMENT Board of Editors.

The authors report no financial relationships relevant to this article.

doi: 10.12788/obgm.0325

LGBTQI+ terms and definitions

The first step in providing quality care to LGBTQI+ patients is to understand the terminology associated with sexual orientation, gender identity, and gender expression.[3–5]

Sexual orientation refers to whom a person is sexually attracted. The term straight/heterosexual suggests a person is sexually attracted to a person of the opposite gender. Lesbian or gay refers to those who are

*The term LGBTQI+ is not used consistently in the literature. Throughout this article, the terminology used matches that used in the cited reference(s).

attracted to their same gender. Some people use bisexual (attracted to both the same and opposite gender) and pansexual (attracted to all humans regardless of gender). Still others refer to themselves as queer—people who identify as someone who is not heterosexual or cisgender. A variety of other terms exist to describe one's sexual attraction. There are also some people who identify as asexual, which suggests they are not sexually attracted to anyone.

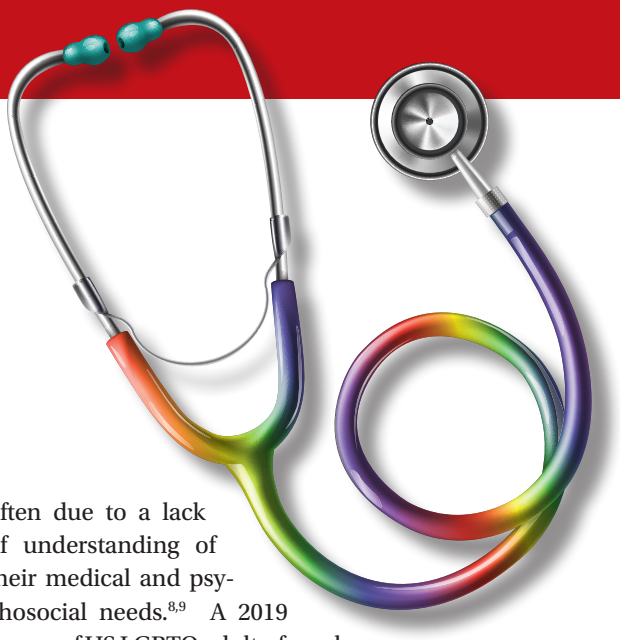
Gender identity relates to how one views their own gender. If you were assigned female at birth and identify as a woman, you are cisgender. If you were assigned male at birth and identify as a woman, you may identify as transgender whether or not you have had gender transitioning surgery or have taken hormones. Some people do not identify with the terms male or female and may view themselves as nonbinary. The terms gender queer, gender fluid, gender diverse, and gender nonconforming also may be used to describe various ways that an individual may not identify as male or female. We also can refer to people as "assigned female at birth" or "assigned male at birth". People with intersex conditions may require taking a unique medical history that includes asking about genetic testing (eg, 46,XX congenital adrenal hyperplasia or 46,XY complete gonadal dysgenesis).

Gender expression refers to how one presents themselves to others through appearance, dress, and behavior. A person may be assigned female at birth, dress in a conventional male fashion, and still identify as a woman. Still others may choose to express their gender in a variety of ways that may not have anything to do with their sexual orientation or gender identity, such as dressing in ways that represent their culture.

People may be fluid in their sexual orientation or gender identity; it may change from day to day, month to month, or even year to year.[6,7]

Health care and the LGBTQI+ community

The LGBTQI+ community has a history of experiencing societal discrimination and stigma, which stems from medical mistrust



often due to a lack of understanding of their medical and psychosocial needs.[8,9] A 2019 survey of US LGBTQ adults, found that about 50% of people who identified as transgender reported having negative or discriminatory experiences with a health care clinician.[10] About 18% of transgender people anticipated being refused medical care due to their gender identity.[10] About 18% of LGBTQ individuals avoid any type of medical care, fearing discrimination.[10] Lesbian women are 3 times more likely to have not seen an ObGyn than women who identify as straight.[11] Sixty-two percent of lesbian women have biological children and received prenatal care; however, of those, 47% do not receive routine cancer screenings.[10,11] Only 45% of age-eligible lesbian women have received at least 1 dose of the HPV vaccine, compared with 60% of straight women.[10,11]

Due to societal stigma, more than 40% of transgender people have attempted suicide.[12] Felt or perceived stigma is also associated with risky health behaviors that contribute to health disparities. LGBTQI+ people are more likely to use substances,[13] lesbian women are more likely to be obese,[14] and 19% of transgender men are living with HIV/AIDS.[15] Rates of unintended pregnancy among lesbian women and transgender men are 28%, compared with 6% in straight women, and 12% in heterosexual teens.[15,16]

In addition to real or perceived discrimination, there are medical misperceptions among the LGBTQI+ community. For instance, sexual minority women (SMW) are less likely to receive regular screening for cervical cancer. In one survey of more than 400 SMW, about 25% reported not receiving regular screening. SMW

may mistakenly believe they do not need Pap testing and pelvic exams because they do not have penile-vaginal intercourse.[17,18] Transgender men may not identify with having a cervix, or may perceive ObGyns to be "gendered" toward people who identify as women.[18]

Embracing cultural humility

Cultural humility expands upon the term cultural competence, with the idea that one can never be fully competent in the culture of another person.[19,20] The National Institutes of Health defines cultural humility as "a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of his/her own beliefs and cultural identities."[21]

Having cultural humility is the recognition that, in order to treat your ObGyn patient as a whole person and engage in shared medical decision making in the office setting, you need to know their sexual orientation and gender identity. Treating each patient the same is not providing equitable care (equality does not equal equity) because each patient has different medical and psychosocial needs. Embracing cultural humility is the first step in creating safe and welcoming spaces in the ObGyn office.[20]

FAST TRACK

Review the patient education and reading materials in your waiting room to ensure they are inclusive. Do they show people with varied gender expression? Do they show same-sex couples or interracial couples?

CASE Ways to better introduce yourself

To revisit the case, what options does the clinician have to start off on a best foot to create a safe space for Alex?

- Open with your own preferred pronouns. For instance, for an introduction, consider: "*I'm Dr. X, my pronouns are she/her.*"
- Don't assume. Do not make assumptions about the relationship between Alex and the person accompanying them.

4 ways for creating welcoming and affirming spaces in ObGyn

1. **Make sure your intake form is inclusive.** Include a space for pronouns and the patient's preferred name (which may differ from their legal name). Also allow patients to choose more than 1 sexual orientation and gender identity.[20] (An example form is available from the LGBT National Health Education Center: https://www.lgbtqiahealtheducation.org/publication/focus-forms-policy-creating-inclusive-environment-lgbt-patients/.)
2. **Create a safe environment in the waiting area.** Try to ensure that at least 1 bathroom is labeled "All Gender" or "Family." Gendered bathrooms (eg, Ladies' or Men's rooms) are not welcoming. Make sure your nondiscrimination policy is displayed and includes sexual orientation and gender identity. Review the patient education and reading materials in your waiting room to ensure they are inclusive. Do they show people with varied gender expression? Do they show same-sex couples or interracial couples?
3. **Use a trauma-informed approach when taking a sexual history and while conducting a physical exam.** Determine if a pelvic exam is necessary at this visit or can it be postponed for another visit, when trust has been established with the patient. Explain each part of the pelvic/vaginal exam prior to conducting and again while performing the exam. Before taking a sexual history, explain why you are asking the questions and be sure to remain neutral with your questioning. For instance, you can say, "It's important for me to understand your medical history in detail to provide you with the best health care possible." Instead of asking, "Do you have sex with men, women, or both?" ask, "Do you have sex with people with a penis, vagina, or both? Do you have anal sex?" Recognize that some patients may be in a polyamorous relationship and may have more than 1 committed partner. For sexually active patients consider asking if they have ever exchanged sex for money or other goods, making sure to avoid judgmental body language or wording. Patients who do engage in "survival sex" may benefit from a discussion on pre-exposure prophylaxis to reduce HIV transmission.[22]

4. **Provide appropriate counsel based on their feedback.**
   - Explain their risk for HPV infection and vaccination options.
   - Respectfully ask if there is a need for contraception and review options appropriate for their situation.
   - Ask about the use of "toys" and provide guidance on sanitation and risk of infection with shared toys.
   - Determine current or past hormone use for patients who identify as transgender and nonbinary (although many do not take hormones and have not had gender-affirming procedures, some may be considering these procedures). Be sure to ask these patients if they have had any surgeries or other procedures.

The receipt of gynecologic care can be traumatic for some LGBTQI+ people. Explain to the patient why you are doing everything during your examination and how it might feel. If a pelvic exam is not absolutely necessary that day, perhaps the patient can return another time. For transgender men who have been taking testosterone,vaginal atrophy may be a concern, and you could consider a pediatric speculum.

Personal introspection may be necessary

In summary, the number of people who identify as lesbian, gay, bisexual, transgender/nonbinary, queer/questioning, intersex, or asexual is not insignificant. Many of these patients or their partners may present for ObGyn care at your office. Clinicians need to understand that there is a new language relative to sexual orientation and gender identity. Incorporating cultural humility into one's practice requires personal introspection and is a first step to creating safe and welcoming spaces in the ObGyn office. ●

References

1. Jones JM. LGBT identification in US ticks up to 7.1%. Gallup News. February 17, 2022. Accessed July 11, 2023. https://news.gallup.com/poll/389792/lgbt-identification-ticks-up.aspx
2. Patterson JG, Tree JMJ, and Kamen C. Cultural competency and microaggressions in the provision of care to LGBT patients in rural and Appalachian Tennessee. *Patient Educ Couns.* 2019;102:2081-2090. doi: 10.1016/j.pec.2019.06.003
3. Grasso C, Funk D. Collecting sexual orientation and gender identity (SO/GI) data in electronic health records. The National LGBT Health Education Center. Accessed October 12, 2023. https://fenwayhealth.org/wp-content/uploads/4.-Collecting-SOGI-Data.pdf
4. Glossary of terms: LGBTQ. GLAAD website. Accessed October 16, 2023. https://glaad.org/reference/terms.
5. LGBTQI+. Social protection and human rights website. Accessed November 2, 2023. https://socialprotection-humanrights.org/key-issues/disadvantaged-and-vulnerable-groups/lgbtqi/
6. Goldberg AE, Manley MH, Ellawala T, et al. Sexuality and sexual identity across the first year of parenthood among male-partnered plurisexual women. *Psychol Sex Orientat Gend Divers.* 2019;6:75.
7. Campbell A, Perales F, Hughes TL, et al. Sexual fluidity and psychological distress: what happens when young women's sexual identities change? *J Health Soc Behav.* 2022;63:577-593.
8. Gessner M, Bishop MD, Martos A, et al. Sexual minority people's perspectives of sexual health care: understanding minority stress in sexual health settings. *Sex Res Social Policy.* 2020;17:607-618. doi: 10.1007/s13178-019-00418-9
9. Carpenter E. "The health system just wasn't built for us": queer cisgender women and gender expansive individuals' strategies for navigating reproductive health care. *Womens Health Issues.* 2021;31:478-484. doi: 10.1016/j.whi.2021.06.004
10. Casey LS, Reisner SL, Findling MG, et al. Discrimination in the United States: experiences of lesbian, gay, bisexual, transgender, and queer Americans. *Health Serv Res.* 2019;54(suppl 2):1454-1466. doi: 10.1111/1475-6773.13229
11. Grasso C, Goldhammer H, Brown RJ, et al. Using sexual orientation and gender identity data in electronic health records to assess for disparities in preventive health screening services. *Int J Med Inform.* 2020:142:104245. doi: 10.1016/j.ijmedinf.2020.104245
12. Austin A, Craig SL, D'Souza S, et al. Suicidality among transgender youth: elucidating the role of interpersonal risk factors. *J Interpers Violence.* 2022;37:NP2696-NP2718. doi: 10.1177/0886260520915554. Published correction appears in *J Interpers Violence.* 2020:886260520946128.
13. Hibbert MP, Hillis A, Brett CE, et al. A narrative systematic review of sexualised drug use and sexual health outcomes among LGBT people. Int J Drug Policy. 2021;93:103187. doi: 10.1016/j.drugpo.2021.103187
14. Azagba S, Shan L, Latham K. Overweight and obesity among sexual minority adults in the United States. *Int J Environ Res Public Health.* 2019;16:1828. doi: 10.3390/ijerph16101828
15. Klein PW, Psihopaidas D, Xavier J, et al. HIV-related outcome disparities between transgender women living with HIV and cisgender people living with HIV served by the Health Resources and Services Administration's Ryan White HIV/AIDS Program: a retrospective study. *PLoS Med.* 2020;17:e1003125. doi: 10.1371/journal.pmed.1003125
16. Jung C, Hunter A, Saleh M, et al. Breaking the binary: how clinicians can ensure everyone receives high quality reproductive health services. *Open Access J Contracept.* 2023:14:23-39. doi: 10.2147/OAJC.S368621
17. Bustamante G, Reiter PL, McRee AL. Cervical cancer screening among sexual minority women: findings from a national survey. *Cancer Causes Control.* 2021;32:911-917. doi: 10.1007/s10552-021-01442-0
18. Dhillon N, Oliffe JL, Kelly MT, et al. Bridging barriers to cervical cancer screening in transgender men: a scoping review. *Am J Mens Health.* 2020;14:1557988320925691. doi: 10.1177/1557988320925691
19. Stubbe DE. Practicing cultural competence and cultural humility in the care of diverse patients. Focus (*Am Psychiatr Publ*). 2020;18:49-51. doi: 10.1176/appi.focus.20190041
20. Alpert A, Kamen C, Schabath MB, et al. What exactly are we measuring? Evaluating sexual and gender minority cultural humility training for oncology care clinicians. *J Clin Oncol.* 2020;38:2605-2609. doi: 10.1200/JCO.19.03300
21. Yeager KA, Bauer-Wu S. Cultural humility: essential foundation for clinical researchers. *Appl Nurs Res.* 2013;26:251-256. doi: 10.1016/j.apnr.2013.06.008
22. Nagle-Yang S, Sachdeva J, Zhao LX, et al. Trauma-informed care for obstetric and gynecologic settings. *Matern Child Health J.* 2022;26:2362-2369.