Chapter 1

Providing Optimal Health Care for LGBT People: Changing the Clinical Environment and Educating Professionals

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Introduction

Perhaps no document has been more significant in focusing attention on health disparities affecting lesbian, gay, bisexual, and transgender (LGBT) people than the Institute of Medicine (IOM) report published in 2011, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (1). The report, which was written for the National Institutes of Health (NIH) to develop a research agenda for the future, begins with a clear statement that "lesbian, gay, bisexual, and transgender (LGBT) individuals experience unique health disparities." It goes on to explain that "although the acronym LGBT is used as an umbrella term, and the health needs of this community are often grouped together, each of these letters represents a distinct population with its own health concerns" (1).

In essence, the report establishes two critical points: 1) the evidence for LGBT health disparities and 2) the great diversity of the LGBT population. This report has become a keystone for advancing research, educational activities, and institutional change across many disciplines. Prior to this, other significant publications on LGBT health included the IOM's 1999 report *Lesbian Health: Current Assessment and Directions for the Future* (2); the LGBT companion document to Healthy People 2010 (3); the first edition of the *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* in 2008 (4); and the release of Healthy People 2020 (5), which for the first time set out strategies for overcoming health disparities specific to LGBT people.

Seen in this context, the publication of the 2011 IOM report represents the largest multidisciplinary effort of a national committee to date to summarize the evidence on LGBT health in order to learn more about the health

needs of the LGBT community and what additional research is required for fully understanding those needs and addressing them. Over the years, teachers, clinicians, and students have looked to all of these documents as consolidated sources of information on a population that has been understudied and remains largely invisible to a health system despite the presence of disparities. It is our hope that with this new edition of the *Fenway Guide* we can provide clinicians and other LGBT health stakeholders with practical tools for addressing what has been learned about disparities thus far, and ultimately help bring an end to the invisibility of LGBT people in health care.

LGBT Terminology

As a start to ending LGBT invisibility, it is important to understand the terminology used to define sexual and gender minorities, keeping in mind that these terms are not static and can vary in different cultures. In general, *sexual orientation* describes a person's emotional and/or physical attraction to people of the same gender and/or a different gender. Most people identify themselves as *lesbian*, *gay*, *bisexual*, or *heterosexual*, but there are many other terms that people use to describe their sexual orientation. For example, a growing number of individuals, especially youth, identify with the term *queer*, which they see as more fluid and inclusive than the traditional sexual orientation categories.

Some individuals engage in sexual behaviors that do not fit with what is typically associated with their sexual identity. For example, studies have demonstrated that there are people who identify as heterosexual but who have intimate relations with members of the same gender (6–8); similarly, some people identify as gay or lesbian and have intimate relations with individuals of the opposite gender (9). Some individuals who engage in sexual activities with people from both genders identify as bisexual, but some do not (8,9). As later chapters in this book will demonstrate, it is important that we understand how people identify, how they behave, and what they desire so we can help them achieve healthy lives.

The *T* in LGBT stands for *transgender*, an umbrella term for people whose gender identity is not consistent with their assigned sex at birth. *Gender identity* refers to a person's internal sense of gender and is distinct from sexual orientation: All people have both a sexual orientation and a gender identity. Many gender minorities identify as transgender or use a related term, such as *transgender man* or *woman*, *trans man* or *woman*, or *MTF (male-to-female)* or *FTM (female-to-male)*. Some transgender people just describe themselves as men or women. A transgender man would have been assigned the sex of a girl at birth, and a transgender woman would have been assigned the sex of a boy at birth. At some point in childhood, adolescence, or adulthood, transgender people recognize that their gender identity is different from their sex assigned at birth and will usually change their

name, appearance, and other personal details in order to affirm their gender identity. Some reject the gender binary and prefer to use a term such as *genderqueer* to define their gender identity, and some may prefer no term. *Gender expression* differs from gender identity in that it refers to the spectrum of normative masculine or feminine characteristics, such as how people dress, how they cross their legs, and how they shake hands. The effect on health is not rooted in the individual's expression or identity but rather is based on the individual's and community's response to it. These concepts are explained in more detail in later chapters (see especially Chapters 16 and 17).

Understanding Disparities

LGBT people experience a higher prevalence of a range of medical and behavioral health issues. The research supporting the evidence on these issues is covered in detail in the 2011 IOM report mentioned earlier (1). Table 1-1 summarizes these disparities to the extent that they have been studied in any depth across the life course, from adolescence to late adulthood. As one can see from Table 1-1, these disparities include common clinical problems, such as smoking and obesity, which require appropriate inquiry but not always approaches that differ from those a clinician would use in the general population. These disparities also include more complex clinical issues, such as HIV infection, which may require clinicians to receive additional education and training, but can still be accomplished by a generalist in the primary care setting.

In summarizing a large body of knowledge, it is critical to recognize that LGBT health disparities largely track to a long history of societal

Table 1-1 Summary of LGBT Health Disparities

LGBT youth are more likely to attempt suicide and be homeless
LGBT populations have higher rates of tobacco, alcohol, and other drug use
LGBT populations have a higher prevalence of certain mental health issues
Transgender individuals have a high prevalence of attempted suicide and victimization
Gay, bisexual, and other men who have sex with men (MSM) are at higher risk for HIV and other sexually transmitted infections
Young MSM and transgender women, especially those who are black, are at especially high risk for HIV
Lesbians and bisexual women are more likely to be overweight or obese
Lesbians are less likely to get preventive services for cancer
Elderly LGBT individuals face additional barriers to optimal health because of isolation and a lack of culturally appropriate social services and providers

Data obtained from references 1 and 5.

stigma and discrimination directed at sexual and gender minorities (1). Herek has defined *sexual stigma* as that "attached to any non-heterosexual behavior, identity, relationship or community" (10). Lacking specific research, one might also talk about *transgender stigma* in a similar way (1). Stigma and discrimination can affect individuals directly (e.g., bias by health care professionals, violence fueled by hatred of LGBT people, and policies that deny health insurance coverage to same-sex partners) and indirectly, with discriminatory actions toward LGBT people around the world creating a negative environment for LGBT individuals wherever they may reside.

Despite growing cultural acceptance of LGBT people, a substantial portion of Americans still hold negative views of homosexuality. For example, a 2013 Pew Research Center study found that 33% of Americans believe society should not accept homosexuality (11). In a separate 2013 Pew Research study that surveyed a nationally representative sample of LGBT Americans, 53% of respondents said there is still a lot of discrimination against gays and lesbians, and an additional 39% said there is some discrimination. When asked if any of the following had ever happened to them as a result of being LGBT, 58% of respondents reported being subject to jokes or slurs, 26% reported being threatened or physically attacked, and 21% reported being treated unfairly by an employer (12).

Despite the existence of discrimination and disparities, it is important to keep in mind that a sizable majority of LGBT people live healthy, productive lives that are integrated into the activities and professions of general society. According to the 2013 Pew Research Center study of LGBT Americans, most respondents viewed their sexual orientation/gender identity as a positive aspect of their lives (34%) or as something that does not make much difference either way (58%) (12). An emerging theory suggests that LGBT people often become resilient in the face of marginalization and discrimination, but because of a lack of research, is it not yet possible to fully delineate predictors of resilience for specific LGBT populations (13–15).

Attitudes among Health Professionals

There is no question that the actions and inactions of health professionals have had a significant effect on the health of LGBT people. It was not until 1973 that the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) removed homosexuality as a pathology (16), but even this did not mean that all health professionals immediately engaged in affirmative treatments for LGB people. Many health care professionals continued to offer reparative (or "conversion") therapies with the promise of "curing" homosexuality. Only starting in 2000 did the American Psychiatric Association officially oppose reparative therapy (17), and reparative therapies weren't banned by states across the country until 2013 (although some have brought lawsuits challenging these bans). It was also just in 2013 that the

new fifth edition of the *DSM* (*DSM-5*) removed the diagnosis "gender identity disorder," which had the effect of pathologizing transgender people, and established the diagnosis "gender dysphoria" to describe those who experience clinically significant distress associated with feeling and seeing themselves as a gender that differs from the sex they were assigned at birth (18).

Studies show that physicians' attitudes toward LGBT people have changed markedly in recent years. For example, in a 1982 survey of physicians in San Diego, California, about 46% of respondents indicated that they would not refer a patient to an openly LGBT pediatrician, and 30% said they would not admit an openly LGBT person to medical school (19). When this survey was repeated in 1999, the percentages had decreased to 9% and 3%, respectively (20). Despite this positive shift in attitudes, there are still signs that full acceptance within the medical profession has not yet been achieved. A survey of medical students in 2005–2006 showed that 15% reported mistreatment of LGBT students at school and that 17% of LGBT students reported hostile working environments (21). The authors' experiences spending time with students at schools across the United States suggest this is a near-universal occurrence. Moreover, acceptance of transgender people in medical settings lags behind that of LGB people. In the 2011 National Transgender Discrimination Survey of more than 6400 transgender participants, 24% of respondents reported being denied equal treatment at a doctor's office or hospital (22).

Of note, some physicians still lack comfort and competency in caring for LGBT people. A 2002 Kaiser Family Foundation Survey reported that 6% of physicians nationally were uncomfortable treating gay or lesbian patients (23), and a 2003 survey of medical residents found that 71% did not ask sexually active adolescents about sexual orientation regularly; 93% of those reporting said this was because they were too uncomfortable to ask (24).

How Stigma and Discrimination Affect LGBT Health

> And to the degree that the individual maintains a show before others that he himself does not believe, he can come to experience a special kind of alienation from self and a special kind of wariness of others.
>
> —Erving Goffman, *The Presentation of Self in Everyday Life*, 1959 (25)

> The stigmatized individual is asked to act so as to imply neither that his burden is heavy nor that bearing it has made him different from us; at the same time he must keep himself at that remove from us which assures our painlessly being able to confirm this belief about him. Put differently, he is advised to reciprocate naturally with an acceptance of

> himself and us, an acceptance of him that we have not quite extended to him in the first place. A PHANTOM ACCEPTANCE is thus allowed to provide the base for a PHANTOM NORMALCY."
>
> —Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity*, 1963 (26)

Erving Goffman's work on stigma dates back to the 1960s but is readily applicable to issues faced by LGBT people through the years up to the present time. Although many have developed resilience and remain unaffected, others live with a "phantom normalcy" or with strong feelings of "undesired differentness" (26). Many constructs have been applied to LGBT people to explain how stigma and discrimination affect them. Much of this work draws on the minority stress theory described by Meyer (27,28), who relates how stigmatized groups "experience excess stress and negative life events due to their minority status in addition to the general stressors experienced by all people" (28). Minority stress includes "internalized and external stress processes that can cause negative mental health outcomes" (1).

Stigma can act on multiple levels to create both personal and structural barriers to accessing care. These barriers may be reinforced for LGBT people who belong to more than one marginalized and stigmatized group related to their race, ethnicity, or socioeconomic status or who simply express themselves in ways that differ from accepted norms. This nexus, which results in accumulated stigma, leads to both medical and behavioral health disparities and reinforces barriers to care (29).

Social Determinants of LGBT Health

Social determinants of health refer to economic and social conditions that influence individual and group differences in health status. There are many constructs and many definitions, but taken together, social determinants tend to include social and economic resources, such as housing, education, employment, and health care, as well as government and institutional policies. Unequal access to these resources and policies across population groups contributes to disparities in morbidity and mortality (30,31). For LGBT people, social determinants of health are often linked to stigma and discrimination (5). For example, state legislation that denies marriage to same-sex couples can leave some families without adequate health insurance (32). Schools that do not include sexual orientation and gender identity/expression protections in their antibullying programs can leave LGBT youth vulnerable to verbal and physical harassment, which is associated with depression, suicidality, and risk for HIV and other sexually transmitted infections (33). Employment discrimination against transgender people can cause many to go without health care and can lead some to

engage in the sex trade as a means of survival, putting them at risk for multiple health issues (34,35).

Unequal access to health care is of critical importance to all LGBT people, particularly those who are poor and/or living with HIV/AIDS. Even with the health care reforms under the Affordable Care Act, many who do not qualify for traditional Medicaid cannot access insurance in the states that have chosen not to expand their Medicaid programs; many of these same people will not be eligible for subsidies to purchase insurance in the health insurance marketplace (36). Beyond insurance issues, many LGBT people continue to lack access to providers who are knowledgeable about their unique health needs or who understand how to address them with cultural sensitivity (37). Although biases and lack of competency with LGBT people in health care have long been present, they are by no means inherent in our health care system.

Creating Affirmative and Inclusive Clinical Environments

While this book has been written to enhance clinical knowledge of LGBT health disparities and how to manage them in clinical settings, it is important to look at what needs to be done to create environments that will expand access to affirmative and inclusive care for LGBT people. This includes changes to the policies and practices of health care settings, as well as changes to how health professionals are trained.

Most of us can relate to the concept of how the environment of care can affect one's overall health care experience. It can begin well before a patient greets a clinician in the exam room. Imagine a gay man walking into a waiting room full of brochures that show images of heterosexual couples but none of same-sex couples. He then sits down to complete a registration form that has options only for single or married; he struggles to answer because he is in a long-term relationship in a state where he is legally unable to marry. How might this man feel about the environment of care at this office? It is unlikely that he feels included, affirmed, or even safe to disclose his sexual orientation to his provider. For transgender people, there are legions of embarrassing and hurtful stories reflecting lack of cultural competency in health care organizations. Common among these are being called by the wrong name and wrong pronoun in reception areas because of medical forms not matching current gender identity and preferred names.

The experience of many LGBT people as a population is that they are often invisible to the health care system in situations where knowledge of their identity may be critical to receiving appropriate preventive care or making appropriate diagnoses. For example, consider the case of a transgender woman who is hospitalized with pneumonia and develops a fever. The cause of the fever turns out to be acute prostatitis. Without knowing this

patient was transgender and had a prostate, an appropriate diagnosis would be delayed at a minimum. These issues are discussed in more detail in other chapters but are highlighted here as they demonstrate the importance of an environment that is welcoming and encourages openness and frank discussion of sexual orientation and gender identity between patients and their providers.

In recent years, many resources have become available to help health care organizations consider ways to create more inclusive environments. There are also several incentives to do so, including provisions of the Affordable Care Act, which encourage management of the health of populations and looking at measurable change by tying goals to financial incentives. Perhaps the most exhaustive look at environmental change can be found in the Joint Commission's *Advancing Effective Communication, Cultural Competence, and Family- and Patient-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community: A Field Guide* (38). The *Field Guide* is available online and highlights critical areas for organizational change, including chapters on leadership; provision of care; workforce; data collection and use; and patient, family, and community engagement. Also included are appendices with useful checklists for organizational assessment.

Two recommendations from the *Field Guide* specific to improving care environments for LGBT people have already been codified into Joint Commission requirements for hospital accreditation (39,40). These are RI.01.01.01: "The hospital respects, protects and promotes patient rights."

- EP 28: The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of the stay.
- EP 29: The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

These 2 basic requirements can dramatically improve an LGBT person's experience of being in the hospital. First, allowing a patient to determine who can visit and who cannot, as opposed to using organizational rules that have historically limited visitation to members of immediate family, allows people with unmarried same-sex partners, or who rely primarily on friends because of intolerance from their biological families, to have the visitors that will support them the most. Second, requiring that nondiscrimination policies apply to sexual orientation and gender identity or expression gives LGBT people reassurance, as well as the basis for speaking up if they perceive that their care is not equitable. Beyond these critical requirements, organizations must take other steps toward achieving truly LGBT-inclusive and -affirming environments for care, as recommended by

the Joint Commission and other organizations. Examples of these steps can be found in Appendix A; resources for improving the environment of care can be found in Appendix C.

Collecting Data on Sexual Orientation and Gender Identity

Both the *Field Guide* and the 2011 IOM report recommend that data on sexual orientation and gender identity be collected in electronic health records (EHRs) (1,38). However, the *Field Guide* goes further in explaining ways to accomplish this, and emphasizes the importance of allowing LGBT people to express their satisfaction with the care they receive (38). The central arguments for collecting data on sexual orientation and gender identity in EHRs are that 1) aggregated data will allow clinicians to recognize and respond to health disparities in their LGBT patient population and 2) asking these questions on forms is a sign to LGBT patients that the organization is interested in their health needs and that they will no longer be invisible to their providers. A 2013 study in 4 health centers that piloted sexual orientation and gender identity questions in registration forms found that patients both accepted and understood the questions (41). Data collection is not without controversy, however; there are important concerns that it not be implemented without expanded training of clinicians to provide culturally appropriate care (42). Nevertheless, change does not occur in a vacuum, and a case can be made that increased data collection will actually lead to greater educational efforts. Some of these concerns can also be alleviated by allowing patients to not answer these questions if they wish.

Data collection does not have to be the sole province of the primary clinician, nor should it always be delegated to a clerk. Perhaps the most efficient and confidential system for collecting these data is through electronic channels. Figure 1-1 is a schematic that highlights how data can be collected directly from patients electronically as part of the registration process, either in the privacy of their homes through a patient portal they can access on their computer or mobile device, or upon arrival at the site, ideally at a private kiosk with a computer or tablet. The primary clinician can then use this information for more nuanced discussion and clarification. If the patient does not complete a form with these questions, then the provider can be the one to ask and enter the information into the EHR. The fact that it will be available for other clinicians appropriately engaged in an individual's care will eliminate the need to repeat this discussion again and again. While some raise concerns about privacy and confidentiality with electronic data, these issues are in general more effectively managed than with use of traditional paper charts, where it is very difficult to track who looks at information concerning an individual patient.

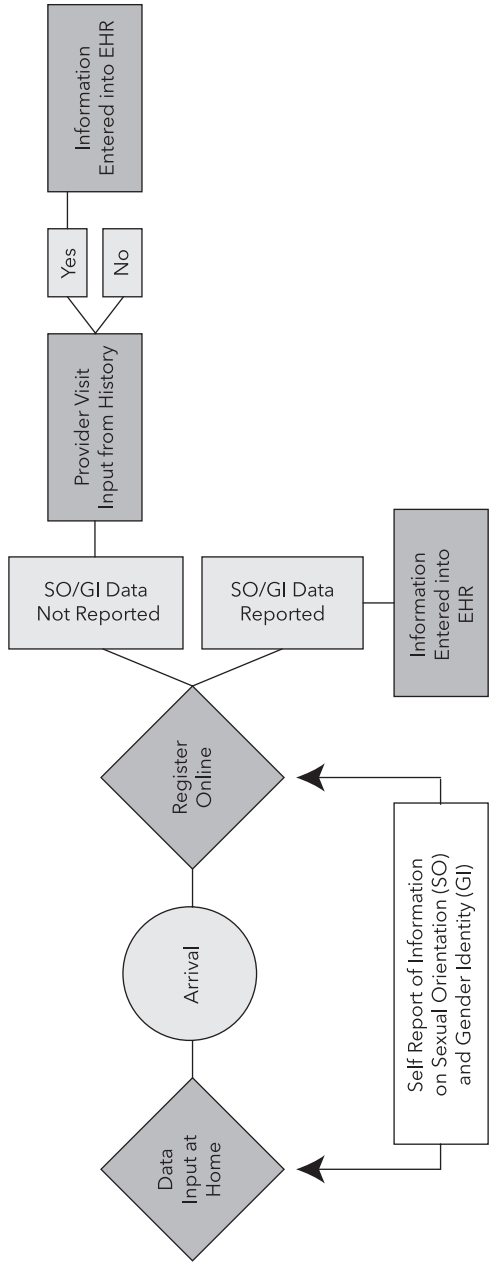

Figure 1-1 Schematic on collecting data from patients in clinical settings. EHR = electronic health record; SO/GI = sexual orientation/gender identity.

Regarding how to frame questions, different examples of questions on sexual orientation and gender identity have been developed. Appendix B provides an example of questions to use. More information can be found on the website of the Center of Excellence for Transgender Health at the University of California San Francisco (www.transhealth.ucsf.edu) and in the issue brief "Asking Patients About Sexual Orientation and Gender Identity in Clinical Settings: A Study in Four Health Centers" (41). These questions are discussed again in other chapters (see Chapters 8 and 17) but are presented here because they represent a critical first step in providing optimal care to LGBT people. Not only does this information help end LGBT invisibility in health care, but it can lead to provision of quality care responsive to their unique needs and experiences.

Standards-Based and Functional Assessments

Beyond the Joint Commission's *Field Guide*, other organizations have designed programs to help assess the degree to which a health care organization adopts leading practices designed to create an LGBT-inclusive environment. The Human Rights Campaign, a large LGBT civil rights organization based in Washington, DC, developed a resource tool for both health care and non–health care organizations to assess how well their policies and programs meet certain requirements for both quality care and a quality workplace for LGBT people. The Corporate Equality Index (CEI) was designed for non–health care organizations, and the Healthcare Equality Index (HEI) was developed for health care organizations. Through a survey process, the HEI identifies leading organizations that comply with criteria set out by the Human Rights Campaign and a group of advisors. Between 2012 and 2013, the number of organizations that completed the HEI increased from 122 to 309. The 309 respondents represented 718 health care facilities, as many of the respondents own more than one facility (43). Facilities that achieve HEI leadership status must demonstrate that they have achieved four core metrics, two of which are now Joint Commission requirements. The four metrics are as follows:

Patient Nondiscrimination Policies

- Patient nondiscrimination policy (or patients' bill of rights) includes the term *sexual orientation.*
- Patient nondiscrimination policy (or patients' bill of rights) includes the term *gender identity.*
- Patient nondiscrimination policy is communicated to patients in at least two readily accessible ways.

Equal Visitation Policies

- Visitation policy explicitly grants equal visitation to LGBT patients and their visitors.
- Equal visitation policy is communicated to patients and visitors in at least two readily accessible ways.

Employment Nondiscrimination Policies

- Employment nondiscrimination policy (or equal employment opportunity policy) includes the term *sexual orientation*.
- Employment nondiscrimination policy (or equal employment opportunity policy) includes the term *gender identity*.

Training in LGBT Patient-Centered Care

- To meet this criterion, facilities participating in the HEI for the first time in 2013 were required to document that they had enrolled at least one staff member in each of five designated work areas for at least 90 minutes of training.

In addition to the questions directed toward achieving leadership status, in 2013 the HEI asked 31 questions based on an "additional best practices checklist" (43).

The HEI has driven hospitals and health centers across the country to demonstrate their concern and make greater efforts to improve LGBT health equity at their institutions. The approach is broadly structural and therefore not tailored to specific organizational needs. On a smaller scale, other groups have focused on gaining a more functional understanding of how organizations approach issues of LGBT health equity in order to address specific needs identified through a participatory process. For example, the National LGBT Health Education Center has developed an online assessment for health care organizations that involves a survey for members of senior management and a survey for all staff (both clinical and nonclinical). Quantitative and qualitative responses are invited. The surveys are the first of a three-part process that involves administering the survey, analyzing the data and reporting back, and providing training and consultation that is tailored to an organization's identified challenges and needs. The results of the surveys might show, for example, that even though an organization has a nondiscrimination policy that includes sexual orientation and gender identity/expression, only 25% of the staff is actually aware of this policy. This suggests that compliance with a standard does not always translate to real-world practice and full achievement of health equity. Educating staff about the policies and helping staff develop protocols for reporting and resolving policy breaches could then become part of the suggested training program for that organization.

Achieving Life-Long Learning: Health Professional Education and LGBT Health Care

LGBT Issues in Health Care Education

Education is at the heart of the health care profession. As we know, when taught well, health care education affects the knowledge, attitudes, and skills of learners. Education, therefore, represents an opportunity to not only help the learner develop LGBT-care competence but also to help improve the care received by that learner's future patients, and, perhaps on a grander scale, to improve overall social equity for LGBT people.

Traditionally, medical, nursing, and other health professional school curricula have contained very little LGBT-specific content, in part at least because of pervasive homophobic attitudes among educators, the health care professions as a whole, and the population at large (as discussed earlier in this chapter). However, as cultural attitudes are shifting to regard LGBT people in the United States more positively, so have attitudes in health care and health care education. In addition to the national programs mentioned earlier that focus on improving LGBT health care, such as the HEI, the National LGBT Health Education Center, and the Joint Commission *Field Guide*, there has been an increased interest in adding LGBT-specific content to health professions curricula. Demonstrating this need is a recent study of medical school curricula reporting that more than 33% of medical schools reported 0 hours of LGBT-specific content delivered in the clinical years, and 6.8% of medical schools reported 0 hours of LGBT-specific content in the preclinical years (44). While the same study found that medical schools that responded had a median of 5 hours of LGBT-specific content in the course of the standard, 4-year curriculum, it is important to note that time devoted to subject-specific education does not necessarily equate to quality of education, nor does it necessarily lead to desirable learning outcomes (knowledge, skills, behaviors, attitudes).

Speaking more to such learning outcomes, another survey demonstrated that 10.5% of graduating U.S. medical school seniors did not agree with the statement that they could "provide safe sex counseling to a patient whose sexual orientation differs from mine," while only 4.5% of students did not agree with the statement that they could "care for patients from different backgrounds." The same survey places this in the broader context of relatively greater student dissatisfaction with education on topics of human sexuality (21.6% found content coverage inadequate) when compared to topics of culturally appropriate care (11.4% found content coverage inadequate) (45).

An increasing amount of curricular material is intended to help learners develop competency in LGBT care, and increasing numbers of resources are

devoted to advancing LGBT health care (see Appendix C). Individual providers may find themselves with the opportunity to advance the LGBT-related knowledge/skills/attitudes of a learner or group of learners. With this in mind, the remainder of this chapter is devoted to the approaches a teacher in different educational settings can take to incorporate LGBT health into established curricula.

Learners in the Classroom Setting

In the classroom or other lecture-based setting, a large amount of teaching and learning deals with foundational science. Here, there are occasionally opportunities for dedicated time for LGBT-related content, particularly an introduction to definitions and concepts related to sexual orientation and gender identity. For those helping to design curricula with time allocated to LGBT-specific content, resources such as chapters of textbooks, or existing presentations (e.g., those available from the National LGBT Health Education Center website: www.lgbthealtheducation.org) are available to help as starting or focal points. However, it should be noted that culturally competent LGBT health care could be taught by introducing key principles in the context of other content. For instance, as a part of a cardiac pathophysiology activity, modifying a case meant to illustrate principles of congestive heart failure by using a patient who presents for care with her same-sex partner allows for exploration of the social determinants of health as they apply to LGBT populations. Likewise, other concepts can be introduced in the context of cases used throughout the preclinical curricula in most medical schools. The primary challenge in taking the latter approach is that it requires added diligence to ensure all key concepts are covered, and usually requires close work with faculty who are primarily responsible for other content areas to determine where concepts might be introduced.

Learners in the Clinical Setting

On occasion, teaching in the clinical setting may take the form of a didactic lecture or activity that is more similar in delivery to content encountered in the preclinical setting. In those instances, the suggestions offered in the preceding section apply. However, in contrast to the situation in the classroom setting, most teaching in the clinical setting centers on active participation by the learner in patient care, whether in a hospital or ambulatory site. The challenge in this setting is that it can be difficult to program in or engineer certain encounters. However, the benefit is that the setting is ideal for direct observation of skills that demonstrate competence in LGBT care. In the early stages, a learner may observe the instructor demonstrate these skills, such as taking a history that is inclusive of LGBT people; performing a physical examination in an appropriately sensitive and respectful way; or discussing care related to sex, sexual orientation, or gender identity. The clinical setting

permits the instructor to then observe the more advanced learner put these skills into practice. It is not necessary for a patient to be LGBT in order for this demonstration of skills to happen; all patients can benefit from LGBT-competent care.

From a broader, curriculum-design standpoint, it is often desirable to measure or demonstrate mastery of LGBT-care skills. In these instances, incorporation of LGBT-related cases into the Objective Structured Clinical Exam setting permits demonstration of these skills along with many others. Examples of such cases are described, and some are available on the Association of American Medical Colleges' MedEdPortal (mededportal.org). The Objective Structured Clinical Exam and direct observation of competence together serve as complementary means of demonstration of skills mastery, and many educators prefer the combination as a means of competency assessment.

Learning in Graduate Professional Education

As learners advance, the service component of patient care can predominate, and learning often takes one of two forms: didactics offered by a graduate professional education program or self-directed (life-long) learning. From the didactic standpoint, while graduate learners may need some refinement of principles learned in the undergraduate professional education setting, most often reinforcement of principles is needed most; thus, lectures given in this setting will be quite similar to those given in the previous settings (see "Learners in the Classroom Setting" earlier in this section). Unfortunately, the demands placed on education program directors are many, and the time available for such didactics is little, so dedicated time for LGBT-specific (reinforcement of) education is rare. It is clear that attitudes of learners with respect to self-directed (life-long) learning are driven by the role modeling of teachers and mentors. Thus, it is helpful for those who are teaching in the clinical setting at the graduate professional level to point out instances when issues or topics relevant to the care of LGBT persons or populations are identified. Resources, such as this book, can provide some of the evidence base for what defines good clinical care and best practices for LGBT persons, and samples from that evidence base can serve as excellent launching points for discussion, reflection, and/or self-directed (life-long) learning.

Life-Long Learning and Continuing Professional Education

As part of a profession, and in keeping with the fundamental importance of practice-based and life-long learning as espoused by many professional societies (e.g., the American Medical Association, the American Nurses Association, the American Pharmacists Association), providers are expected to continually update knowledge, skill, and behavior domains of their practice. It is possible that some reading this book for the first time will be

doing so in pursuit of that goal. Others, and even those just mentioned (after reading this book), may be in a position to offer education to their peers. Continuing professional education may take many forms, including didactics such as grand rounds (usually at medical centers), webinars or asynchronous learning (often offered by medical centers or societies), and conferences. For those looking to further their knowledge of LGBT care-related issues, it is important to take advantage of the many venues currently available for the delivery of such content, including journals and conferences (see Appendix C). Likewise, it is important to realize that the full potential of LGBT-related research is not achieved without appropriate dissemination and incorporation into practice, and thus it is critical that LGBT care-related research and issues be discussed in non–LGBT-specific journals/conferences. We must all continue to be producers and disseminators of peer education content and provide these resources for those who identify, and would like to address, gaps in practice, skills, or knowledge.

Summary Points

- Lesbian, gay, bisexual, and transgender (LGBT) is an umbrella term for all sexual and gender minorities; however, LGBT people are very diverse, and many use different terminology to describe themselves.
- There has been growing awareness of LGBT health needs, culminating in the 2011 Institute of Medicine report on LGBT health disparities. This report has become a keystone for advancing LGBT health research, educational activities, and institutional change across many disciplines.
- A long history of anti-LGBT stigma and discrimination has created both individual and structural barriers to accessing health care and achieving optimal health outcomes.
- Cultural attitudes are shifting more positively toward LGBT people in the United States, including attitudes in health care and health care education; nonetheless, many clinicians continue to experience discomfort, lack of knowledge, and/or lack of experience and training in caring for LGBT people.
- Establishing inclusive and welcoming health care environments for LGBT people can help eliminate disparities by 1) increasing access to and retention in care and 2) encouraging patients to be open about their sexual orientation and gender identity, thus enabling providers to offer more appropriate, targeted, and sensitive care.
- Examples of ways to create inclusive environments include nondiscrimination policies for LGBT patients and staff; hospital equal-visitation policies; training in LGBT patient-centered care for all staff members; health promotion and marketing materials that contain

LGBT visuals, such as images of same-sex couples and gender-nonconforming people; engaging with LGBT community groups; and using inclusive language on registration and medical history forms.

- Collecting data on sexual orientation and gender identity in electronic health records allows clinicians to recognize and respond to health disparities in their LGBT patient population and signals to patients that the organization understands the importance of sexual and gender identity in providing optimal care.
- Organizations such as the Human Rights Commission and the National LGBT Health Education Center offer assessments and training for health care organizations interested in improving the quality of care for LGBT patients.
- A growing number of curricular materials and other resources can be used in educational settings to help learners develop competency in LGBT care.
- This material can be used for dedicated classroom time or can be incorporated into cases in the context of other topics. There are also opportunities for learning in the clinical setting through direct observation and practice.
- Learning about LGBT health care can be a life-long process; it is important to take advantage of the many venues currently offering continuing education on such content, including journals, webinars, grand rounds, and conferences.
- Despite the existence of discrimination and disparities, the sizable majority of LGBT people live healthy, productive lives.

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