

## **Cultural Competency on Lesbian, Gay, Bisexual or Transgender (LGBT)**

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### **Abstract**

There are over 100 million patient encounters each year in emergency departments across the country. As emergency care providers, we acknowledge and appreciate the wide diversity of patients who we evaluate and treat. Our departments often serve as a safety net for some of these patients. We see a disproportionate number of racial, ethnic, and sexual minorities; legal and illegal immigrants, and poor people, those who are disenfranchised and socially stigmatized. We pride ourselves in serving those who seek emergency care, prioritizing their care based on medical acuity.

Regardless of practice size or location, emergency medicine clinicians evaluate and treat significant numbers of people who self- identify as lesbian, gay, bisexual, or transgender (LGBT). They represent a broad spectrum of our population, spanning ethnic or racial identity, age, education, marriage or parental status, occupation, earning power, and political/cultural/religious demographics. Many LGBT patients seen in the emergency department each day may not be recognized as non-heterosexual by the clinician. Those who identify as LGBT may not disclose their orientation in an emergency department setting, at least initially until confidence and trust in their health care providers is established.

The goal of this chapter is to give the emergency medicine clinician information that will enhance communication with LGBT patients and their families, as well as provide specific information and resources about certain health care issues pertinent to :LGBT patients.

### **Introduction**

*“The emergency clinician’s ability to obtain an accurate history and effectively treat patients will be dependent to a large part on his or her ability to establish a patient-physician relationship. Providers who are uncomfortable working with LGBT patients or fail to recognize the sexual orientation of a patient will manage patients incompletely, perhaps incorrectly. They will fail to obtain pertinent information or to recognize important elements of evaluation and treatment.”(1)*

In 1948, Kinsey reported that 37% of males and 20% of females had homosexual experiences during their lifetime, with fewer (8% of men and 4% of women) exclusively having same-sex orientation.(2) There is an overall paucity of empiric demographic information and national-level health data on LGBT persons. Limited evidence suggests that 3-6% of patients seen by health care providers self-identify as LGBT.(3) In addition, some individuals engage in same-gender sexual activity yet would not identify themselves as LGBT.

The fear of many LGBT Americans, particularly the young and the elderly, of disclosing their sexual identity limits an understanding of their health care needs. However, Healthy People 2010 (4), a broad-based federal government initiative to promote health and prevent illness, disability, and premature death, includes LGBT patients as a focus area. The document helps focus a public health and research agenda at multiple levels of the public and private sectors for the next decade. Such initiatives may help the clinician better care for LGBT patients in the future. The Companion Document to Healthy People 2010 for LGBT health(5) is a 450- page reference that complements Healthy People 2010. In addition, a review by Dean et al(6) serves as an evidence-based resource for LGBT health.

LGBT individuals go about their lives much like heterosexual individuals. Similarities far outweigh differences. They may live in urban environments or rural areas. They work, play, grow old. Most of the health care concerns of LGBT people are the same as those of the general population. They desire a compassionate, knowledgeable clinician who they can trust and who is non-judgmental. Fear or discrimination and stigma cause many LGBT individuals to avoid or postpone seeking medical care. Many withhold from their providers personal information that may be clinically important until they can feel they can trust their clinician.

## **Establishing an optimal clinical relationship with LGBT patients in an emergency care setting**

### *Creating a safe, non-judgmental environment for LGBT patients*

Developing a clinician-patient relationship in the ED may be more difficult than in other clinical environments. The ED is often chaotic and crowded, with little privacy. A patient may never have been seen in that facility before and likely may not have first-hand knowledge of the ED staff. The patient may be uncomfortable talking about the medical problem that brings her or him to the ED.

The patient may scan the ED physical space for signs or clues that the ED environment is safe, inclusive, and non-judgmental. Are there posters that include sexual orientation in nondiscrimination statements displayed in the waiting areas? Does the waiting area have brochures for LGBT community resources? Are the ED intake and registration forms designed with words that do not assume heterosexual family structures? Are staff who have contact with patients skilled in making the patient feel comfortable and at ease? Are the clinicians who see the patients skilled in establishing trust, obtaining culturally sensitive histories (including sexual behaviors history) in a non-judgmental fashion? Are the clinicians knowledgeable regarding health care issues pertinent to their lesbian, gay, bisexual, and trans-gendered patients? Are local community LGBT-sensitive and appropriate services available incorporated into discharge planning instructions when pertinent?

### *Barriers to effective communication*

Clinicians may be reticent about giving care to LGBT patients as they may be unsure of what language to use to elicit information respectfully from patients, may be uncomfortable obtaining a detailed sexual behaviors history, or be inexperienced in LGBT health care issues. LGBT patients may often feel uncomfortable discussing their sexual orientation and sexual behavior history with their health care provider. Various studies report between 13 and 90% of lesbian and gay patients failed to disclose their

sexual orientation to their primary clinician based on prior bad experiences or for fear of negative judgments, or stigmatization.

From 20-75% of lesbians and gay men report negative responses from a health care provider after disclosure of their sexual orientation. Although many lesbian and gay patients prefer to have a lesbian or gay primary care clinician, the sexual orientation of their clinician is not as important as their clinician's perceived non-judgmental attitude and ability to communicate well.(7)

### *Social-cultural history taking*

Many patients seen in the ED do not require a sexual behaviors history as it may not be relevant. However, for many clinical presentations, sexual behavior may be a part of a complete history and affect clinical decision-making. Clinicians who ask open-ended questions regarding the patient's family and support network that do not assume the patient is heterosexual may allow the patient to feel comfortable giving the clinician a truthful response. Such questions include, 'Do you have a significant other?' or, "Are you in an intimate relationship with someone?"

Simply asking if a patient has been or is married, or if he or she has had children, implies the patient is heterosexual. In reality, up to 34% of lesbians and 22% of gay men have had children and a significant number of lesbians and gay men have been married. Further, recent judicial and political developments in Massachusetts, San Francisco, CA, Portland, OR, and Canada may alter our definition of marriage.

Marital status is especially important for LGBT patients who have the potential for serious illness or who are admitted because we need to know who should be involved with their care if they no longer are capable of making health care decisions. Federal law requires that all admitted patients be given an opportunity to complete an advance directive. For LGBT patients, unless they explicitly designate their significant other as having visitation or decision-making rights, that individual may not be able to see the

patient in the hospital or be able to act as surrogate decision-maker in the event the patient does not have decision-making capacity.

### *Sexual history taking*

The taking of a detailed sexual practices history is not germane to every patient seen in the ED setting. However, when it is necessary, the clinician should be comfortable, professional, and non-judgmental. The clinician should strongly encourage that this portion of the history be done in private, without family or friends present. At times, this may require creating the opportunity for the patient to be alone without asking people to leave. For example, the physician might take the opportunity to ask these questions while the patient is in the radiology suite and others are not in the room.

The patient will be looking for clues in the clinician's approach to see if she or he can be trusted. Clinicians should be mindful that men and women come in all shapes, sizes, ages, colors, and cultures. Their patients' sexual practices, sexual orientation, and comfort with their own sexuality may vary over their lifetime. If you do need detailed information regarding sexual practices, it would be advisable to let the patient know why you need the information prior to asking specific questions. A question such as 'are you sexually active, are your partners men, women, or both?' does not assume heterosexuality and may facilitate other questions.

### *Medical record documentation*

Self-identified LGBT patients or patients who disclose that they are men who have sex with men (MSM) or women who have sex with women (WSW) may have concerns about what will be entered into their medical record. You should have a proactive discussion with the patient about such issues while obtaining the social or sexual behaviors history. Although federal and state privacy laws cover medical records, illegitimate access to these records remains a concern for LGBT patients. Medical records continue to play an important role in the denial of medical or disability insurance, worker's compensation; tort claims; child custody and visitation rights, and in dishonorable discharges from the military. Primary care providers often devise a code if patients do not want their sexual

orientation or sexual behaviors documented in a medical record. ED clinicians should talk with their patients to find out their comfort level with documentation. Sometimes the information is important to clinical decision-making, and communicating with other health care providers and must be documented. Other times, it is of little relevance and can be left out.

### **Specific lesbian, gay, and bisexual health concerns in the emergency care setting**

Like most people, many LGBT individuals desire to find a partner and many are in monogamous, committed long-term relationships. Most are sexually active with their same sex, others may be celibate, or have been or are sexually active with the opposite sex. Although they may seek emergency care for a health concern directly pertinent to their sexuality, this scenario would be the exception rather than the rule.

In the emergency care setting, recognizing the medical and psychosocial nuances between non-heterosexual patients and heterosexual patients depends to a large extent on the ability to obtain a valid and accurate history. Taking such a history will allow the emergency clinician to develop a problem-focused approach to medical decision-making for all of their patients, including LGBT patients and patients who have same-sex sexual intimacy but do not identify as LGBT. Often LGBT patients and patients who have same-sex sexual intimacy but do not identify as LGBT are less likely to seek health care maintenance and may often be in more advanced stages of illness than their heterosexual counterparts when they present to an emergency care facility.

Some examples illustrate these issues. An 'out' lesbian of child-bearing age who develops abdominal pain and vaginal bleeding must have a Beta HcG to determine if she is pregnant. Assuming that she cannot be pregnant because she describes herself as lesbian is at best simplistic.

A medically unstable, unconscious young gay man who presents to the emergency department after an assault may be the victim of simple assault, domestic violence, or a hate crime. The type of injuries he sustained are likely different in each of those scenarios.

An elderly woman presents to the emergency department with chest pain, hypotension, and shortness of breath. A female friend accompanies her in the ambulance. As her emergency care provider, you quickly diagnose acute myocardial infarction and congestive heart failure, and admit her to an intensive care unit. She asks you if she has a chance of dying. You gently talk with her about her prognosis, and about end-of-life issues. If you approach her in such a way that she trusts you, she may tell you that her 'friend' is actually her life partner for 40 years and she wishes that her partner make decisions for her regarding end-of-life issues should she no longer have medical decision-making capacity. If she doesn't trust you, she may say that her next of kin is a sister she has not seen in 10 years.

A 45-year-old man presents with rectal pain for six months. Social history reveals he is employed, married and has two children. Physical examination reveals a hemocult positive stool, and anal genital warts.

#### *Sexually-transmitted diseases (STD) and immunizations*

A patient's risk of STD infection such as gonorrhea, chlamydia, hepatitis A or B virus, HIV, syphilis, human papillomavirus, or herpes simplex virus varies dramatically, depending upon the number of partners, safer sex practices including barrier protection, and specific sexual practices. Asymptomatic patient screening for STDs in the emergency care setting is not routine. However, should a patient develop symptoms consistent with STDs, the emergency care provider must obtain a detailed and accurate sexual behaviors history, then medically manage accordingly.

Vaccinations for Hepatitis A and B are readily available. For those not vaccinated, the emergency care provider should consider referring the patient to a primary care provider or a public health agency because LGBT patients may be at risk for contracting hepatitis and many are not vaccinated.

For men who are sexually active with men, there has been an increase in gonorrhea and syphilis in the US for the past several years.(8) Reasons likely include a decrease in safer sex practices including decreased condom utilization. STD transmission patterns traditionally reflect behavior patterns. If safer sex practices are becoming less prevalent among men who have sex with men, increasing HIV infection rates are likely to follow.

For women who are sexually active exclusively with women, STDs are significantly less common than heterosexual women or men of any sexual orientation. The more sexual partners a woman has, either female or male, the greater the risk of being diagnosed with an STD. Bacterial vaginosis may be more common in women who exclusively have sex with women than in the general population.

### *HIV*

Prior to the advent of *highly active anti-retroviral therapy* (HAART) in 1996, providers and patients alike often had a fatalistic view of AIDS, as the disease often rapidly progressed despite therapy. Since that time period, the annual mortality rate has been reduced dramatically (29.4 deaths per 100 years prior to 1996 to 3-4 deaths per 100 years depending on the medical regimen in 2001)(9).

The emergency care provider who worked during the last decade noted the dramatic decline in ED visits in AIDS patients for opportunistic infections such as *Pneumocystis carinii*, wasting syndromes, or Kaposi's sarcoma. As the mortality and morbidity of AIDS continues to remain relatively low for patients on HAART, AIDS patients are continuing to live longer, with enhanced quality of life. The provider must broaden his or her differential diagnoses on AIDS and HIV-positive individuals seen in the ED setting to reflect this phenomenon. As an example, young, otherwise healthy HIV-positive patients on HAART therapy appear to have an excess risk of myocardial infarction, perhaps due to increased risk of diabetes mellitus, hypertriglyceridemia, and lipodystrophy, or pathological changes in the coronary arteries.(10).

In 2000, 25% of people with AIDS in the US were women. Heterosexual contact is now the most common reported risk factor for women, overtaking injection drug use. There are a small number of cases reported to the CDC for women who have sex with women exclusively without any other identifiable risk factors and HIV has been cultured from vaginal secretions.(11).

### *Cancer*

Asymptomatic screening for cancer is not routine in the emergency department. However, some malignancies are more prevalent in LGBT patients. Lesbians have an increased relative risk of breast cancer. They historically have had fewer screening mammograms and routine health visits than their heterosexual counterparts and are less likely to have been pregnant.

Gay and bisexual men who are not HIV sero-positive have excess risk for anal cancer, non-Hodgkins lymphoma, and Hodgkins disease and sero-positive individuals have excess risk and mortality for anal cancer, non-Hodgkin's lymphoma, and Kaposi's sarcoma.(12) The incidence of anal cancer among homosexual and bisexual men exceeds that of cervical cancer in women prior to the institution of Pap screening. HIV-positive homosexual men may be at even higher risk. The incidence of squamous intra epithelial lesion (ASIL), a precursor to anal cancer, has been estimated to be as high as 36 per 100,000. Human papillomavirus (HPV) is thought to be the etiologic agent. Rectal Pap smears to detect HPV infection are an area of active research.(13).

### *Reproductive health/parenting*

Estimates vary, but approximately three-fourths of lesbians have experienced heterosexual coitus sometime in their adult life. Consequently, women of child-bearing age, lesbian or heterosexual, with symptoms or signs concerning for ectopic pregnancy should be screened with a beta-HcG.

Increasing numbers of lesbian and gay men are raising children. Approximately 20% of male couples and 30% of female couples have at least one child in their household. The

family structure of the lesbian or gay couple likely is not legally recognized in most parts of the country. The non-biological parent who brings a member of their family to an unknown provider in an emergency care setting has concern they may be viewed by ED personnel as a non-relative.

#### *Mental health and mental disorders*

In 1973, the American Psychiatric Association officially removed homosexuality as a psychological pathology from its Diagnostic and Statistical Manual. Up until that time, mental health providers and clinicians generally viewed homosexuality as a disease state: abnormal, dysfunctional, perhaps immoral or criminal.(14).

LGBT patients experience rates of depression, anxiety, eating disorders/body image disorders, substance abuse, and suicidal ideation higher than the general population(15). Although the etiologies certainly are multi-factorial, a portion of emotional disturbances experienced by lesbians and gay men are a result of a sense of alienation in an unaccepting environment.(16).

#### *Domestic violence, sexual assault*

Many emergency physicians participate in medico-legal evidence examinations for sexual assault. While most frequently the examination involves a female who alleges sexual assault by a male, certainly many other situations may arise including examination of a male assaulted by another male. Protocols should be developed to address the legal requirements of evidence collection, as well as the psychological and medical needs of the patient.

### **LGBT patients of different generations**

#### *Adolescents and young adults*

Adolescents of all sexual orientations may be reluctant to share their sexuality with adults. During adolescence, people coalesce their sexual identity. Sexual behaviors during this period of sexual experimentation do not reliably predict future homosexual behavior or self-identification as lesbian or gay as an adult. In studies comparing

children raised by lesbian and gay parents with those of heterosexual parents, no difference in self-concept, moral judgment, intelligence, sex-role behavior, peer and adult relationships, and sexual orientation were noted.(17).

An estimated 46% of all US high school students are or have been sexually active and 42% did not utilize condoms at their last intercourse(18). Reducing high-risk behavior may be difficult to achieve for adolescents who have a sense of invulnerability to the consequences of their actions or who lack partner-negotiation skills to use condoms effectively.

Adolescents and young adults have the highest rates of acquisition of STDs including gonorrhea and syphilis, as well as HIV seroconversion. Fifty percent of HIV seroconversions occur in people younger than 25 years of age.(19).

Suicide is also an important public health problem for children and adolescents. Evidence suggests that LGBT youth have a greater risk of suicide than the general population(20). The suicide rate for youth in the United States has dramatically increased during the past four decades and now suicide is the third leading cause of death in this age group. By one estimate, 8.8% of youth reported a suicide attempt during the past 12 months(18).

### *Elder LGBT*

During the past 20 years, the number of people over the age of 65 has been increasing nearly twice as fast as the rest of the population. This trend will accelerate in the next two decades. By 2030, nearly one in five Americans will be elderly(21). Current estimates range from one to three million elder Americans self-identify as LGBT. It should be emphasized that the majority of health concerns that would bring a homosexual elder patient to an ED are the same as their heterosexual counterparts.

The elder population seen in the ED has a much higher acuity as measured by multiple parameters. They are nearly twice as likely to be triaged as “emergent”, nearly four times

more likely to be admitted to the hospital, and six times more likely to be admitted into an ICU setting than patients under the age of 65(22). The elderly also represent a significantly greater proportion of the 379,000 patients in 2000 pronounced DOA (dead on arrival) or died in an ED setting(23). Clearly, this population may present to the ED with sudden catastrophic illness and often surrogates may need to be involved with important health care decisions(24). For LGBT elders, the people they entrust with their surrogate decision-making may not be their family of origin. Durable power of attorney for health care instruments often do not accompany ill or injured elderly to the ED. Without a valid document, non-biological (lesbian or gay) family surrogate decision-makers do not have legal standing to represent the health care interests of the patient in nearly all states. In some jurisdictions, they may not even have visitation rights.

Elder LGBT individuals are among the most invisible of all Americans. They are likely very reticent to disclose their sexual orientation to providers, particularly providers they do not know. The pertinent medical and social literature is very limited for this population. Only recently have mainstream medical publications begun to focus on the elder LGBT patient(21,25).

### **Special populations**

#### *Transsexual*

Transsexuals are persons who identify so strongly with the opposite sex or gender that they use long term cross-sex hormone therapy and surgery to change their bodies, in order to look and feel more like the other sex. The trans-gendered individual may or may not identify as lesbian or gay. Establishing trust and a non-judgmental attitude is particularly important while caring for these patients, as this population is one of the most misunderstood of the sexual minority subcultures and likely the most stigmatized. Fear of ridicule often prevents many trans-gendered individuals from seeking prompt medical care. These patients, even early on in the transition from one sex to the other, likely prefer to be called by their transgender name than their birth first name. If you are not sure how the individual prefers to be addressed, simply ask. Questions can also arise, especially if the patient is admitted and the patient may be sharing a room, about which

gender to classify the patient. Often the best approach is a private room if one is available.

### **Summary**

Questions surrounding sexual orientation most frequently need to be addressed in two circumstances: 1) when the patient's medical complaint could be directly affected by his/her sexual orientation, and 2) when questions arise about surrogate decision-makers and visitation. Emergency physicians should be sensitive to the medical and psychosocial needs of all of their patients, especially their vulnerable patients. Patients with non-heterosexual gender identification are among these patients. Unlike certain other diverse populations, these patients may not always be recognized if it is assumed that all patients that come to the emergency department are heterosexual. Emergency physicians must remain aware of the diversity of their population and be willing to explore the sexual identity issues of their patients in a respectful and compassionate manner.

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