Meeting the Healthcare Needs of LGBT Patients

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Disclosure

• I have nothing to disclose.
By the end of this presentation, participants will be able to:

• List five documented health disparities experienced by the LGBT community.
• Know how to access best practice guidelines and strategies to improve care to the LGBT community.
• Gain insight into culture “blind spots” which often ignore the needs of this community.
• Employ strategic arguments for prioritizing improvement of care to the LGBT community including recently developed Joint Commission standards.
I have no conflicts of interest or financial disclosures.

This presentation will include no discussion of pharmaceuticals.
Consider these experiences

• A pediatrician father in his own practice site

• An FTM transgender patient with chest pain in ED

• Three coworkers
Background

- Greater Worcester Community Foundation effort
  - How can we improve life in Worcester for the LGBT community?
- Surveyed key constituents in Worcester: health care identified as a high priority need
  - Nearly half of respondents leave Worcester for their health care
Key findings

- Non-clinical staff need training on working with LGBT patients.
- Provider and staff knowledge and comfort levels are not consistent throughout the hospital system.
- Issues present in customer service throughout the system may disproportionately affect LGBT patients.
Key findings

- Providers’ knowledge and attitude towards LGBT issues are often difficult to ascertain, which can make it challenging for patients to come out to providers.

- Protocols and standards of care for transgender patients would greatly improve care for this population.
Key findings

- Patients need a coordinated system for identifying LGBT-culturally competent providers.
- The computer system and forms that track patient information do not adequately reflect the lives of many LGBT patients.
The population

- Kinsey estimated 10% of the population is a member of a LGBT community
  - More recent surveys suggest 3-5% identify as LGBT but same gender sexual behavior similar to Kinsey estimates
- Due to fear of disclosure, accurate statistics are probably not possible
- 2000 Census
  - Same gender couples live in 99.3% of all US counties
  - Same gender couples raising children in 96% of all US counties
- Higher percentages in urban areas
- Cross race, ethnicity, SES and education levels
Paucity of evidence-based guidance

• Between 1980-99, 0.1% of all published manuscripts on GLBT concerns
• Between 1979-92, only a half million dollars of designated NIH research funding
• Meta-analysis in AnnFamMed point to low level of evidence for recommended clinical guidelines
LGBT persons underserved by Healthy People 2010

• LGBT persons are reluctant to seek health care due to anticipated discrimination
• Physicians often don’t ask about sexual orientation or gender identity
• In a survey of LGBT persons, 98% felt sexual orientation is important to health but 64% withhold information for fear of substandard care
Being LGBT does not –in and of itself-mean you are ‘at risk’
Specific best practices

- Environment of care
- Sexual and gender history taking
- Adolescents and families
- Adults
- Transgender adults
Environment of care

• Waiting Room
  – Rainbow sticker; pink triangle
  – Wear a rainbow pin
  – Posters and brochures
  – Recognize LGBT Pride Day
  – Post non-discrimination policy

• Single use bathrooms

• Change forms/questionnaires to be more inclusive
  – Gender, Family Status

• Staff training and personnel policies
  – Zero tolerance for discrimination
Gender, to be completed by the patient as desired:
- Female
- Male
- Transgender
  - Female to Male
  - Male to Female
  - Other
Other (leave space for patient to fill in)

Sexual orientation identity:
- Bisexual
- Gay
- Heterosexual/Straight
- Lesbian
- Queer
- Other (state “please feel free to expand” leave space for patient to fill in)
- Not Sure
- Don’t Know

Current relationship status (An alternative is to leave a blank line next to current relationship status):
- Single
- Married
- Domestic Partnership/Civil Union
- Partnered
- Involved with multiple partners
- Separated from spouse/partner
- Divorced/permanently separated from spouse/partner
- Other (leave space for patient to fill in)

What safer sex methods do you use?

Do you need any information about safer sex techniques? If yes, with:
- Men
- Women
- Both

Are you currently experiencing any mental health problems?

Do you want to start a family?
Sexual History Taking

• Documented high degree of homophobia and physician discomfort with sexual history taking
  – Avoidance is common; need to work at gaining comfort with difference

• LGBT individuals have a high degree of suspicion and fear about mistreatment and will often not disclose sexual orientation or gender differences
Recommended questions

1. Incorporate into every new patient visit and annual health maintenance visit
2. Start with a statement about sexual history taking as important
3. Are you sexually active?
4. Do you have sex with men, women or both?
5. Are you attracted sexually to men, women or both?
Not just asking questions…

It’s also about gaining comfort with difference
GLBT Youth
GLBT adolescents are more likely to...

- Feel isolated
- Use cocaine, alcohol, tobacco, and other substances
- Contract an STD
- Experience dating violence
- Get pregnant or get someone pregnant
- Be threatened or injured with a weapon at school
- Be kicked out of their home
- Attempt suicide
Risk factors for LGBTQ youth directly correlate to safety and support in their environment.

Increased safety and support leads to better health outcomes.
Best practices for supporting GLBT youth

▪ Support positive development and expression of sexual orientation and gender identity

▪ Reject “solutions” or approaches that pathologize or further stigmatize GLBT identity and expression

▪ Create safe space and invite disclosure

▪ Use gender-neutral language and open-ended questions
Best practices (continued)

- Manage confidential information appropriately re: families, insurance, and office staff

- Assess risk and attend to mental health needs and safety concerns re: self-injury, family rejection, school environment

- Provide appropriate medical and sexual health information and resources
Best practices (continued)

- Provide affirming, non-judgmental counseling

- Bridge connections to culturally competent mental health care providers, endocrinologists, or other specialists as needed

- Bridge connections to other LGBT youth and adult mentors
Supporting Families
The impact of family rejection was measured for:

Mental health:
- Suicide attempts
- Suicidal ideation
- Depression

Substance use/abuse:
- Heavy drinking
- Illicit substance use
- Substance-related problems

Sexual risk behavior:
- Unprotected sex with a casual partner (last experience)
- Unprotected sex with a casual partner (last 6 months)
- STD diagnosis
Findings:

Increased experience of family rejection **directly correlates** to negative health outcomes.
Best Practices

- Ask adolescents about family reactions and refer to community support and counseling as needed.

- Identify community and online resources so parents can connect with positive parental role models to decrease rejection and increase support.

- Advise parents that negative reactions adversely influence their child’s health and mental health.
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move equality forward!

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News

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Family Medicine and Community Health
Health equity and practice standards for adult patients
Important considerations

• Screening for STIs
  – Guidelines predicated on sexual history taking

• Anal Pap smears for persons having anal penetrating sex
  – Not just for MSM

• Don’t forget preventive health screening
Health risks for MSM

- Stress of homophobia
- Hate crimes
- Avoidance of health care
- Lack of health insurance
- Higher rates of smoking, substance abuse
- Intimate partner violence
- Depression, PTSD
- Viral and bacterial infections
Screening recommendations

- Screen for symptoms of STIs: urethral d/c, dysuria, ulcers, warts, adenopathy, rectal pain, bleeding or d/c
- Smoking and drug use history
- Depression screen
- Violence screen
- Stratify as high or low risk behaviors
- Immunize all against HAV and HBV
Recommendations for MSM

• Take a sexual behavior history
  – Number of partners; casual sex; monogamous relationship
  – Drug use with sex
  – Oral, anal receptive, condom use

• History of HIV testing and status

• Above will identify as high or low risk
Screening recommendations

- High risk=3-6 months; low risk=annual
  - HIV serology; Syphilis serology
  - Urethral or urine GC and Chlamydia
  - High risk: pharyngeal GC
  - Receptive intercourse: rectal GC, Chlamydia

- HIV + or High risk=annually; low risk=q2-3 years
  - Anal PAP smear
Anal Pap smear

• For 24 hours prior, no receptive intercourse, use of lubricants, creams or use of sex toys
• Use dacron swab to swab also surfaces of anus and rectum
• Send for PAP and HPV testing
• Fenway has a culposcopy clinic
Recommendations for WSW

• Health Risks
  – Homophobia and associated stress
  – Avoidance of medical care
  – Lack health insurance
  – Higher risk of overweight
  – Higher prevalence of tobacco use and substance use
  – Lower rates of pregnancy
Screening recommendations

- Sexual behaviors history
- Smoking and drug use history
- Depression screen
- Violence screen
- Intimate partner violence
- Desire for children and fertility referral
Screening recommendations

• PAP, STDs (don’t assume not at risk)
• Mammography
• Conditions associated with obesity
  – Diabetes
  – HTN, Heart disease
• Colon cancer screening
• Diet, exercise
Considerations for the transgendered patient
Terminology

• Transsexual- A person who believes that they are the opposite gender to which they were born into genetically.
• Transgendered- A person who does not feel as though they completely fall into the gender that they were born into. This is usually viewed as an umbrella term that would include crossdressers and transsexuals.
• Crossdresser (old term transvestite) – A person who enjoys wearing clothes of the opposite gender. They may or may not have gender identity issues.
• Gender Orientation – Whether you identify as male or female. This is not the same as sexual identity.
• Sexual Orientation – Who you are sexually attracted to – women, men or both
• MTF–Male to Female transsexual (sometimes referred to as a transwoman)
• FTM – Female to Male transsexual (sometimes referred to as a transman)
• RLE (Real Life Experience) Living fulltime in the new gender. Required prior to having sexual reassignment surgery.
• FFS - Facial Feminization Surgery - A type of plastic surgery that modifies the soft tissue and bony structure of the face to make it appear more feminine. Changes can be distinctive but are also subtle.
• Sexual Reassignment Surgery (SRS) / alternatively Genital Reassignment Surgery (GRS)- Genital surgery (vaginoplasty for MTF/ phalloplasty for FTM)
• GID (Gender Identity Disorder aka Gender Dysphoria – The psychiatric diagnosis given transsexuals vis a vis their discomfort with their biological gender.
Trans-specific Areas of Focus

1. Create trusting relationship
   a. Begin with open-ended questions of how content s/he is with life today.
   b. Ask directly if s/he has any short term needs (make sure the patient knows you mean all needs and not just medical needs) Safe housing? Financial crisis?
Trans-specific training

- History: support system; trauma; hormones; body modifications
- Routine Preventive Health measures
- Hormones in the primary care office
  - Desirable and negative effects of treatment
  - Hormone specific medical monitoring
History
Trans-Specific

- What is your current support system with family and friends?

- Are you or have you ever taken hormones. Were they prescribed by a doctor?

- Have you had or contemplated any ‘body modifications’ from hair removal to various trans-related procedures.
Plan With Patient

1. Discuss non-gender related diagnoses with patient and their treatment with the patient i.e. hypertension, need for colonoscopy.

2. Gender related issues would potentially be:
   a. Need for mammogram in MTF and FTM (if no mastectomy, still need annual chest exam as some breast tissue retained for shaping)
   b. PAP smear still likely indicated for FTM
   c. Hepatitis B immunization if IV drug use or not monogamous
   d. Continued need for prostate monitoring in MTF
   e. Long term goals regarding having children prior to start of hormones
   f. Discuss effects of hormones on fertility
   g. Need for the FTM to monitor more closely for ovarian cancer if on testosterone and had not had an oophorectomy
Hormones

Current effort to train primary care physicians to initiate hormonal treatment

Paper will be distributed via email
Hormone Regimen Effects: FTM

- Increased muscle mass and tone
- Increased libido
- Permanent increase in facial and general body hair
- Male-pattern baldness (If genetically inclined)
- Permanent deepening of voice
- May have sense of finally feeling normal/calmer
- Clitoral enlargement to up to 4-5 cm. (1-3 years)
- Decrease or cessation of menses
- Change in body odor
- At some point infertility will likely become permanent
Effects of Hormones
FTM – Potential Negative Side Effects

- May have more volatile nature
- Increased risk ovarian cancer
- Increase in polycythemia
- Worsening of lipid profile to that of typical male
- Hypertension
- Unhealthy male pattern fat distribution
- Hepatitis – especially with oral testosterone
Effects of Hormones: MTF

- Breast development
- Fat redistribution to hips/buttocks
- Decrease in muscle mass
- Decreased libido
- Decrease in testicular mass
- Erections usually less firm or absent
- Halting of further scalp hair loss
- Slow decrease in body hair except on face
- Often a significant calming effect
- Sometimes more emotionally sensitive
- Change in body odor
- Softening of skin
- Improved cholesterol profile
- Erectile and Fertility issues often permanent after 6-12 months
- Any breast development is irreversible
Effects of Hormones
MTF- Negative Side Effects

- Thrombophlebitis and PE
  - Higher in smokers and age over 40
- Elevated potassium with spironolactone
- Hepatitis
- Elevated prolactin and prolactinomas
- Possible increase risk of MI
- Increased risk of breast cancer
- Increased risk for hypertension
- Spironolactone lowers this risk
The good news
Resolution by AMA

• “... AMA supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient’s physician.”

- June 2008
Going forward

• There is both a quality and business argument for system focus on improving care systems for community
  – Hospital system has catchment of 1 million lives
  – 50% of the five percent who identify as LGBT = 25,000 customers!

• New focus by Joint Commission and Governor’s proclamation
References and Resources

• Gay and Lesbian Medical Association’s Guide for Care of the LGBT persons
  

• Center for Population Research in LGBT Health
  
  http://www.icpsr.umich.edu/fenway/

• AETC Anal PAP video guide
  
  http://www.aidsetc.org/aidsetc?page=etresdisplay&resource=etres-229

• 2005 Youth Behavior Risk Survey
  
  http://www.doe.mass.edu/cnp/hprograms/yrbs/05/

  
References and Resources

• Makadon HJ. Improving health care for the lesbian and gay communities. NEJM. 2006 Mar 2;354(9):895-7
