

# Establishing Effective Health Care Partnerships with Sexual and Gender Minority Patients: Recommendations for Obstetrician Gynecologists

Scott C. Cook, PhD<sup>1</sup> Kathryn E. Gunter, MPH, MSW<sup>1</sup> Fanny Y. Lopez, MPP<sup>1</sup>

<sup>1</sup> Department of Medicine, The University of Chicago, Chicago, Illinois

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Address for correspondence Scott C. Cook, PhD, Department of Medicine, The University of Chicago, 5841 S. Maryland Avenue, MC 2007/Room B208, Chicago, IL 60637 (e-mail: scook1@bsd.uchicago.edu).

## Abstract

Sexual and gender minority patients have historically experienced high rates of inappropriate and low-quality care, disrespect, and discrimination in health care settings, as well as significant health disparities. Obstetricians and gynecologists can take action on multiple fronts if they wish to improve the quality of care for their sexual and gender minority patients. Examples include improving their relationships with sexual and gender minority patients and family members by purposefully reflecting upon individual and team biases, engendering empathy for sexual and gender minority patients, and creating effective working health care partnerships with them. They can also take steps to improve their cultural competency by improving their knowledge base about sexual orientation and gender identity, using welcoming language and creating health care environments that signal to sexual and gender minority patients that they are welcomed and understood. This article documents multiple suggestions and resources that health care teams can use to improve the health and health care of their sexual and gender minority patients.

## Keywords

- ▶ sexual orientation
- ▶ gender identity
- ▶ prejudice
- ▶ patient–provider interactions
- ▶ culturally competent care

## A Call to Action

The evidence that sexual and gender minority patients experience high rates of inappropriate treatment, disrespect, discrimination, and harassment in health care settings is clear and strong.<sup>1–7</sup> Even when sexual and gender minority patients do not experience outright mistreatment or disrespect, they describe interacting with health care teams who are under-educated and unprepared to provide culturally relevant care or address many of the health care issues and challenges they face.<sup>1,2,7–12</sup> And when sexual and gender minority patients anticipate or experience culturally incompetent or disrespectful care, they are less likely to disclose these parts of their identities to health care team members, which can result in inadequate communication, lack of preventive services, inaccurate diagnosis, inappropriate treatment, and poor health outcomes.<sup>11,13</sup>

Examples of sexual and gender minority patients' negative health care experiences include, but are not limited to, registration systems and forms that do not allow patients to specify same-sex partners, a transgender identity, or a preferred name that is different than the legal name; assumptions that parents of pediatric patients are opposite-sex and hold heterosexual identities; electronic health records that do not prompt providers that transgender patients may require preventive screenings not associated with their gender identity (e.g., male patients may require cervical or breast cancer screening); providers assuming that patients who identify as lesbian do not require screening for sexually transmitted infections or cervical cancer; patient education materials and images in clinics that depict only heterosexual families and gender conforming individuals; restroom designations that require identification with either the male or female binary gender; staff and providers deliberately or

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mistakenly misgendering patients when interacting with them (e.g., referring to a female-identified patient as “he” or using her male-gendered legal name instead of her preferred name); and micro-aggressions such as emotionally and interpersonally distant or “cold” body language, lack of eye contact, and assumptions of particular sexual practices and activities, illegal substance use, sex work, or engagement in gender-stereotyped recreational activities and interests (e.g., assuming same-sex partners recreate stereotypically binary male and female gender roles often associated with heterosexual relationships among cisgender individuals, or those whose sense of personal identity and gender corresponds with their sex at birth).

Mirroring the reports of sexual and gender minority patients, health care professionals also describe lacking the education and experience necessary to provide high-quality care for these populations.<sup>14,15</sup> Trainees and health care team members report being ill equipped to effectively discuss sexuality, having inadequate knowledge regarding gender identity and the specifics of gender-affirming transition care, a lack of familiarity with the routine health maintenance needs of sexual and gender minority patients, and that they are unsure how to respond when they witness the discriminatory behavior of colleagues.<sup>12,16–23</sup> It is not surprising that sexual and gender minority people are more likely to delay or avoid health care than their heterosexual and cisgender counterparts, given the significant quality gaps that they experience.<sup>24,25</sup> Nor is it surprising that they suffer significant health disparities related to the homophobia, transphobia, heterosexism, and systemic oppression that they experience within health care organizations and the broader culture.<sup>1,10,11,26,27</sup>

The specialty of obstetrics and gynecology and individual providers have a responsibility to address the role they are playing in creating and exacerbating the burden of disparities in health care quality and health outcomes carried by sexual and gender minority people. They can do this by taking fundamental steps to create environments in which all patients feel safe enough to reveal key aspects of their sexual and gender identities related to health, welcomed when they identify themselves or family members as a sexual or gender minority, and encouraged to engage fully in their care.<sup>24</sup> In 2014, Flemmer et al introduced a six-element interdisciplinary framework of Empathic Partnership as a tool that primary care nurse practitioners and other health care team members can use to create effective and therapeutic relationships with marginalized populations.<sup>28</sup> The framework elements include (1) the use of *language* that avoids assumptions that can alienate minority patients (e.g., assumptions of heterosexuality); (2) having *knowledge* about specific populations, including specific health care needs and disparities; (3) a *physical environment* that is welcoming and affirming; (4) *reflection*, defined as an ongoing process of examining our culture including the assumptions and biases inherent in the culture; (5) *empathy*, or the ability to tap into our own experiences to connect with patients' experiences; and (6) the ability to create a working *partnership* that acknowledges and values

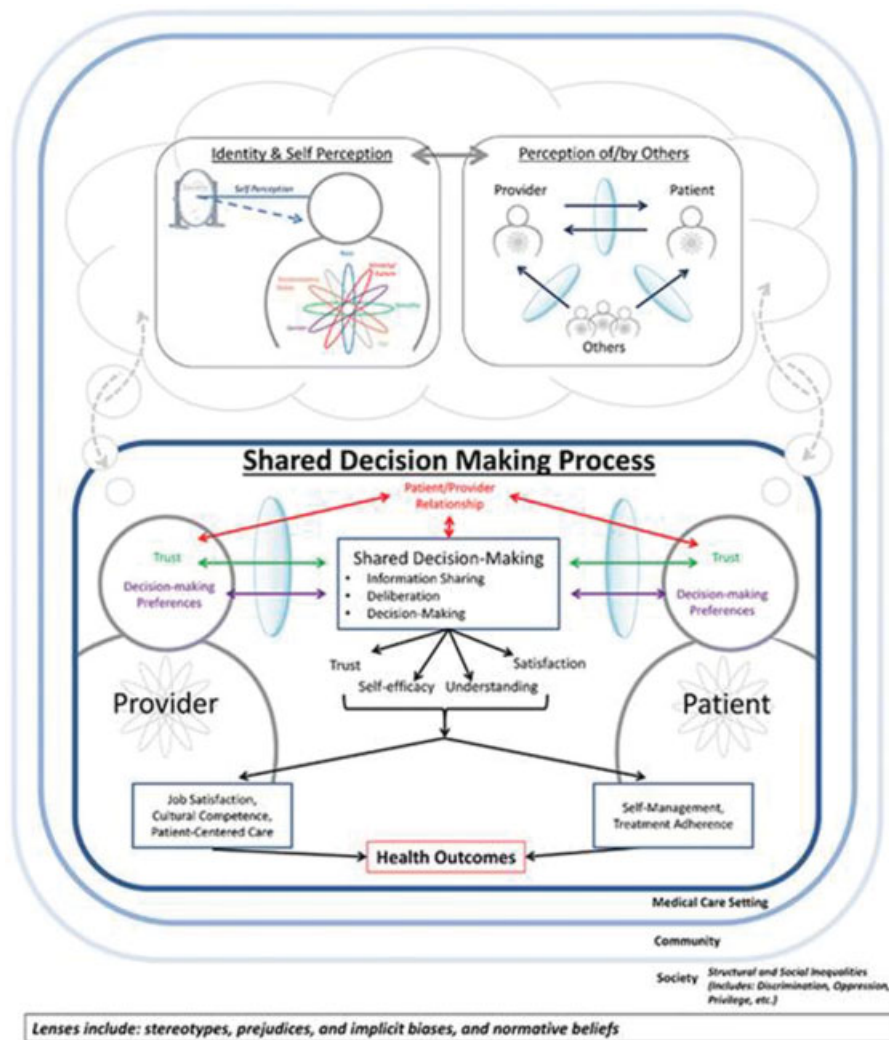
the patient's goals and autonomy. They use the provision of health care to women who have sex with women to illustrate application of the framework.

Many health care organizations are now taking steps to improve the quality of care they provide to sexual and gender minority patients.<sup>3</sup> Most of these efforts include improving the language, knowledge, and environment components of the Empathic Partnership framework. The latter part of this article (section “Language, Knowledge, and Environment”) will address these components and provide additional sources of information and technical assistance. Language, knowledge, and environment consist of the easiest steps to take from the framework because they involve specific concrete actions and factual knowledge. Alternatively, the elements of reflection, empathy, and partnership can be nebulous and challenging because they involve team members' explicit and implicit beliefs and feelings that can affect patient engagement and shared decision making. They should not be overlooked because these elements have a powerful influence on quality of care, even though addressing them may take more time or be more complex.

## Reflection, Empathy, and Partnership

Neither health care team members nor patients are immune to the influence of dominant society, culture, and biases in which they are embedded, and their interactions will be influenced as a result. Peek et al<sup>29</sup> illustrated that health care team members can experience implicit and explicit biases based on their perceptions of a patient's sexual and gender minority identities and have internal and external positive, negative, or neutral reactions whenever they interact with patients holding sexual or gender minority identities (→Fig. 1). Additionally, because patients are aware of this process, they will often manage the disclosure of their sexual and gender minority identities, or expression of them, based on their predictions or fears of how team members will perceive them and react. The model also indicates that health care team members manage various aspects of their own outward expression and disclosure of their various identities for similar reasons. Because dominant culturally based attitudes and beliefs surrounding sexual and gender identity and expression influence patients' and team members' conscious and subconscious perceptions of themselves and each other, they will ultimately influence how well they communicate and make decisions together.

If health care team members are to communicate and partner effectively with sexual and gender minority patients, they will need to understand how society and culture have affected not only their patients' lives but also their own beliefs, perceptions, and assumptions. To date, most health care teams have struggled to communicate effectively and engage empathically with their sexual and gender minority patients. It is important to note that all of us live within cultures that result in positive and negative beliefs, perceptions, associations, and assumptions about people with sexual and gender minority identities. This is a normal part of the human condition. The following sections provide



**Fig. 1** The conceptual model of shared decision making among LGBT African Americans (Reproduced with permission.<sup>29</sup>)

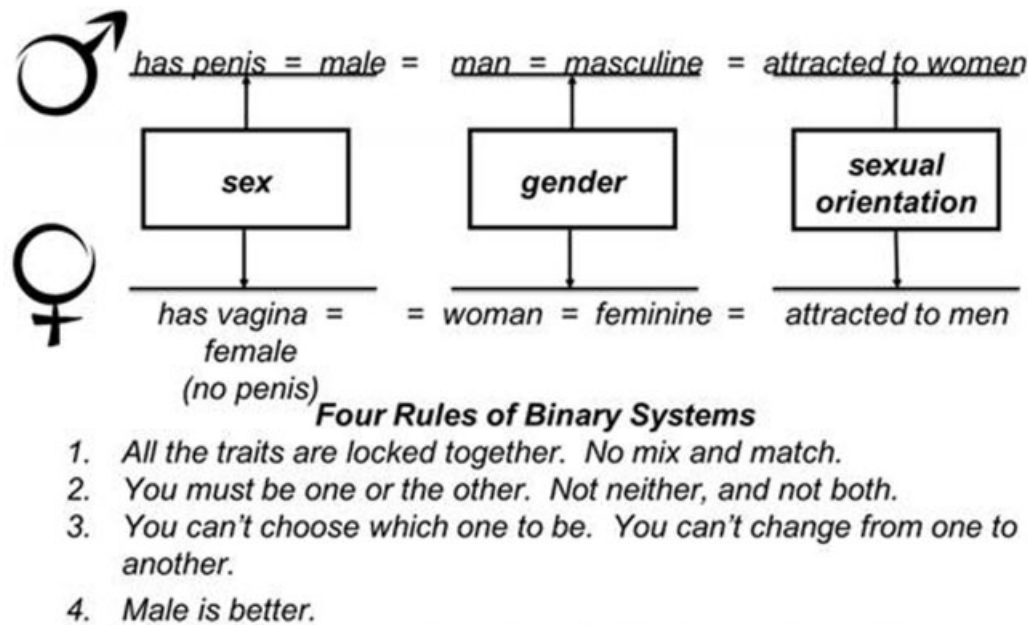
suggestions to assist health care teams to provide better care to sexual and gender minority patients by learning to identify these beliefs, perceptions, associations, and assumptions.

**Understanding sexual orientation and gender identity: the dominant culture of sex and gender.** Fawcett's model of the dominant culture of sex and gender (→ **Fig. 2**) delineates the common assumptions underlying most beliefs and behaviors related to sex and gender in the United States.<sup>30</sup> The model illustrates that we have historically viewed sex, gender, and sexual orientation as a linear and fixed progression with individuals moving horizontally through the model over the life course, with no vertical movement. For example, a baby assigned female sex at birth will develop and express a stereotypically female gender identity and ultimately become attracted to, and have sex with, individuals assigned male sex at birth. Finally, the model stipulates that people do not choose their sexual orientation or gender identity and that these identities never change.

**Implicit bias.** The Kirwan Institute for the Study of Race and Ethnicity (2017), summarizing the implicit bias scientific literature, describes implicit bias as the attitudes or

stereotypes about classes or groups of people that unconsciously affect our understanding, actions, and decisions regarding them.<sup>31</sup> Implicit biases can be favorable or unfavorable and are activated without our awareness or intentional control. Implicit biases can be based on characteristics such as race, ethnicity, age, and appearance and develop over the course of a lifetime, beginning at very early ages, through exposure to direct and indirect messages. Implicit biases are different from explicit biases that individuals may choose to conceal for the purposes of social or political desirability and are not accessible through self-examination.

The Kirwan Institute lists key characteristics of implicit biases including the fact that everyone possesses them, even people with avowed commitments to impartiality, and that they may not always align with our declared beliefs. Racial and ethnic implicit bias in health care is present in physicians and can play a role in health disparities because it is related to maladaptive patient-provider interactions, treatment decisions, treatment adherence, and health outcomes.<sup>32–35</sup> While we need more research, there is initial evidence that sexual and gender minority implicit bias exists in health care,



Source: *Thinking Transgender, Re-thinking Domestic Violence*, Jake Fawcett, Seattle, WA.

**Fig. 2** The dominant culture of sex and gender.

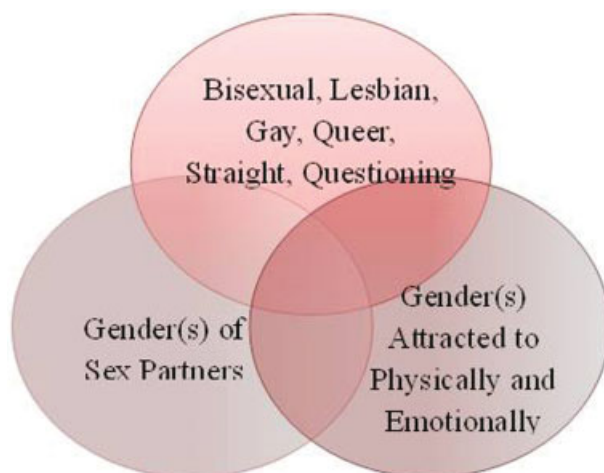
including in medical training and substance abuse treatment.<sup>36–38</sup> It is reasonable to assume that sexual and gender minority implicit bias plays a role in treatment and health outcomes in ways similar to racial and ethnic implicit bias. The next three sections describe aspects of sexual orientation, gender identity, and gender expression that do not always conform to the dominant culture of sex and gender and how they can trigger implicit and explicit bias unless we spend time actively contemplating them.

**Sexual orientation.** **Fig. 3** illustrates the concept that sexual orientation consists of an individual's attraction, behavior, and identity related to romantic and sexual desire. The attraction component of sexual orientation consists of the sex and genders of the people we are romantically

attracted to. The behavior component consists of the sex and gender of people with whom we have sex. The identity component of sexual orientation consists of the way that we describe our sexual orientation to others.

Historically, a person assigned female sex at birth born in the dominant culture of the United States has been expected to experience an innate attraction to biological males, to convey to others a heterosexual identity, and to engage in sexual behavior only with people assigned male sex at birth. However, for many people, one or more of the three components of their sexual orientation may or may not align with each other in a manner prescribed by the dominant culture. For example, a person assigned female sex at birth may be romantically and sexually attracted to both men and women, be engaged in sexual activity only with a man in a long-term monogamous relationship, and identify as bisexual. Surveys collecting data on the three components of sexual orientation consistently show small percentages of respondents self-identifying their sexual orientation in a manner that does not align with their sexual behavior.<sup>39–41</sup> Finally, it is important to understand that sexual attraction, behavior, and identity can shift throughout the life course.

**Gender identity.** Everyone has a gender identity and expresses that identity to others. The dominant culture of sex and gender has historically conceptualized gender identity as a binary either/or construct in which a person can hold a gender identity as either a man or a woman and that this identity should align with their sex assigned at birth. However, gender identity is a component of identity that does not always align with sex assigned at birth. Moreover, the innate experience of some people is that their gender may not be binary or static. Gender identity instead consists of an individual's innate sense of where they belong along a



**Fig. 3** The three components of sexual orientation: identity, behavior, and attraction (Reprinted with permission.<sup>56</sup>).



spectrum of gender that can consist of solely woman on one end of the spectrum, solely man on the other, and mixtures of both in between. In addition, some individuals describe an innate sense of gender that is neither man nor woman, but something different. Finally, it is important to note that gender identity and sexual orientation are conceptually distinct and unrelated concepts and experiences. Therefore, they may not align in ways expected by the dominant culture. For example, an individual assigned male sex at birth who identifies as a woman may have any combination of sexual attractions, behaviors, and identities. Gender expression is an important component of gender identity; the following section describes how some forms of gender expression may not conform to expectations of the dominant culture.

**Gender expression.** Most cultures have spoken and unspoken norms regarding the outward expression of gender. For example, specific clothing and styling, hairstyles, leisure activities, vocations, and specific kinds of physical posturing are often associated primarily with binary male or female gender. Community and family members often respond in a negative manner, and with varying degrees of intensity ranging from mild nonverbal communication to assault or homicide when individuals do not conform to the gender norms of the dominant culture. One outcome of this aspect of the dominant culture of sex and gender is that gender minority individuals suffer a higher rate of homicide because of their gender identity.<sup>42,43</sup> Transgender women of color are at even higher risk of assault and homicide, illustrating how intersecting minority identities influence how others perceive and react. Seventy-two percent of the 111 gender minority individuals killed during 2010 to 2016 were black. Based on 2010–2014 data, the average annual chance of being murdered for all people 15 to 34 years old in the United States was 1 in 12,000. For black gender minority women, their chances were 1 in 2,600.<sup>42</sup> It is important to understand how intersecting identities in gender and sexual minority patients can affect their health care experiences if we are to succeed in creating a culturally competent and relevant health care environment. The following section introduces basic concepts of intersectionality in gender and sexual minority communities.

**Intersectionality in gender and sexual minority communities.** The concept of intersectionality has its roots in black feminist theory. Crenshaw defined intersectionality as the ways in which systems of oppression (e.g., racism, sexism, classism) interconnect and cannot be fully understood if studied in isolation.<sup>44</sup> People with sexual and gender minority identities can be found in all races, ethnicities, age cohorts, physical and cognitive ability levels, and social classes. Thus, many sexual and gender minority patients hold multiple minority identities that affect their status in society generally and their health care experiences and outcomes specifically. Teams at the University of Chicago Medicine are currently studying the health care experiences of sexual and gender minority people of color and their recommendations for improvement. Initial analyses of individual interview and focus group qualitative data indicate that many participants report negative health care experiences that are the result of health care team

members reacting to their sexual or gender minority identity and/or their racial or ethnic minority identity (M. Chin and other team members, oral communication, April 2017). In addition, many participants also report feeling that their health care experiences and interactions with team members would be better in some ways if they were a white sexual or gender minority and in other ways if they were a heterosexual, cisgender, person of color. Both their sexual or gender minority identity and their racial/ethnic minority identity resulted in aspects of their care that were suboptimal or negative in ways that are different for heterosexual and cisgender patients of color or white sexual and gender minority patients.

There are varieties of intersectional challenges that sexual and gender minority patients face, partly because communities composed of sexual and gender minorities exist within, and therefore can exhibit the dominant culture's beliefs and attitudes. For example, individuals who identify as bisexual may not feel fully embraced and experience bias and oppression in both primarily heterosexual and primarily gay male or lesbian contexts. Transgender or gender nonconforming individuals may not feel fully embraced in primarily cisgender contexts regardless of the racial or ethnic composition. In addition, as described earlier, racial and ethnic minority people who also hold a sexual or gender minority identity may not feel fully embraced, and may experience bias and oppression, within primarily white heterosexual, cisgender contexts; primarily white sexual and gender minority contexts; and primarily heterosexual, cisgender contexts composed of people with similar racial and ethnic minority identities. Thus, transgender and bisexual populations of color have unique life experiences and health care teams should avoid assuming that different subgroups of sexual and gender minority populations will have similar life experiences and health care needs.

**Shifting beliefs, values, and biases in the dominant culture.** The bias, oppression, and discrimination that sexual and gender minority patients face is not monolithic and unwavering, in part because the beliefs and values of the dominant culture shift over time and vary regionally or within population subgroups. In the United States, the dominant culture has generally grown more accepting of sexual and gender minority populations over time.<sup>45–48</sup> However, there are subgroups and subcultures that differ in their levels of acceptance as measured by explicit and implicit bias. In addition, cultural and political shifts over time effect how accepting or rejecting the dominant culture is of other oppressed identities. Thus, sexual and gender minority patients who also hold other oppressed identities can experience a complex array of shifting privilege and oppression as a result of changes in the dominant culture.

### **Actions to Address Reflection, Empathy, and Partnership**

Developing an understanding of the dominant culture of sex and gender is an important initial step to overcoming explicit and implicit biases because we can often respond negatively when our conscious and unconscious expectations based on

the dominant culture of sex and gender are challenged. For example, we might engage in explicitly biased behavior such as refusing to acknowledge or respectfully address a same-sex parent of a pediatric patient or we might respond to the unconscious influence of our implicit biases by unintentionally being less accepting or welcoming when caring for a transgender patient.

Fortunately, there is a growing literature exploring potential interventions to reduce and mitigate the effects of implicit biases.<sup>49–53</sup> **Table 1** provides examples of direct and indirect bias reduction interventions. Individuals and teams can be encouraged to avoid attempts to be “colorblind”

or “to see everyone as the same” as tactics to be inclusive and provide equitable care, because research indicates that this can have unintended negative consequences of increased stereotyping of minority group members.<sup>54</sup> Instead, seeking specific information about individual sexual or gender minority patients or community members to assess or evaluate them based on their own personal attributes can hinder the influence of conscious and unconscious stereotyping.

Identifying, addressing, and reducing explicit and implicit biases as a team to improve the health care they provide to sexual and gender minority patients can be challenging and emotional work. While some may find it energizing and

**Table 1** Recommendations for health care teams

Advice	Examples <sup>a</sup>
Reflection, empathy, and partnership <sup>28,49,55–58</sup>	
Understand the dominant culture of sex and gender and how it may have affected your patients	<ul style="list-style-type: none"> <li>• GI and SO are distinct, unrelated concepts. They can be fluid and change throughout the life course</li> <li>• The three components of SO (attraction, behavior, and identity) do not always align</li> <li>• Some patients have experienced sexual abuse, rape, or other violence or trauma perpetrated by others in response to their sexual or gender identity</li> <li>• Some patients have had prior discriminatory health care experiences that affect their current fears and expectations of your health care team</li> <li>• Do not focus on sexual or gender identity if it is not relevant to your patient’s presenting health concerns</li> <li>• Family, friends, and spiritual organizations may have rejected, ostracized, or abused patients due to their SO or GI</li> </ul>
Understand intersectionality. Avoid assuming that different subgroups of sexual and gender minority populations have similar life experiences and health care needs	<ul style="list-style-type: none"> <li>• Many sexual and gender minority patients hold multiple minority identities that affect their status in society generally and their health care experiences and outcomes specifically</li> <li>• Do not expect gender and sexual minority patients to have similar beliefs, values, needs, or life experiences</li> <li>• Not all patients holding a sexual or gender minority identity will prioritize it over other aspects of their identity</li> <li>• Terms describing SO and GI can vary by race, ethnicity, socioeconomic status, or other demographics</li> <li>• Individuals’ and communities’ preferred terms can change over time</li> <li>• Symbols of acceptance and pride in sexual and gender minority communities can also vary in importance and meaning for different racial and ethnic groups</li> </ul>
Recognize and reduce personal and team biases	<ul style="list-style-type: none"> <li>• Interact directly with sexual and gender minority individuals and groups. For example: <ul style="list-style-type: none"> <li>– Invite people with minority sexual and gender identities to give presentations on how to provide culturally competent and relevant health care for them</li> <li>– Partner on a health care or research project with sexual and gender minority individuals and encourage them to take a leadership role</li> <li>– Attend a conference on sexual and gender minority health and engage in active discussion with sexual and gender minority attendees</li> <li>– Spend time in activities or organizations where heterosexual/cisgender individuals and sexual and gender minority individuals relate with each other cooperatively, interactively, and as equals (e.g., sports teams, military, work groups)</li> </ul> </li> <li>• Interact indirectly with sexual and gender minority individuals and groups. For example: <ul style="list-style-type: none"> <li>– Discuss a book, documentary, or movie that positively and empathically portrays sexual or gender minority individuals</li> </ul> </li> <li>• Avoid attempts to be “colorblind” or “to see everyone as the same.” Instead, seek specific information about individual patients or community members to evaluate them based on their own personal attributes</li> <li>• Attempt to take on the perspective of sexual and gender minority patients and try to understand their experiences</li> <li>• Recognize personal responses, thoughts, and feelings regarding sexual and gender minority patients that are based on stereotypes</li> </ul>

**Table 1** (Continued)

Advice	Examples <sup>a</sup>
Language, knowledge, and environment <sup>3,11,24,25,28,52,56,59–61</sup>	
Be culturally competent and sensitive with terminology and language	<ul style="list-style-type: none"> <li>• Patients sometimes reject labels. Allow them to choose their own terms to describe their SO, GI, and partners</li> <li>• Take the time to ask about, and understand, the SO and GI of someone who identifies as queer or genderqueer</li> <li>• Transgender patients should be identified with preferred names and pronouns, even when they are not present</li> <li>• Avoid language that assumes SO or GI               <ul style="list-style-type: none"> <li>– Instead of “Do you have a husband?” say “Are you in a relationship?”</li> <li>– Instead of “How may I help you, Mam?” say “How may I help you?”</li> <li>– Instead of “She is here for her appointment” say “The patient is here for their appointment.”</li> <li>– If you are unsure about a patient’s name or pronoun, ask “I would like to be respectful. What name and pronoun would you like for me to use?”</li> <li>– If you accidentally use the wrong term or pronoun say, “I’m sorry. I did not mean to be disrespectful.”</li> <li>– If a patient’s name does not match insurance or medical records you can ask “Could your chart/insurance be under a different name?” or “What is the name on your insurance?”</li> </ul> </li> <li>• Pay attention to your body language and facial expressions</li> </ul>
Improve knowledge	<ul style="list-style-type: none"> <li>• Review the recommended actions in the study of DeMeester et al to create culturally competent and welcoming environments<sup>59</sup> <ul style="list-style-type: none"> <li>– Use welcoming visual cues in your clinic and tailored patient education materials</li> <li>– Provide training and education to all staff</li> </ul> </li> <li>• Consider participating in the Health Equality Index (HEI) national benchmarking tool<sup>3</sup></li> <li>• Take advantage of the training and technical assistance resources provided by the National LGBT Health Education Center<sup>56</sup></li> <li>• Learn guidelines for primary and gender-affirming care for gender minority patients. The Center for Excellence for Transgender Health defines its mission as increasing access to comprehensive, effective, and affirming health care services for trans communities, accessible online<sup>61</sup></li> </ul>
Improve the care environment	<ul style="list-style-type: none"> <li>• Create a safe environment for SO and GI disclosure:               <ul style="list-style-type: none"> <li>– Assure confidentiality. Ask if information about SO and GI can be included in the health record</li> <li>– Understand that any patient may question their SO or GI</li> <li>– Be honest with patients about your knowledge limitations; avoid relying on them to educate you</li> <li>– Avoid asking unnecessary questions simply to satisfy your own curiosity</li> </ul> </li> <li>• Seek technical assistance to ensure best practices for collecting and using SO and GI data</li> </ul>
Be familiar with the community dynamics and policy	<ul style="list-style-type: none"> <li>• Be aware of the cultural competence of health care and community-based organizations, social service providers, and legal services providers before providing them as referrals</li> </ul>

Abbreviations: SO, sexual orientation; GI, gender identity.

<sup>a</sup>Some of the examples listed have been adapted from training materials published by the National LGBT Health Education Center.<sup>56</sup>

innately interesting, others may find it threatening or anxiety provoking. It is recommended that teams utilize a facilitator skilled and experienced in leading groups through a process to identify and reduce bias. For example, The National Conference for Community and Justice of Metropolitan St. Louis provides education, training, and capacity building for teams wishing to address all forms of diversity, equity, inclusion, cultural competency, and social justice, including sexual orientation and gender identity.<sup>55</sup> Finally, it is important to remember that identifying and addressing bias is a lifetime activity and a daily process of unlearning what the dominant culture has taught us about sex and gender.

## Language, Knowledge, and Environment

Research into reducing and eliminating racial and ethnic bias has indicated that white individuals can experience stereotype threat that manifests as fears of being perceived as racist which can degrade the quality of communication with patients of color.<sup>52</sup> Behavioral scripts and other tools, especially for initial encounters, can help reduce anxiety and improve communication with racial/ethnic minority group members.<sup>32,52</sup> Similar dynamics might also exist for heterosexual/cisgender health care team members eager to provide culturally competent care for sexual and gender minority

patients and they might benefit from similar tools and resources. In addition, simply being familiar with applicable terminology and general expectations regarding culturally competent interactions held by sexual and gender minority patients can go far in ensuring a higher quality of care.

► **Table 1** provides suggestions for ways to interact in a culturally competent and relevant manner with sexual and gender minority patients. In general, team members should be encouraged to be honest with patients about any knowledge deficits related to the health care needs of sexual and gender minority patients. However, they should avoid relying on patients to educate them about how to best care for them and instead seek out and learn what is necessary to provide high-quality and culturally competent care. Health care team members should also promptly and genuinely apologize when they make communication mistakes such as accidentally misgendering a patient or verbalizing a wrong assumption about a patient's sexual orientation. Most patients will forgive these mistakes if the provider is trying to provide high-quality, culturally competent, and empathic care.

*Language and sexual orientation.* Some of the current terms commonly used to convey sexual orientation include heterosexual, straight, gay, lesbian, bisexual, queer, and same-gender loving. Many people avoid the term homosexual due to its close association with oppression and discrimination, including past health care diagnostic practices that labeled same-sex attraction as disordered and a mental illness. Men who have sex with men and women who have sex with women often identify as gay. Some people prefer the term queer because it is nonspecific and requires others to ask a series of questions to understand the three components of sexual orientation, thereby reducing the chances that heterosexual people will rely on stereotypes or assumptions that are often inaccurate or stigmatizing. Taking the time to ask questions about, and understand, the sexual orientation of someone who identifies as queer can help reduce negative biases by building connection and fostering empathic perspective taking. Patients may sometimes identify as queer because it can convey the idea that sexual orientation may shift or change over time, an aspect of sexual orientation that is not commonly associated with other terms. The dominant culture has historically used the term "queer" to oppress and stigmatize sexual and gender minorities and the term has been re-appropriated by some, but not all, members of sexual and gender minority communities to convey strength, inclusion, and pride.

There are personal and cultural considerations that impact how sexual and gender minority patients self-identify, including racial, ethnic, religious, or familial identities. Thus, it is best to allow patients to choose how to describe their sexual orientation and for health care providers to use the same terms. It avoids making inaccurate assumptions that can damage rapport, such as assuming that a female patient who has sex with women identifies as lesbian, when in fact she identifies as straight. Also, many people may feel uncomfortable using specific identity terminology during the process of exploring and coming to a personal understanding of a shifting sexual orientation. Thus, it is important to create a health care environment where patients can feel comfor-

table communicating that they are questioning their identity and that health care team members understand that this is not a sign of pathology or a maladaptive state, but rather a normal process of identity development that can occur throughout the life course. Similar considerations apply to symbols of acceptance and pride in sexual and gender minority communities. For example, the gay pride flag is typically associated with white sexual and gender minority populations and might not hold positive meaning for racial and ethnic populations. Famous and historically significant sexual and gender minority icons can also vary in importance and meaning for different racial and ethnic groups.

*Language and gender identity.* Individuals and communities use multiple terms to describe diverse identities under the gender minority label. They include, but are not limited to, transgender, gender nonconforming, and gender nonbinary. Some people will describe their gender identity as queer or genderqueer for reasons similar to those held by people who use it to describe their sexual orientation. Some people with a minority gender identity may have never felt that they are, or were, in a process of transition from one gender to another. For example, a person assigned female sex at birth who identifies as a man might not identify as transgender. Gender identity is an individual construct determined by the internal sense of each individual. As a result, health care related to gender identity, such as hormone therapy, can be conceptualized as gender-affirming health care.

### **Actions to Improve Knowledge and Environment**

There are multiple resources available to health care teams wishing to improve their knowledge regarding health care for sexual and gender minority patients and how to improve their health care environments. DeMeester et al recommended multiple actions that health care organizations can take to improve shared decision making with sexual and gender minority people who also hold racial and ethnic minority identities.<sup>59</sup> The model posits six drivers of operations and structure that work through four mechanisms. The six drivers are workflows, health information technology, organizational structure and culture, resources and clinic environment, training and education, and incentives and disincentives. The four mechanisms are continuity and coordination, ease of shared decision making, knowledge and skills, and attitudes and beliefs. The model offers a large array of actions that health care organizations can take to improve care for these populations. Additional recommendations can be found in the study of Demeester et al<sup>59</sup> and in ► **Table 1** of this article.

*Collecting and utilizing sexual orientation and gender identity data.* Patient's sexual orientation and gender identity information, when collected in a sensitive and affirming manner, can help improve knowledge and the care environment. When collected at the point of patient registration, it provides an initial strong message to sexual and gender minority patients that they are in a health care environment that acknowledges and welcomes their presence.<sup>25</sup> Health care teams can stratify quality metrics by sexual orientation and gender identity to uncover disparities in care and health outcomes to inform tailored quality improvement interventions.



Finally, identifying disparities will help team members overcome implicit bias by reminding them of the need to provide high-quality care for this population. Bjarnadottir et al conducted an integrative literature review regarding the collection of patient-level sexual orientation and gender identity data in health care settings.<sup>60</sup> They found that sexual and gender minority patients are comfortable revealing their identities when they are assured that the information is being gathered to improve care. However, collecting sexual orientation and gender identity data is a complex process with multiple nuanced actions and decisions to accomplish these goals in a manner that does not inadvertently harm sexual and gender minority patients. The National LGBT Health Education Center provides technical assistance to help guide organizations through this process.<sup>56</sup>

*Knowledge of community dynamics and referral organizations.* It is important that health care team members are familiar with the prevailing local climate and culture and how it might affect sexual and gender minority patients. Organizations and local news outlets that serve sexual and gender minority community members can be a good source of information to learn about what sexual and gender minority patients are experiencing in their lives outside of the health care system. Similarly, it is critical to know about the cultural competence of other health care and community-based organizations before providing them as referrals to sexual and gender minority patients.

## Conclusions

Sexual and gender minority patients are in need of culturally relevant, high-quality health care. Progress is being made, but more needs to be done. This article and the external resources referenced within it provide a menu of options that health care teams can choose from to improve the care they provide to sexual and gender minority patients. The health care team's knowledge, language, and physical environment are areas of focus where they can implement concrete activities and actions to improve. The work of reflection, building empathy, and establishing effective partnership with patients is currently less well defined and there are fewer concrete resources available. However, there are options that teams can implement to address these areas of focus as well.

Andriote described a growing movement to conduct research that will help us understand the majority of sexual and gender minority individuals who, despite the cultural homophobia, transphobia, sexism, and heterosexism in their lives, manage to be mentally and physically healthy and productive.<sup>62</sup> He noted that the research community has perhaps overly focused on their challenges and understudied their strength and resilience, thus missing important factors that can contribute to health and well-being. In the same way, health care teams should recognize that their sexual and gender minority patients will have strengths and resilience in spite of the challenges they face. Identifying the positive attributes and resilience of their sexual and gender minority patients will facilitate providing the most relevant and high-quality care.

Finally, the tasks of improving our knowledge, language, and care environments will never end if we wish to achieve and maintain high-quality care for our gender and sexual minority patients. Cultural beliefs, attitudes, and values change quickly, including how we conceptualize sexual orientation and gender identity and even the words our patients use to describe them. The specialty of obstetrics and gynecology will need to follow and understand these changes and, ideally, be a positive cultural influence.

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## References

- 1 Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities; Board on the Health of Select Populations; Institute of Medicine. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. The National Academies Press website. [http://www.nap.edu/catalog.php?record\\_id=131282011](http://www.nap.edu/catalog.php?record_id=131282011). Accessed April 21, 2017
- 2 Grant J, Mottet L, Tanis J, Harrison J, Herman J, Keisling M. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. National LGBTQ Taskforce. [http://www.thetaskforce.org/static\\_html/downloads/reports/reports/ntds\\_full.pdf2011](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf2011). Accessed April 6, 2017
- 3 Healthcare Equality Index. Human Rights Campaign website. <http://assets.hrc.org/files/assets/resources/HEI-2017.pdf2017>. Accessed April 30, 2017
- 4 Li CC, Matthews AK, Aranda F, Patel C, Patel M. Predictors and consequences of negative patient-provider interactions among a sample of African American sexual minority women. *LGBT Health* 2015;2(02):140–146
- 5 Macapagal K, Bhatia R, Greene GJ. Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health* 2016;3(06):434–442
- 6 Eaton LA, Driffin DD, Kegler C, et al. The role of stigma and medical mistrust in the routine health care engagement of black men who have sex with men. *Am J Public Health* 2015;105(02):e75–e82
- 7 Jaffee KD, Shires DA, Stroumsa D. Discrimination and delayed health care among transgender women and men: implications for improving medical education and health care delivery. *Med Care* 2016;54(11):1010–1016
- 8 Kano M, Silva-Bañuelos AR, Sturm R, Willging CE. Stakeholders' recommendations to improve patient-centered "LGBTQ" primary care in rural and multicultural practices. *J Am Board Fam Med* 2016;29(01):156–160
- 9 Quinn GP, Sutton SK, Winfield B, et al. Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) perceptions and health care experiences. *J Gay Lesbian Soc Serv* 2015;27(02):246–261
- 10 Krehely J. How to Close the LGBT Health Disparities Gap. Center for American Progress website. [https://cdn.americanprogress.org/wp-content/uploads/issues/2009/12/pdf/lgbt\\_health\\_disparities\\_race.pdf](https://cdn.americanprogress.org/wp-content/uploads/issues/2009/12/pdf/lgbt_health_disparities_race.pdf). December 21, 2009. Accessed April 29, 2017
- 11 Wilson PA, Yoshikawa H. Improving access to health care among African-American, Asian and Pacific Islander, and Latino lesbian, gay, and bisexual populations. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities*. New York, NY: Springer; 2007:607–637
- 12 Potter J, Goldhammer H, Makadon HJ. Clinicians and the care of sexual minorities. In: Makadon HJ, Mayer KH, Potter J, Goldhammer H, eds. *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. Philadelphia, PA: ACP Press; 2008:3–24

- 13 Durso LE, Meyer IH. Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sex Res Soc Policy* 2013;10(01):35–42
- 14 Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA* 2011;306(09):971–977
- 15 White W, Brenman S, Paradis E, et al. Lesbian, gay, bisexual, and transgender patient care: medical students' preparedness and comfort. *Teach Learn Med* 2015;27(03):254–263
- 16 St Pierre M. Under what conditions do lesbians disclose their sexual orientation to primary healthcare providers? A review of the literature. *J Lesbian Stud* 2012;16(02):199–219
- 17 Dorsen C, Van Devanter N. Open arms, conflicted hearts: nurse-practitioner's attitudes towards working with lesbian, gay and bisexual patients. *J Clin Nurs* 2016;25(23–24):3716–3727
- 18 Walsh D, Hendrickson SG. Focusing on the "T" in LGBT: an online survey of related content in Texas Nursing Programs. *J Nurs Educ* 2015;54(06):347–351
- 19 Richardson BP, Ondracek AE, Anderson D. Do student nurses feel a lack of comfort in providing support for Lesbian, Gay, Bisexual or Questioning adolescents: what factors influence their comfort level? *J Adv Nurs* 2017;73(05):1196–1207
- 20 Unger CA. Care of the transgender patient: a survey of gynecologists' current knowledge and practice. *J Womens Health (Larchmt)* 2015;24(02):114–118
- 21 Safer JD, Tangpricha V. Out of the shadows: it is time to mainstream treatment for transgender patients. *Endocr Pract* 2008;14(02):248–250
- 22 Glad J, Tan WN, Erlen JA. Fear of AIDS, homophobia, and occupational risk for HIV. A staff development challenge. *J Nurs Staff Dev* 1995;11(06):313–319
- 23 Beagan BL, Chiasson A, Fiske CA, et al. Working with transgender clients: learning from physicians and nurses to improve occupational therapy practice. *Can J Occup Ther* 2013;80(02):82–91
- 24 Mail P. The case for expanding educational and community-based programs that serve lesbian, gay, bisexual, and transgender populations. *Clin Res Regul Aff* 2002;19(2–3):223–273
- 25 Gay & Lesbian Medical Association. Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients. Gay and Lesbian Medical Association website. Available at: [http://glma.org/\\_data/n\\_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf](http://glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf) 2006. Accessed April 27, 2017
- 26 Cahill S, Makadon H. Sexual orientation and gender identity data collection in clinical settings and in electronic health records: a key to ending LGBT health disparities. *LGBT Health* 2014;1(01):34–41
- 27 Simoni JM, Smith L, Oost KM, Lehavot K, Fredriksen-Goldsen K. Disparities in physical health conditions among lesbian and bisexual women: a systematic review of population-based studies. *J Homosex* 2017;64(01):32–44
- 28 Flemmer N, Dekker L, Doutrich D. Empathetic partnership: an interdisciplinary framework for primary care practice. *J Nurse Pract* 2014;10(08):545–551
- 29 Peek ME, Lopez FY, Williams HS, et al. Development of a conceptual framework for understanding shared decision making among African-American LGBT patients and their clinicians. *J Gen Intern Med* 2016;31(06):677–687
- 30 Fawcett J. Thinking transgender, re-thinking domestic violence. Presented at: Q&A for Advocates National Training Institute at the NW Network of Bi, Trans, Lesbian and Gay Survivors of Abuse Annual Training Meeting, Seattle, WA; 2007
- 31 Understanding Implicit Bias. Kirwan Institute for the Study of Race and Ethnicity. Available at: <http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/>. Accessed April 21, 2017
- 32 Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med* 2013;28(11):1504–1510
- 33 Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health* 2015;105(12):e60–e76
- 34 van Ryn M, Burgess DJ, Dovidio JF, et al. The impact of racism on clinician cognition, behavior, and clinical decision making. *Du Bois Rev* 2011;8(01):199–218
- 35 Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med* 2007;22(09):1231–1238
- 36 Sabin JA, Riskind RG, Nosek BA. Health care providers' implicit bias and explicit attitudes toward lesbian women and gay men. *Am J Public Health* 2015;105(09):1831–1841
- 37 Burke SE, Dovidio JF, Przeworski JM, et al. Do contact and empathy mitigate bias against gay and lesbian people among heterosexual medical students? a report from medical student CHANGES. *Acad Med* 2015;90(05):645–651
- 38 Cochran BN, Peavy KM, Cauce AM. Substance abuse treatment providers' explicit and implicit attitudes regarding sexual minorities. *J Homosex* 2007;53(03):181–207
- 39 Pathela P, Hajat A, Schillinger J, Blank S, Sell R, Mostashari F. Discordance between sexual behavior and self-reported sexual identity: a population-based survey of New York City men. *Ann Intern Med* 2006;145(06):416–425
- 40 Kerker BD, Mostashari F, Thorpe L. Health care access and utilization among women who have sex with women: sexual behavior and identity. *J Urban Health* 2006;83(05):970–979
- 41 Agénor M, Muzny CA, Schick V, Austin EL, Potter J. Sexual orientation and sexual health services utilization among women in the United States. *Prev Med* 2017;95(95):74–81
- 42 Talusan M. Unerased: Counting Transgender Lives. Mic website. <https://mic.com/unerased/2016>. Accessed April 30, 2017
- 43 Waters E, Jindasurat C, Wolfe C. Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence in 2015. National Coalition of Anti-Violence Programs website. [http://avp.org/wp-content/uploads/2017/04/ncavp\\_hvreport\\_2015\\_final.pdf](http://avp.org/wp-content/uploads/2017/04/ncavp_hvreport_2015_final.pdf) 2016. Accessed April 29, 2017
- 44 Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev* 1991;43:1241–1299
- 45 Dimock M, Doherty C. In Gay Marriage Debate, Both Supporters and Opponents See Legal Recognition as 'Inevitable'. Pew Research Center website. <http://www.people-press.org/2013/06/06/in-gay-marriage-debate-both-supporters-and-opponents-see-legal-recognition-as-inevitable/>. June 6, 2013. Accessed April 21, 2017
- 46 Pew Research Center. A Survey of LGBT Americans: Attitudes, Experiences and Values in Changing Times. Pew Research Center website. <http://www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbt-americans/>. June 13, 2013. Accessed April 21, 2017
- 47 Smith TW. Public Attitudes Toward Homosexuality. NORC website. [http://www.norc.org/PDFs/2011 GSS Reports/GSS\\_Public Attitudes Toward Homosexuality\\_Sept2011.pdf](http://www.norc.org/PDFs/2011%20GSS%20Reports/GSS_Public%20Attitudes%20Toward%20Homosexuality_Sept2011.pdf). September 2011. Accessed April 21, 2017
- 48 Westgate EC, Riskind RG, Nosek BA. Implicit preferences for straight people over lesbian women and gay men weakened from 2006 to 2013. *Collabra. Psychology (Irvine)* 2015;1(01):1–10
- 49 Lai CK, Marini M, Lehr SA, et al. Reducing implicit racial preferences: I. A comparative investigation of 17 interventions. *J Exp Psychol Gen* 2014;143(04):1765–1785
- 50 Rudman LA, Ashmore RD, Gary ML. "Unlearning" automatic biases: the malleability of implicit prejudice and stereotypes. *J Pers Soc Psychol* 2001;81(05):856–868
- 51 Godsil RD, McGill Johnson A. Transforming Perception: Black Men and Boys. Perception Institute website. [www.perception.org/publications/transforming-perception/](http://www.perception.org/publications/transforming-perception/) Perception Institute. March 2013. Accessed: April 24, 2017
- 52 Godsil RD, Tropp LR, Goff PA, et al. The Science of Equality, Volume 1: Addressing Implicit Bias, Racial Anxiety, and Stereotype Threat in Education and Health Care. Perception Institute website. [www.perception.org/science-of-equality-volume-1](http://www.perception.org/science-of-equality-volume-1)

- perception.org/publications/transforming-perception/. November 2014. Accessed April 22, 2017
- 53 Devine PG, Forscher PS, Austin AJ, Cox WT. Long-term reduction in implicit race bias: a prejudice habit-breaking intervention. *J Exp Soc Psychol* 2012;48(06):1267–1278
  - 54 Apfelbaum EP, Sommers SR, Norton MI. Seeing race and seeming racist? Evaluating strategic colorblindness in social interaction. *J Pers Soc Psychol* 2008;95(04):918–932
  - 55 National Conference for Community and Justice of Metropolitan St. Louis. National Conference for Community and Justice of Metropolitan St. Louis website. <http://www.nccjstl.org/>. Accessed April 28, 2017
  - 56 The National LGBT Health Education Center. The National LGBT Health Education Center website. <https://www.lgbthealtheducation.org/>. Accessed April 28, 2017
  - 57 Boscardin CK. Reducing implicit bias through curricular intervention. *J Gen Intern Med* 2015;30(12):1726–1728
  - 58 Sharman Z. *The Remedy: Queer and Trans Voices on Health and Health Care*. Vancouver, BC: Arsenal Pulp Press; 2016
  - 59 DeMeester RH, Lopez FY, Moore JE, Cook SC, Chin MH. A model of organizational context and shared decision making: application to LGBT racial and ethnic minority patients. *J Gen Intern Med* 2016;31(06):651–662
  - 60 Bjarnadottir RI, Bockting W, Dowding DW. Patient perspectives on answering questions about sexual orientation and gender identity: an integrative review. *J Clin Nurs* 2017;26(13-14):1814–1833
  - 61 The Center for Excellence for Transgender Health. The Center for Excellence for Transgender Health website. Available at: <http://transhealth.ucsf.edu/>. Accessed April 28, 2017
  - 62 Andriote J-M. The power of choosing resilience. *The Atlantic* 2013. <https://www.theatlantic.com/health/archive/2013/02/the-power-of-choosing-resilience/273245/>; February 17, 2013. Accessed April 30, 2017