For all humans, sexual orientation and gender identity are essential elements of identity, informing how we plan and live our lives. The historic invisibility of sexual minorities in medicine has meant that these important aspects of their identities as patients have been ignored, with the result that these patients have been denied respect, culturally competent services, and proper treatment. In 2011, the Institute of Medicine took a major step in bringing greater visibility to sexual minorities when it released its groundbreaking report identifying serious health disparities for lesbian, gay, bisexual, and transgender communities that previously received little attention. The IOM still overlooked some groups, as it reported little on health disparities experienced by members of sexual minority populations whose health disparities are less well documented. In addition to lesbian, gay, bisexual, and transgender people, sexual minorities include those who are intersex (I) (born with ambiguous genitalia, or experiencing sexual developmental differences at puberty), those who identify as queer (Q) (vocally embracing nonheterosexual orientation or nonbinary gender identity, which includes certain individuals who are LGBT as well as others), and those who are questioning (Q) (unsure of or testing sexual orientation or gender identity). However, the ethical issues that the IOM report points to are salient to the provision of education about and care for all these populations in medicine. The report made clear an ethical obligation for medicine to improve LGBTIQQ health by recognizing members of sexual minorities and improving prevention and intervention for their health care needs.

Likely due to historic rejection and mistreatment, there is evidence of reluctance on the part of LGBT patients to disclose their sexual orientation (SO) or gender identity (GI) to their health care providers. There is some perception of risk in sharing SO and GI for many patients who have had bad prior experiences. Despite these risks, we argue that we can improve the quality of care provided LGBTIQQ patients only by encouraging them to self-identify and then using that information to improve quality of care. (For this report, we will refer to LGBTIQQ patients when we refer to all potentially identified in this population by opening the conversation about SO and GI in care, while we will use a shorter acronym when data exist only for more well-documented subpopulations.)

One strategy both to prompt patient self-identification and to store and use SO and GI information to improve care centers on the use of electronic health records. However, gathering SO and GI data in the EHR requires a workforce that knows both how to obtain and how to use that information. To develop these competencies, educational programs for health professionals must prepare students and educators to elicit and to use LGBTIQQ identity data to improve care while simultaneously ensuring the safety of patients, trainees, and staff and faculty members as SO and GI become openly discussed and integral parts of ongoing medical discussion and care. As determination of SO and GI demographics becomes more common in health research, we will more
Knowledge of a patient’s sexual orientation and gender identity can trigger exploration of social history, sexual practices, family support, and social stressors.

fully understand the health risks for all the LGBTIQQ populations.

**The Challenge Posed by SO and GI Information**

Successfully collecting and using SO and GI requires acknowledging both the obstacles to collecting them and the benefits of having them. Visibility through self-identification or being perceived as LGBTIQQ can both expose individuals to mistreatment due to homophobia, including microaggressions, and perpetuate health disparities. Recognition of serious health disparities experienced by LGBTIQQ populations has created an ethical obligation for providers and systems to improve care for them. Current LGBTIQQ health disparities developed in an era in which providers rarely inquired about sexual orientation or gender identity. This neglect prevented recognition of LGBTIQQ patients and their unique health needs, rendering quality, personalized care impossible. Medicine continues to work to improve health for other disadvantaged populations by using the EHR to document identities and prompt appropriate care. EHRs hold similar promise and similar challenges for accelerating the changes needed in health care for LGBTIQQ patients. For example, LGBT youth experience higher rates of bullying, depression, and suicidal ideation than their heterosexual peers. After learning a youth’s SO and GI status, a health professional can intervene directly or through mental health services to address bullying, depression, and suicidal ideation.

Invisibility, or not being recognized, denies access to quality care needed to reduce or eliminate health disparities. For example, the Centers for Disease Control and Prevention recommends that sexually active gay and bisexual men receive frequent testing for sexually transmitted diseases and be immunized against Hepatitis A and B. Invisibility also occurs when patients delay or avoid care because of prior negative experiences with providers. The Lambda Legal Survey report “When Healthcare Is Not Caring” documents harsh physical and emotional treatment of LGB patients at the hands of their medical providers, with trans patients reporting parallel, and usually worse, treatment. Nearly five thousand LGBT people completed the first survey, and over half reported experiencing discrimination in care. Such treatment often triggers avoidance of regular appointments with providers, increasing the rate of treatment in emergency rooms. Emergency room care is much more expensive than primary care but, more critically, often yields late diagnoses of preventable conditions, increasing patient risks for complications from diseases. Systematic collection of SO and GI data at all points of contact within the health care system, from the primary care office to surgical suite to emergency room, can promote prevention and treatment efforts for LGBTIQQ patients.

Youth, as a special population, can benefit from SO and GI data collection in the EHR. Stigmatization by family members and others can lead youth to adopt maladaptive coping behaviors (smoking, substance use, unhealthy eating, unsafe sexual practices, and so on), which offer short-term relief while leading to long-term damage to the individual’s health. The IOM documents multiple health disparities that appear to stem from long-term maladaptive coping. For example, lesbian and bisexual women and gay men report higher rates of smoking and alcohol consumption than heterosexuals, leading to higher risk for lung and liver diseases. Family rejection can both exacerbate maladaptive coping and prevent or limit youth access to health care. However, young adults who report strong family acceptance of their SO and GI report higher self-esteem, better general health, lower rates of depression and substance abuse, and fewer lifetime suicide attempts. It is estimated that 40 percent of homeless youth are LGBT, with little emotional or financial support, these youth are more likely to engage in sex work or “survival sex,” often without condoms, in exchange for food or housing, leading to higher rates of HIV and sexually transmitted infections. With awareness of the critical nature of family support, clinicians can invite youth to disclose their SO and GI to guide appropriate preventive counseling. In addition, providers observing early signs of maladaptive coping can refer youth and their families to helpful behavioral health resources. Health professionals can support LGBTIQQ teens by encouraging family acceptance of youth as they explore their SO or GI or come out.

Knowledge of the patient’s SO and GI can trigger exploration of social history, sexual practices, family support, and social stressors, and a broader assessment of the patient’s strengths and challenges can help in tailoring health maintenance plans. Clinician acceptance of youth SO and GI demographics is likely to increase appropriate use of
primary care services and foster improved health outcomes. Awareness of these potential benefits drives an ethical responsibility to learn how to gather and utilize these data competently.

The Electronic Health Record: An Opportunity

Since the American Psychiatric Association removed homosexuality as a mental disorder from the *Diagnostic and Statistical Manual of Mental Disorders* in 1973, there have been substantial increases in cultural acceptance of lesbian, gay, and bisexual persons and a somewhat lesser increase in acceptance of transgender individuals.20 This acceptance signals that it is now possible to make needed changes in health care, such as the introduction of SO and GI demographics into the EHR. While institutional changes will likely occur unevenly, introducing the expectation that providers seek to learn and document SO and GI in the EHR can accelerate needed changes.

As health systems launch use of the EHR to improve care, they assume an increased ethical responsibility for protecting LGBTIQQ people from insensitive data collection, information misuse, and mistreatment because of their increased visibility. Currently, there is considerable variability across states on protections from discrimination based on SO and GI. Twenty-nine states fail to protect people from discrimination based on sexual orientation, while thirty-four states fail to protect patients against discrimination because of gender identity.21 This variability makes it critical that patient autonomy be respected (patients have the right to choose not to reveal SO or GI data) and that access to data gathered to enhance health care be monitored so that SO or GI data are not used to harm the employment or reputation of patients. With the steady flow of people across state lines for residency and work, the lack of unified and clear federal policies prohibiting discrimination permits worrying variability by geography.22 Robust security for electronic information is imperative if we are to ensure protection of patients who disclose their SO or GI.

In seeking to gather sensitive information about an individual’s SO and GI, health care institutions assume heightened responsibility for ensuring that these data are kept secure and not misused.23 Further, patient autonomy requires that individuals have the right to share these data with a provider while asking that the data not be entered in the EHR. Health centers already recognize the need for protecting personal health information. As electronic record usage has increased, safeguards for electronic patient data have increased around HIV status, infectious diseases (such as tuberculosis and syphilis), mental health, cancer diagnoses, substance abuse, and other potentially stigmatizing conditions.24 Institutional safeguards include preventing external hacking efforts and internal misuse with policies forbidding employees access to records of patients except in the process of care. Sanctions against employees who violate this rule are powerful, including potential termination.

Other safeguards for patients have been developed concurrently with the introduction of SO and GI collection in health care, including development of robust EHR security measures and training of patient-relations staffs in supporting LGBTIQQ patients who report negative care experiences. In addition, some health care systems have created lists of LGBT-welcoming health care providers to allow patients to arrange care with supportive clinicians. Protective measures will need to evolve to protect patients, but perhaps the most critical change needed is the development of health care workers’ competence in care for LGBTIQQ patients.

Developing a Competent Workforce

Incorporating SO and GI data into the EHR and utilizing it well requires a culturally competent health care workforce. Otherwise, the EHR cannot develop its potential as an effective tool in reducing LGBTIQQ health disparities. For providers to deliver better care, undergraduate, graduate, and postgraduate health curricula need to integrate LGBTIQQ health information. The unevenness of attitudes toward LGBTIQQ people across geographic areas and provider beliefs requires that talking about SO and GI be incorporated into all levels of health education, including continuing professional education. Even simple skills for asking about and documenting SO and GI have not yet been included in standard medical training.25 A crucial next step is to develop and integrate competency-based health curricula to prepare health professionals for care of LGBTIQQ patients. Such learning requires that trainees and staff and faculty members experience a safe environment to learn and provide care as effectively as possible.

Simulated patient scenarios can allow practice of comfortable discussions of SO and GI in preclinical training. All lectures should be scrutinized to identify opportunities to integrate and normalize information on LGBTIQQ health. As medical schools teach cultural awareness, LGBTIQQ issues must be included. Such lessons must make health care professionals mindful of health disparities for sexual minorities and clinicians’ roles in reducing them. Curricular development will also require focus on team-based quality care for LGBTIQQ patients.

Successful curricular reform cannot occur, however, without additional focus on the hidden curriculum (unintended, generally negative assumptions learned in health care systems). Traditional anti-LGBTIQQ prejudices have been a piece of the hidden curriculum, with homophobic taunting in operating rooms, emergency departments, and
other high-intensity care delivery sites. A systemic effort to reduce microaggressions (for example, insensitive joking or exclusionary language) that marginalize LGBTIQQ individuals or any patient or trainee is critical to making health institutions safe. Institutional culture must embrace and celebrate diversity, fostering a positive environment for all.

Graduate School Safe Zone Programs

Perhaps the most effective way to improve learning about LGBTIQQ health issues, as well as to counter negative aspects of the hidden curriculum, is to foster academic health settings that are supportive of LGBTIQQ students and faculty and staff members. An increasing number of students are graduating from high schools and universities that offer supportive climates and programming, such as Safe Zones. Safe Zone programs typically represent a proactive effort by an institution to create a welcoming and inclusive space for LGBT individuals and their allies to meet, share their experiences, and gain awareness, knowledge, and skills to aid in advocating for their patients, peers, family members, friends, and coworkers. Safe Zone programs have spread to many middle schools, high schools, and universities. Students with Safe Zone programs at their institutions graduate with an expectation of acceptance and with pride in the LGBT community. Although rigorous evaluations of Safe Zone programs are only slowly appearing,26 these programs lead many students to expect an equally accepting environment in their later learning or work environments. Advisors in premed or prehealth programs and graduate program admissions’ committees and advisors are now challenged to share which graduate programs and institutions may or may not provide a supportive climate for personal and professional development for LGBTIQQ trainees and allies. Only in a safe environment can a trainee from a sexual minority population function optimally, share his or her rich perspectives, and possibly enhance colleagues’ LGBTIQQ care competence.

Faculty members also deserve personal and professional development. Faculty members hold multiple roles in academic health centers: providing clinical care, teaching, conducting research, role modeling, and mentoring. A major challenge is the lack of faculty, especially “out” faculty, to advise LGBTIQQ students with particular sensitivity to their needs and experiences. Unlike the current generation of trainees from sexual minority populations, senior LGBTIQQ faculty members rarely experienced supportive learning environments. These faculty members may lack the confidence and fundamental skills to help students excel as “out” providers or as scholars on LGBTIQQ health research or curriculum development. Faculty members who perceive their own success as tied to remaining in the “closet” may focus their recommendations to students on being less out or not out in training. The kinds of manifestations of homophobia documented in “When Healthcare Is Not Caring” must be confronted by out LGBTIQQ faculty members and straight allies to create a workforce capable of eliminating LGBTIQQ health disparities.

Given the significance of supportive learning environments for LGBTIQQ students and faculty and staff members, it is disconcerting that few health graduate programs provide a Safe Zone program. Among the exceptions is the Safe Zone Program at the Albert Einstein College of Medicine in The Bronx, New York, implemented in 2011.27 Its mission is to establish and maintain an environment to support the personal and professional development of LGBTIQQ students and to prepare all students to address LGBTIQQ-related health disparities and health care issues. The program was initiated after a group of LGBTIQQ community members submitted a report, detailing personal and professional experiences and published diversity standards and best practices for institutions, to the dean entitled “Recommendations to Build a More Supportive Climate for the LGBT Community at the Albert Einstein College of Medicine.” Initially, the twelve-member LGBT Steering Committee, led by John Paul Sánchez, investigated existing undergraduate Safe Zone Programs and then adapted key components of these programs to fit the recommendations itemized in the dean’s report with consideration for the culture of graduate medical and biomedical education. We hope that, building off the experience of Einstein and other schools, graduate-level health programs will soon make Safe Zone or similar programs widely available to their future health care professionals.28

Future Efforts

There is broad policy consensus that reducing health care disparities is an ethical responsibility in health care. Accomplishing that ethical responsibility requires multifaceted local efforts to incorporate SO and GI variability as a normative aspect of culture and care. To accomplish these changes, institutions must develop efforts to educate, to improve climate, and to innovate improvements in care. Welcoming environments in which LGBTIQQ patients and health care workers feel safe and accepted must be developed and enhanced. In such environments, SO and GI data will become a normal part of the patient-provider discussion and result in robust EHR data registries that can be used to implement effective vaccinations and educational, counseling, and intervention programs in an effort to enhance individual LGBTIQQ patient health and reduce health disparities. These efforts taken together can help create health care systems that treat LGBTIQQ patients, trainees, and health care professionals with respect; reduce health disparities; promote LGBTIQQ-related scholar-
ship (teaching, research, service, and clinical) and allow for more just and beneficial health care. Efforts are needed to create safe spaces at institutions, regionally and nationally. In these safe spaces, LGBTIQ people and allies can share resources and best practices. Such efforts can help ensure that their institutions become drivers of excellence.


15. Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, *The Health of Lesbian, Gay, Bisexual, and Transgender People*, 162.


24. Ibid.


