Looking Through the Prism: Comprehensive Care of Sexual Minority and Gender-nonconforming Patients in the Acute Care Setting

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The following commentary synthesizes a didactic session coled by the SAEM Sex and Gender in Emergency Medicine Interest Group and the Academy for Diversity and Inclusion that was presented by the authors at the SAEM 2018 annual meeting in Indianapolis, Indiana. The National Institutes of Health have recently recognized LGBTQ (lesbian, gay, bisexual, transgender, queer) as an official health disparity and designated the Sexual and Gender Minority Research Office in an effort to support evidence-based medical care for this underserved patient population. As the front line of medical care for the underserved, emergency medicine (EM) physicians need to be equipped with the tools to care for these patients in a culturally competent and clinically appropriate manner. EM providers must develop an understanding of their patients' social and medical context to provide both sensitive and effective care and to teach residents and other learners. A significant number of patients who seek treatment in the emergency department define themselves as LGBTQI—lesbian, gay, bisexual, transgender, queer, or intersex. Our commentary combines both affective and objective information on the

importance of semantics and language, appropriate communication, and confronting our own implicit biases in caring for this vulnerable population, creating a unique perspective and paradigm for the practice of EM and a blueprint for education. Narratives were collected anonymously from patients who consented to their publication for medical education.

My legal name should be on the last page of forms, hidden under pages of other records, because that name leads to confusion that is just hurtful. I am sitting in the ED waiting room, and they dead-name me, use a name I haven't heard in years. I am outed in front of the whole waiting room. I am a trans woman; my birth name is not gender neutral. I want a form that has my preferred name, my preferred pronouns. I don't want to have to stand up and react to that other name. There is a look on the nurse's face that says, "this isn't you." But it is me. I'm trapped. I need medical care. I just want to leave and never be in this situation again, and we haven't even started.

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Competent and appropriate clinical care demands precise communication between patient and clinician. Standardized terminology that transcends ambivalence, embarrassment, and misunderstanding establishes a linguistic foundation with the individual and an overarching commitment to respect and inclusivity. EM clinicians must accurately determine the biologic sex of their patients, their current gender identities, and their social and sexual orientation by collecting accurate data and nomenclature and obtaining and using patients' preferred names. Health care intake forms and EMRs should record the patient's preferred name and pronouns, sex at birth, and current gender identity. The clinician's history should begin with this information, clarifying and adding appropriate details. When this information is not provided, clinicians should inquire with the patient their preferred name and pronouns. The effective clinician must truly carry a "tabula rasa" (clean slate) upon which the patient can record the facts of their life as well as their medical history.

Addressing the health needs of our patients may also require a transcendence of the binary paradigm, an anachronistic concept that is no longer relevant. Sex is a biologic variable: XX/XY refers to chromosomal females and males, while intersex refers to those whose gonadal, chromosomal, or anatomic characteristics are not clearly binary. Gender may traditionally have biologic roots but is often shaped by the social and cultural environment, refracted through the lens of social institutions and norms. Gender identity is often a person's sense of themselves as "man"/"woman" or some "blended/other." "Woman" and "man" may be defined by feminine and masculine behaviors and characteristics that are socially determined. "Cisgender" identity is one that is consistent with one's biologic sex; "transgender" identity encompasses individuals whose gender identity does not match their biologic sex at birth. "Gender nonconforming" includes any individual who does not fit neatly into either binary category and who challenges their society's traditional gender roles and expressions.

I was admitted to the hospital. A resident came in. He wanted to know if he could ask a few questions. Of course I said yes, it was a teaching hospital. I openly acknowledged that I was a gay man and was HIV positive. Then he started his inquisition, "So, I see you're HIV+. Are you still sexually active?"

He went on, "Did you got HIV because you were receiving or giving?" And then he got really specific about the details. I told him to get out of my room. "Do not come back. Ever. You're not allowed to ask those questions. I will not answer them." He was intrusive. He was trying to shame me. It was a horrible conversation. He could stick his judgment.

Along with biologic sex and gender identity, our patients also have a sexual identity, which encompasses behavior and attraction. Self-reported demographics, which are likely significant underestimates due to concerns about stigma and bias, suggest that 8 million Americans (3.5%) identify as gay, lesbian, or bisexual. In contrast, 19 million Americans (8.2%) reported having same-sex partners (along with opposite-sex partners) and 26 million (11%) reported sexual attraction to people of the same sex (as well as to the opposite sex).¹ It is clear that sexual identity, sexual acts, gender identity, and gender expression are not predictably or causally linked. Our patients represent a wide range of sexual expression that may not fit prescriptive social norms and we should ask clear, non-judgmental questions relevant to the care we are providing to understand our patients' clinical presentation.

In the ED, I always am uncomfortable when they ask, "What medications are you on?" and I say, "Truvada." I just don't know what kind of reaction I'm going to get. There is a lot of judgment. I explain what the drug is and why I am on it, but I am just giving them fuel. I am asking them to think of me as one of the 'good ones' because I am HIV negative; I am tested regularly. I take care of myself. I'm lucky. I have a job, insurance. But there's all this internalized homophobia that I'm fighting when really all they should want are the names of my drugs and doses. Listing my meds shouldn't be the hardest part of the ER visit.

Patients who identify as LGBTQI expect to encounter stigma and bias from health care providers and their expectations may unfortunately be accurate. The 2015 U.S. Transgender Survey reported that 23% of transgender patients avoid health care out of fear of mistreatment, 33% report trans-specific negative experiences, and 24% report that they needed to educate clinicians to obtain appropriate care.² Even in an ED-based study, Bauer et al.³ reported that 52% of trans

patients had a negative experience, 32% were subject to insulting language, and 10% were refused care altogether. Clearly, it is important for EM clinicians to suspend preconceptions, bias, stigma, and ignorance with regard to their LGBTQI patients.

LGBTQI patients have a much higher probability of having suffered violence and trauma in their lives.⁴ Seeking and receiving health care should not increase the suffering of these vulnerable patients. EM clinicians should seek to understand the trauma that these patients may have undergone. Sensitivity in obtaining a thorough history with a clear understanding of the signs and symptoms of trauma is needed. EM policies and procedures as well as personal practices should integrate the knowledge of how to guide the traumatized patient along the often roughly paved road of the ED, avoiding opening old wounds or creating new ones. Examinations and procedures must be discussed and negotiated before proceeding to create empowerment and trust. Significant others and support persons should always be present if the patient wishes.

Sexual trauma, gender-affirming body modification, fear, and shame demand that any examination of the genitalia must be undertaken with extreme sensitivity, caution, and an understanding of medical and surgical gender affirming body modifications and their clinical complication. Transwomen may use breast prosthetics and may tuck their penis and scrotum, which can lead to scrotal and urinary trauma, reflux, epididymo-orchitis, urinary tract infections, and prostatitis. They may be taking exogenous estrogen with associated risks of deep venous thrombosis, pulmonary embolism, and cerebrovascular accident. Surgeries for transwomen may include breast augmentation, orchiectomy, and vaginoplasty. Transmen may bind their breasts that restrict breathing and cause skin irritation, cutaneous fungal infection, and breast pain. They may be taking testosterone, which increases risks of uterine bleeding and cancer and may opt for mastectomy, metoidioplasty, or phalloplasty.

Being an effective, competent, and caring clinician in the ED, a health care provider and healer for all people who seek our care no matter how different their lives may seem from ours, requires medical knowledge, emotional intelligence, deep-seated empathy, and honest self-evaluation. When we walk into an examination room to examine and treat a patient, we are wearing lenses that have been shaped for us and by us throughout our lives. We see the patient as they are, but also as we are, what we have come to believe, what has been inculcated, often unfiltered into our minds and hearts throughout our lives by family, friends, teachers, and the media. Know the medicine, know your patient, know yourself. Being open to learning and to the human being in front of you as well as the one inside of you will help us provide more competent and compassionate patient centered care.

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