

## Addressing the Needs of LGBT Patients

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In 2008, during my first year of medical school, I remember feeling distinctly uncomfortable sitting in our designated one-hour class on lesbian, gay, bisexual, and transgender (LGBT) health. The class started with a presentation that provided basic definitions of different LGBT identities, and ended with a question-and-answer session with a transgender woman. Although this session presented an important conceptual foundation, it included little guidance about concrete ways in which to adequately address the specific and unique health concerns of LGBT patients. As presented in the article on preventive health care for women who have sex with women (WSW) in this issue of *American Family Physician*, these are essential skills for any clinician.<sup>1</sup>

Now as a medical school faculty member and practicing physician, I seek to show my students and colleagues that sexuality is an integral part of a patient's identity that needs to be uniquely defined by each patient; it cannot be determined simply by looking at someone. In every well adolescent interview, I ask about sexual identity, behavior, and attraction in an open and nonjudgmental way, which also leaves room for a patient's uncertainty. For example, I often start by asking: "Do you know if you're attracted to men, women, both, or neither?" I then go on to ask separate questions about sexual practices and identity. LGBT youth are at greater risk of many health problems and of bullying, depression, and suicide.<sup>2</sup> Because of this, I always ask adolescents what their parents and friends know about their sexuality, and I am conscious of the importance of maintaining confidentiality.

The article by Drs. Knight and Jarrett notes that negative interactions with the health care system are a major barrier to medical care for WSW. It is important when communicating with patients that clinicians do not assume heterosexuality. This means they should ask their patients specific questions about their sexual orientation and sexual identities. Directly asking these questions—using paper forms before the encounter or during the clinical encounter itself—avoids the risk of making inaccurate assumptions that result in providing inadequate or inappropriate care.<sup>3</sup>

To this end, clinicians should create an inclusive office environment that features photos of same-sex and

opposite-sex couples, the rainbow flag, and office staff who are comfortable with nontraditional family structures. Office staff and clinicians should be trained in health concerns unique to LGBT communities and the importance of maintaining confidentiality about sexual orientation and identity. Questions about sexual history and identity should never be asked in a public space. In the examination room, clinicians should offer indicated screenings and examinations based on biologic sex. This means clinicians must be comfortable examining bodies that may diverge from the patient's presented gender.<sup>4</sup> Physicians who teach medical students or residents in their offices should model an approach to the care of sexual minorities that is consistently open and nonjudgmental.

A recent study of data from the 2013-2014 National Health Interview Survey examined associations between self-identified sexual orientation and a variety of self-reported health conditions, including psychological distress, smoking, alcohol use, multiple chronic diagnoses, and perceived health status.<sup>5</sup> The study found significant health disparities for patients who identified as lesbian, gay, or bisexual, reinforcing the importance of being conscious of and sensitive to the unique needs of these patients. Family physicians must be mindful of the increased risks LGBT patients face, and put the principles of comprehensive and inclusive care outlined by Drs. Knight and Jarrett into practice.

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