Provider Perspectives on the Application of Patient Sexual Orientation and Gender Identity in Clinical Care: A Qualitative Study

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BACKGROUND: The federal government and other organizations have recommended that healthcare institutions collect and document patient sexual orientation and gender identity (SO/GI) information in order to advance the understanding of the health of sexual and gender minority populations and to combat existing health disparities. Little is known, however, about provider perception of the clinical relevance of, or how they might use, patient SO/GI information in individual care.

OBJECTIVE: To explore providers' perspectives on and experiences with collection of patient SO/GI information and how the knowledge of this information may impact clinical care.

DESIGN: Qualitative study using in-depth individual interviews of healthcare providers.

PARTICIPANTS: Twenty-five healthcare providers, including physicians, physician assistants, and nurse practitioners, from the fields of family medicine, internal medicine, gynecology, and urology within a single healthcare system in an east coast city.

APPROACH: Interviews were recorded and transcribed verbatim. Transcripts were coded and analyzed using principles of grounded theory and thematic analysis to identify themes emerging from the data.

KEY RESULTS: Providers recognized the importance of collecting patient SO/GI information for understanding population-level public health concerns and disparities, as well as understanding and respecting the context of patients' lives. However, providers also emphasized the importance of knowing patients' sexual behaviors and physical anatomy for addressing health risk and preventive care needs—and noted the distinction between these characteristics and patient SO/GI. Providers cautioned that assumptions based on knowledge of patient SO/GI may unintentionally obscure accurate profiles of patient behavior and anatomy.

CONCLUSIONS: Along with the potential benefits of routine collection of patient SO/GI, it is important that providers continue to inquire about patient behaviors and anatomy to inform individual risk and needs assessments. Findings from this study can inform the development of guidelines, trainings, and practices for incorporation of patient SO/GI along with existing assessment practices to improve individual and population health.

KEY WORDS: sexual orientation; gender identity; clinical care.

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INTRODUCTION

Gender and sexual minority populations, including individuals who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), face numerous physical and mental health disparities (i.e., increased risk of depression or anxiety disorders, smoking, and substance use) and have higher rates of unmet health needs compared with heterosexual and cisgender populations.^{1–4} These disparities are largely due to societal stigma and discrimination experienced by sexual and gender minorities. Provider discrimination, or the anticipation thereof, can adversely affect both access to and quality of care.^{5, 6} Without routine collection of information about patient sexual orientation and gender identity, we are limited in our ability to identify, measure the magnitude of, and track such disparities, as well as to avoid further stigma, discomfort, or distrust experienced in the medical encounter. In order to advance the understanding of health and combat health disparities of sexual and gender minority populations, the US federal government has released guidelines recommending that healthcare institutions collect and include patient sexual orientation and gender identity (SO/GI) data in their medical records to obtain a more accurate depiction of LGBTQ health.^{6–8}

Few studies examining the process of inquiring about patient SO/GI information and the use of this information have been performed outside of LGBTQ specialty clinics, and research has identified mixed perspectives of providers on the appropriateness and importance of asking and documenting patient SO/GI information.^{9–12} Maragh-Bass and colleagues¹² examined emergency department provider perceptions of the risks and benefits of routine collection of patient SO/GI information. The study did not examine how SO/GI information would be obtained or how it would inform their clinical care decisions. Providers in the study acknowledged the possibility that collecting this information could result in increased screening for health conditions or diseases that are more prevalent in sexual and gender minority populations. The emergency department providers largely

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focused on the possibility that SO/GI collection could improve the patient-provider relationship and interactions during clinical visits and the fear that they would offend patients by inquiring about their SO/GI. While patients in this study, and in previous studies,^{13, 14} expressed that they are open to the collection of their SO/GI information. A substantial gap appears in the literature around whether and how providers actually use SO/GI information in their clinical care decisions.

The present study used semi-structured qualitative interviews to explore healthcare provider perspectives on collection of patients' SO/GI and the ways in which knowledge of patients' SO/GI may be relevant to and used in clinical care. We sought to gain information from healthcare providers in fields in which patient SO/GI information, along with their sexual behaviors and anatomy, may be particularly relevant to care: primary care (family medicine or internal medicine), gynecology, and urology. Findings can help inform and improve the development and implementation of policies and practices regarding inquiry and documentation of patient SO/GI information in clinical settings.

METHODS

Recruitment and Data Collection

Healthcare providers, including physicians, physician assistants (PA), and nurse practitioners (NP), were recruited from the departments of family medicine, internal medicine, gynecology, and urology within a single large university health system in the northeastern United States from January to August 2017. We obtained lists of providers in each of the four departments from the health system and purposively selected potential participants in order to achieve diversity in discipline, gender, years of experience, and focus/expertise serving LGBTQ patients (based on professional profiles). The research team sent individual recruitment e-mails to 64 providers across the four departments. Of the 64 providers individually contacted, 20 completed interviews, 33 did not respond, 4 declined to participate, 5 agreed but did not schedule an interview appointment, and 2 scheduled an appointment but did not show to the interview. Five additional providers learned about the study through word-of-mouth and volunteered to participate, bringing the total of completed interviews to 25.

Study participation consisted of a one-time confidential interview conducted in-person or via telephone. The study was approved by the University of Pennsylvania Institutional Review Board and oral informed consent was collected prior to the start of the interview. Participants did not receive any compensation for participation. Interviews were conducted by trained graduate-level interviewers. Interviews ranged in length from 28 to 57 min, with an average length of 43 min. The interviews were guided by a semi-structured interview guide, developed for this study. Interview guide topics included prompts about providers' perspectives on the importance of obtaining patient SO/GI information; how the knowledge of

patients' SO/GI might affect their clinical care; the best methods of inquiry and documentation of patients' SO/GI; any foreseen barriers or challenges in obtaining and utilizing patient SO/GI information; and what information, training, or resources would be needed in order to effectively collect and use patient SO/GI data in clinical care.

Participants

A total of 25 participants were enrolled in this study. Participants included 20 physicians and 5 PAs/NPs, with a range of experience from current residents to providers with 35 years of experience since their board certification. Participants were also spread out across 4 departments of interest: 9 family medicine, 8 internal medicine, 4 gynecology, and 4 urology (Table 1). Fourteen (56%) of the 25 providers interviewed indicated that they had particular training and/or extensive experience with treating LGBTQ populations.

Analysis

All interviews were audio recorded for accuracy and transcribed verbatim by a professional transcription service. The data (transcripts) were managed using NVivo 11 software; two research team members independently coded each of the transcripts, with five transcripts being double-coded to test for intercoder reliability. The coders, who were trained in qualitative research, started with a thematic analysis, identifying passages of the transcripts that fit within pre-established domains derived from the interview guide topics. Then, they employed principals of grounded theory¹⁵ to identify sub-themes and additional themes that emerged from the data that were relevant to the study aims. The research team met regularly during the coding process to discuss coding decisions and resolved coding discrepancies through consensus. A study codebook was developed with code definitions and example quotes. For this paper, we focused on the interview data related to provider perspectives on the relevance and clinical use of patient SO/GI information in individual care.

Table 1 Participant characteristics

Participant characteristics (n = 25)	
	n (%)
Years since board certification	
0 (current resident)	2 (8.0)
1–5	9 (36.0)
6–15	7 (28.0)
> 15	7 (28.0)
Gender (self-identified)	
Female	15 (60.0)
Male	10 (40.0)
Department	
Family medicine	9 (36.0)
Internal medicine	8 (32.0)
Gynecology	4 (16.0)
Urology	4 (16.0)

RESULTS

Providers recognized the importance of tracking patient SO/GI data for understanding population-level public health concerns and disparities. In the discussion of ways in which patient SO/GI information is used in individual clinical care, however, providers focused on the distinction between the following: (a) understanding patient health risk and preventive care needs and (b) understanding the broader context of patients' lives and building a respectful patient-provider relationship. The following are specific findings related to (a) sexual orientation and (b) gender identity, with exemplar quotes from the data to support the findings.

Sexual Orientation and Behavior

In discussing the relevance of sexual orientation, providers noted that knowing a patient's sexual orientation may enhance the patient-provider relationship and help the provider to understand potential stressors and the social context of a patient's life in a way that may be relevant to clinical care. However, they expressed that the primary clinical relevance in primary care, gynecology, or urology would be understanding the sexual behaviors that may contribute to health risks. With limited time in the patient encounter, providers noted the need to prioritize the focus on behavior. A family medicine provider explained:

[Their identity] also certainly plays an important role in who they are as people and in their social lives. But, it's a balance, right?... it can be a potential minefield to try to take, as part of my 15-minute appointment, to try to figure out what their identity is with that, when I'm just more interested in, should I screen them for gonorrhea?

Some providers noted that a focus on identity could result in the inappropriate conflation of sexual orientation with sexual activities, thus assuming behavior based on identity and potentially missing clinically important information. Providers noted the importance of asking detailed questions about sexual risk behaviors, when clinically relevant, and cautioned that knowing a patient's sexual orientation or partner's gender is not sufficient for clinical preventive and diagnostic care. A gynecologist shared that she makes a point to stress to residents she teaches not to assume a patient's behavior based on their sexual orientation:

I really have to explain to them that just because someone, um, identifies themselves as gay – a gay woman, you cannot assume that they have not been heterosexually active and that they have not had male partners.

In fact, some providers indicated that they may make assumptions and related clinical decisions about sexual behavior based on sexual orientation. An internal medicine provider reflected on his clinical practice, explaining situations in

which he might conflate sexual orientation with sexual behavior in their clinical decision-making:

I don't ask heterosexual individuals it's like do you have anal sex? Or I don't even say do you have oral sex?... But I'm absolutely much more explicit with the gay men I see about what type of sexual practice [they are engaging in] so I understand where they are. Because part of it is you don't want to have stupid conversation about worrying about anal intercourse when the person practices like mutual masturbation and maybe occasionally oral sex, right?... And so [knowing a patient's sexual orientation] helps me know where to go with the conversation.

This provider noted a tendency to assume or anticipate particular kinds of sexual behaviors based on the patient's sexual orientation and to steer clinical inquiry based on those assumptions.

A family medicine provider additionally noted this tendency and that it is likely problematic:

If a patient kind of comes out to me, I'll oftentimes kind of presume some practices based on that. I probably shouldn't.

A family medicine resident raised the concern that asking about sexual orientation could impact a patient's comfort with fully disclosing sexual behaviors, in particular when the behaviors may not fit with the assumptions based on orientation:

I'm concerned about patients who may have same-sex sexual behaviors, but may hold a heterosexual identity and may be less willing to disclose those behaviors if I ask for an identity first, and they give me this heterosexual identity and then feel like they need to go down that pathway when I ask about behavior.

In summary, providers in this study reported that knowing a patient's sexual orientation could be helpful in understanding the full context of the patient's life. However, considering time constraints, some providers felt it was better to prioritize asking about sexual behavior over sexual orientation as behavior was generally considered to be more relevant to clinical care. Some providers noted potential problems when capturing identity as well, including the risk that providers might make assumptions about behavior based on identity and the possibility that patients could feel pressured to report only those behaviors that are seemingly consistent with their stated identity. Providers, therefore, stressed that it is critically important that the collection of sexual orientation does not replace or stand in for the collection of sexual behavior.

Gender Identity and Anatomy

Regarding gender identity, providers emphasized the critical importance of respecting a patient's identity, most clearly demonstrated through the use of the patient's self-identified name and pronouns, and providing care that is sensitive to gender minorities. Similar to the discussion around sexual orientation, providers indicated that a patient's gender identity may be relevant to the provider's understanding of the patient's social context (e.g., support networks, housing or employment, and stressors related to their gender identity), but is not necessarily otherwise relevant to the medical aspects of clinical care.

For clinical care, providers expressed that they need to know about a patient's anatomy in order to guide the types of tests or interventions to be performed. A family medicine provider explained:

It's important for me to know not so much natal sex and current gender identity as much as what body parts they do have because it does determine what sort of screening and diagnostic testing I would offer them. And if their gender identity is discordant with either of those body parts or their natal sex, it does change how I might counsel them and services that I may offer to them as far as gender affirming care.

The same provider, along with others from specialty fields, further elaborated on the importance of knowing a patient's anatomy for assessing patient risk and diagnosis:

As far as our routine screening guidelines for things like Pap smears, mammograms, and also, screening for sexually transmitted infections, all of that depends on anatomy. So knowing does someone have a cervix, does someone have a uterus... how much breast tissue someone has, all of that influences our screening tests. And if they present with some problem like abdominal pain, it's important to know what organs they have in their abdomen.

Other providers noted that some health conditions may result from medical transition-related measures, such as taking gender-affirming hormones, or gender-affirming practices, like binding the breasts or tucking the penis. Therefore, from the providers' point of view, knowing a patient's experience of their gender identity and their experiences related to their transition or their efforts to affirm their gender identity, can inform clinical inquiry, diagnosis, and testing. For example, a urologist explained:

A lot of [transgender patients] are on hormone replacement therapy, and there are side effects. So for instance, if someone is taking a medication that's commonly used in part of hormone replacement therapy called spironolactone. It's a diuretic. It makes everyone

urinate. A lot of these people may have urologic urgency, frequency and so forth. So I think it's important to kind of know that in terms of their health record and what they're on. Because that's an easy fix.

An internal medicine provider gave another example:

So if I'm thinking about someone who's male transitioned to female and who's taking estrogen there's a different set of cardiac risks that come along with that [and] you want to make sure you're doing the right exams and screenings.

Another urology provider relayed an anecdote about a transgender patient who was having urinary tract problems related to a common practice among transgender women of "tucking" or folding back the penis as a means of concealing it:

The patient was coming in and kept having problems with urethral irritation and post-void dribbling and some other bothersome urinary symptoms... if they're really tucking back there and leaving it back there – their penis sort of tucked under for long periods of time – that, in some cases, it might actually cause a little bit of urethral irritation or even lead to urethritis or a [urinary tract infection]... So there's some unique things that come up now and then when patients are having urethral irritation and stuff like that, that we can help them out. But we have to know what our patients are doing with their genitalia to be able to help them out.

Whereas it may, then, be helpful for providers to know about a patient's status as a transgender person, there is also a recognition that individual transgender patients may not identify as "transgender," thus making it important to inquire about anatomy and transition-related behaviors, when this is relevant to clinical care. For example, a family medicine provider explained:

There's also lots of patients that we see who may have gone through the entire process of transitioning. So they were male at birth, for example. They went through the whole transition process. They are now entirely considered female. They've completed all of their; you know, things and they're on maintenance hormone therapy, but they consider themselves female. And so, if you say what's your gender, they don't say I'm a trans woman. They say I'm a woman. I'm female. And that's all there is to it. So trying to identify them as transgender is, you know, maybe from a medical standpoint valuable, but from the patient's viewpoint, it could be something that's off-putting because they don't see themselves as different from any other woman.

As demonstrated in this quote, providers noted the importance of distinguishing between gender identity and transgender status, asking about anatomy and transition-related behaviors when it is clinically relevant and respecting the patient's gender identity. Providers noted situations in which the relationship between a patient's gender identity to their sex assigned at birth may not be relevant to clinical care; for example, a family medicine provider noted:

[Knowing about trans/cis gender status] feels more voyeuristic than anything else. You know... if I was just seeing them in an acute care setting and they had a sore throat, I don't need to know. And, I'm just [asking] just for my curiosity, I don't need to know.

In summary, providers expressed the importance of using patients' self-identified names and pronouns (which may differ from those listed in legal or insurance documents) in order to be respectful in the clinical setting. However, providers reported that identification of patients' anatomy and their gender-affirming or transition-related behaviors or procedures that can affect their health (e.g., tucking, hormone use) are most relevant to clinical decision-making and noted that they are not relevant for all aspects of clinical care.

DISCUSSION

This study contributes to the conversation about collecting patient SO/GI information in the healthcare setting by presenting providers' perspectives about implications for clinical care. Providers acknowledged both the public health benefits of collecting SO/GI data in order to track population-level data and the potential clinical benefits of knowledge of a patient's identity and social context. However, providers in this study also highlighted that SO and GI do not necessarily reflect patient sexual behaviors and anatomy, which, in some cases, are important for clinical decision-making. With limited time in the clinical encounter, providers noted that they prioritized the inquiry into patient behaviors and experiences rather than orientation and identity. Some providers expressed concern that having information about a patient's SO/GI could potentially obscure clinically important information about the patient's behaviors and anatomy. If, for example, providers made erroneous assumptions—and failed to inquire—about behaviors and anatomy, or patients felt inhibitions about disclosure, based on reported SO/GI. The attention to behavior and anatomy, in addition to identity, is supported by existing best practices in LGBT care and guidelines on taking routine sexual health histories.^{16–18}

Sexual orientation is a multidimensional construct encompassing identity, behavior, and attraction, with the potential for these components to act independently of and possibly incongruently with each other.^{19–24} Prior research

has identified that providers may make heteronormative assumptions about their patients and/or fail to ask their patients about their sexual orientation.^{25, 26} Providers in this study indicated that it is important to withhold assumptions about behavior based on SO/GI labels, as they are not adequate stand-ins for behavior, and to not assume how a patient identifies based on their reported behaviors. Providers indicated that provider heteronormative bias can also prevent important follow-up questions about behavior that could be used to develop a more accurate risk profile.

Patients with sexual or gender minority identities or behaviors may face disclosure barriers due to internalized homophobia or transphobia, concern of stigma or discrimination, legal impacts, and lack of comfort with the provider.^{27–31} Reback and Larkins²³ found that heterosexually identified men who have sex with men engaged in distancing strategies because they saw their behaviors as incongruent with their identity, which brought up feelings of shame and disgust for many of them. Lack of disclosure to healthcare providers has been found to decrease recommendations for appropriate health services, including HIV testing services.^{32, 33} More research is needed to understand the extent of the medical implications of non-disclosure of sexual behavior and the provider's role as facilitator in this disclosure.

Patient and provider discussions around, and comfort with, gender identity and anatomy are important for the patient-provider relationship and for provider adherence to clinical screening guidelines. Research has shown, for example, that female-to-male transgender individuals are more likely to receive inadequate Pap tests and less likely to return for a follow-up test, compared with their cisgender peers. This is likely due to a combination of the effects of testosterone treatment and provider and/or patient discomfort during the exam.³⁴ The World Professional Association for Transgender Health (WPATH) has issued recommendations for developers and users of electronic health record (EHR) systems, including the inclusion of preferred or chosen name, pronouns accurately reflecting patients' identities, sex-assigned-at-birth, and current anatomical inventory in order to improve patient satisfaction and quality of care along with informing research and policy.^{35, 36} However, there has been minimal research on providers' perspectives on what documentation is relevant for clinical care. Dunne and colleagues¹¹ conducted semi-structured interviews with transgender and gender nonconforming patients and healthcare providers and found that providers wanted to know if their patients' sex-assigned-at-birth was incongruent with current gender identity in order to guide their care provision, especially in terms of preventive screenings. However, as the providers in the current study expressed, the gender identity and anatomy relationship is not always clinically necessary information.

Limitations and Methodological Considerations

This qualitative study was conducted with providers within a single healthcare institution in an east coast city with considerable legal protections for sexual and gender minority individuals. However, within this single site setting, the study included providers from several different clinical care training backgrounds and medical specialties, differing experience with treating LGBTQ populations, and a wide spread of years of medical experience. The study included providers in primary care (internal medicine and family medicine), gynecology, and urology; thus, we do not know how patient SO/GI may be used in other clinical contexts. As a qualitative study, the data are deep in richness but lack the breadth of a larger and more expansive study. Further research is needed to understand the perspectives of providers in other settings, including those that are non-urban and non-academic.

Implications

As healthcare systems move toward including the collection and documentation of SO/GI patient data in their electronic medical records, an important step for collecting population health data and combating health disparities, it is imperative that this process not replace the gathering of other information (i.e., sexual behavior, anatomy, and gender-affirming practices) critical for clinical care decision-making. In consideration of findings of potential assumptions about patient behavior and anatomy based on orientation and identity, it is vital that the healthcare field commits to education and training around the nuances of sexual orientation, sexual behavior, and gender identity. In particular, as has been found in prior studies,^{37, 38} providers may lack comfort and competence around understanding and responding to the needs of transgender or gender non-binary or non-conforming patients. Provider perspectives revealed in this study also suggest that it may be helpful for providers to understand for themselves and to explain to patients when and for what reasons it is helpful to know about a patient's identity, behaviors, and anatomy. The collection of patient SO/GI information may help to both inform our understanding of population-level health and to combat stigma, discrimination, and related health disparities faced by sexual and gender minority patients. The ways in which this information is collected and used in the clinical care setting, however, must be sensitive to the nuances of and diversity in patient identities and experiences and to avoiding further stigma and potentially erroneous assumptions.

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Compliance with Ethical Standards:

The study was approved by the University of Pennsylvania Institutional Review Board and oral informed consent was collected prior to the start of the interview. Participants did not receive any compensation for participation.

Conflict of Interest: The authors declare that they have no conflicts of interest.

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