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Best Practices for LGBTQIA + Patient Care in Otolaryngology

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Abstract

Purpose of Review This chapter introduces LGBTQIA + concepts, communities, and terminology in an effort to improve health care provider education, patient communication, and patient care.

Recent Findings This chapter provides an overview of best practices to incorporate when treating LGBTQIA + patients in health care and more specifically in otolaryngology—head and neck surgery. We discuss issues unique to this population that may influence patient care.

Summary This review aims to provide an overview of best practices to use in the care of sex and gender-minority patients while also illuminating some of the unique joys and challenges of serving this diverse population. Best practices should be shared with all clinic and operating room staff to ensure that LGBTQIA + patients feel safe and welcomed at every step of their visits.

Keywords LGBTQIA + · SGM · Lesbian · Gay · Bisexual · Transgender · Nonbinary · Queer · Intersex · Asexual · Patient care · Otolaryngology · Inclusivity · Representation

Introduction: Overview of LGBTQIA + Patient Care

Sexual and gender minorities (SGM) comprise a substantial and growing proportion of the US population (*see Glossary*). Currently, 7.2% of all US adults identify as LGBTQIA + , with even higher rates among Millennials (11.2%) and Generation Z (19.7%) [1]. These numbers have increased on every survey with additional growth noted across a variety of racial and ethnic groups [2]. In light of the strides in LGBTQIA + visibility and public acceptance since the twentieth century, it is debatable whether these generational differences accurately depict a rising prevalence or simply a greater willingness to come out. Regardless, it is clear that the LGBTQIA + population is diverse and growing.

Despite the past few decades of social progress, the LGBTQIA + community continues to face numerous health disparities. Lack of familial and peer acceptance as well as historical segregation to socializing in bars has led to significantly higher rates of mental illness, substance abuse, and tobacco dependence among SGM patients [3–5]. Meanwhile, they are less likely to undergo preventive health screening, including routine cancer surveillance [3–5]. Some LGBTQIA + patients avoid seeking medical care altogether out of fear of judgment, discriminatory treatment, and/or violence. Considering the characterization of "homosexuality" as a

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mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1974, as well as the ongoing pathologization of "gender dysphoria," this mistrust must be understood in the context of long-standing medical marginalization. Like all physicians, otolaryngologists will undoubtedly encounter LGBTQIA + patients within our practice. Given the importance of voice characteristics and facial features to gender perception, our community is also uniquely situated to fill gaps in gender-affirming care. It is our duty to not only provide the best possible medical and surgical care to LGBTQIA + patients, but to create environments in which they feel valued, respected, and "seen."

SGM-related curricula have been increasingly incorporated into undergraduate and graduate medical education. Despite this, 1 out of 5 otolaryngology residency programs offers no didactic exposure or clinical training to develop LGBTQIA + competency [6]. A recent survey demonstrated that while most otolaryngology faculty and residents hold highly positive attitudes toward LGBTQIA + patients, few have adequate basic knowledge and clinical preparedness to treat SGM patients [7•]. This discrepancy is particularly apparent among attending physicians. Although expanding gender and sexual diversity (GSD) in otolaryngology would lead to more thorough physician education on LGBTQIA + patient care, we currently do not know how diverse otolaryngology is because we do not collect sexual orientation and gender identity (SOGI) data on the otolaryngology workforce [8]. Increasing GSD and representation in otolaryngology would foster discussions that expose people to different thoughts and opinions, which improves humility, open-mindedness, and inclusivity. Moreover, SGM patients who see LGBTQIA + physicians undergo more preventive care and have better outcomes than SGM patients who see cisgender, heterosexual physicians [9••]. Otolaryngology would benefit from promoting GSD within the field to enhance cultural humility and patient outcomes for SGM patients.

To address the needs of SGM patients, otolaryngology training must adapt to provide not only foundational knowledge about the LGBTQIA + community but also pragmatic skills to improve communication with individual patients. More importantly, this process must be embraced as a professional responsibility: one that is lifelong, ever-evolving, and marked by inevitable mistakes. Humility will transform the latter into powerful lessons.

The goal of this review is to provide an overview of best practices to incorporate when treating LGBTQIA + patients. Additionally, we discuss issues unique to this population that may influence their care.

Sexual Orientation and Gender Identity

Sexual orientation represents the complex summation of multiple components, including sexual and/or romantic attraction, sexual behavior, and sexual identity (Fig. 1). These are often congruent (for example, a woman who is solely attracted to women, only dates women, only has sex with women, and identifies as a lesbian). Sometimes, however, they are incongruent (for instance, a man who is primarily sexually attracted to women, only dates women,

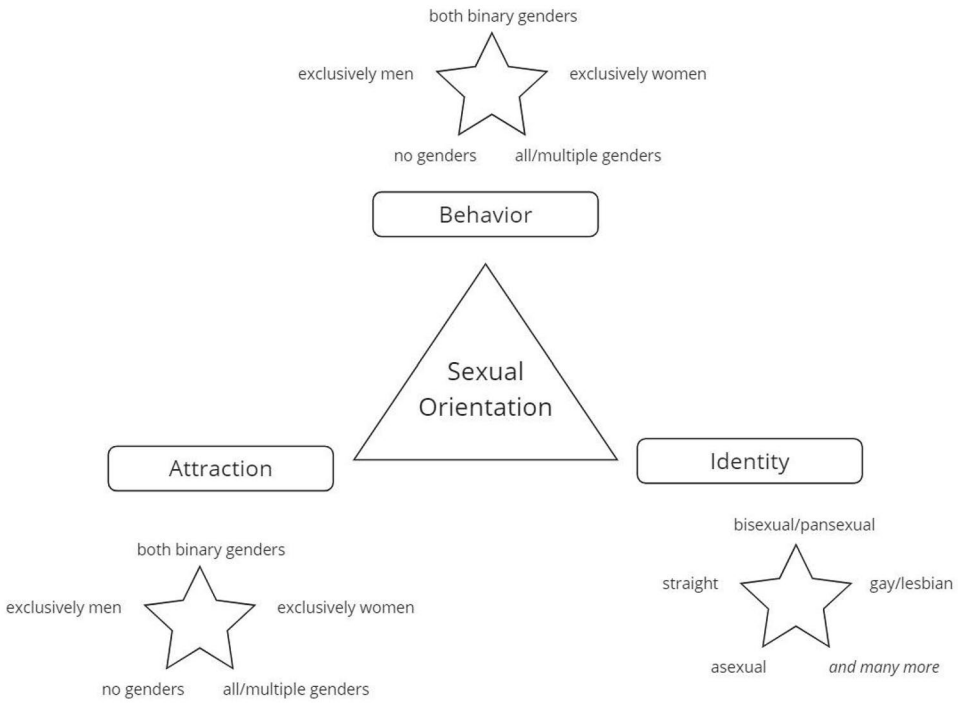

Fig. 1 Components of sexual orientation

usually has sex with women but occasionally has sex with men, and identifies as straight). When a thorough sexual history is necessary, inquiring about individual behaviors with an open, nonjudgmental attitude may reveal important information that would otherwise be missed. For most other purposes, a good rule is to accept and reflect the patient's stated identity. A patient who identifies as bisexual is bisexual, even if she has only ever had male partners. A patient who identifies as asexual is asexual, even if they are currently sexually active.

Gender identity represents the deeply held, internal sense of one's own gender (e.g., "I am a woman," "I am a man," "I am neither a man nor a woman," etc.) This is usually stable and established early in life but can change over time. The patient is the *only* person who can determine and define their gender identity. This differs from sex assigned at birth, which refers to biological factors that are influenced by chromosomes, sex hormones, internal/external genitalia, and more. Both gender identity and sex assigned at birth have long been defined within a gender binary (man versus woman), but many people identify with genders outside this rigid binary. Gender identity and sex assigned at birth do not always align, which is when someone may identify as transgender or gender non-conforming community.

Gender expression or gender presentation describes the external representation of gender, including choices of clothing, hairstyle, makeup, and grooming. This is more flexible than gender identity and may change even during the course of a day (consider gender presentation while running to the supermarket versus attending a cocktail party). Gender expression may be congruent with gender identity (for example, a non-binary person who prefers androgynous clothing) or incongruent (for instance, a woman who proudly wears her facial hair). However, gender expression does NOT supersede gender identity. Finally, and importantly, gender identity, gender expression, and sexual orientation are not synonymous. A cisgender woman who dates a transgender woman is in a same-sex relationship. A patient who identifies as non-binary and continues to wear the clothing stereotypically associated with their assigned sex is still non-binary. A straight man who enjoys wearing make-up and painting his nails is still a straight man.

Creating an Inclusive Clinic

Creating a positive clinical experience begins long before a patient enters the exam room. LGBTQIA + patients often seek out indicators of inclusivity in their environments and may modify their behaviors based upon whether they perceive a space to be friendly. The lobby should feature visual cues, such as recognizable LGBTQIA + symbols, magazines focused on LGBTQIA + issues, and educational pamphlets or posters depicting same-sex couples or families. Intake forms should include a wide range of gender identities and specifically request preferred/chosen name/pronouns. Any single-stall bathrooms should be designated as all-gender/gender-neutral. Ideally, gender-neutral bathrooms should be featured in the main waiting area. If not, signs indicating the availability and/or location of a private restroom should be clearly posted. Care should be taken when calling patients from the waiting room to the clinic space to use the patient's preferred name and to avoid gendered language (for example, "Jack Smith?" or "last name Smith?" versus "Mr. Jonathan Smith?"). If there is a discrepancy requiring verification of a patient's legal name, this conversation should be broached privately and respectfully. The initial interaction between front desk staff and patients is critical, as it sets the tone for the remainder of the encounter. Alliance signaling through visual cues and inclusive language can positively impact patients' well-being if coupled with affirming care but is not, in itself, enough. On the contrary, alliance signaling can irreparably erode a patient's trust if their treatment is otherwise invalidating, offensive, or discriminatory [10, 11•].

In the exam room, patients should similarly be greeted by their preferred name. Offering one's own pronouns, either verbally or via badge accessory, can help put LGBTQIA + patients at ease and may encourage them to share more information during the medical interview. In a systematic review of 31 studies, queer (i.e., not heterosexual or cisgender) patients were significantly more likely to disclose their sexual orientation if the physician used inclusive language [12]. While heterosexism and cissexism posit that male–female relationships and non-transgender people are "normal" and that everyone else is an anomaly, our questions should aim to be unassuming and nonjudgmental. Using gender-neutral language or open-ended questions helps avoid unintentional harm while still building rapport with the patient. Best practices dictate that we follow up yes-or-no questions with open-ended ones and that we welcome "surprises" in the answers—that is, challenges to our implicit biases. "I see you're wearing a ring. Are you married? …Tell me about your partner." Questions which may seem innocuous, such as asking, "What does your wife do?" to a man wearing a wedding ring, are in fact rooted in deeply ingrained and painful systems of oppression. That phrasing conveys an underlying assumption (the patient is straight) and may imply that other sexual orientations are less valid. Although the question may be well-intentioned, the impact could harm the patient-physician relationship.

Inclusivity should also be extended to pediatric patients and their caregivers. Data estimate that roughly 200,000 children in the USA are being raised by same-sex couples, and an additional 1.8–3.5 million have one parent who is LGBTQIA + [13]. Bias against same-sex families, whether explicit or unconscious, is widespread and anchored in

historic misinformation. Numerous studies have demonstrated no significant differences in the sexual orientation, gender identity, gender role conformity, and emotional and executive functioning of children raised by gay/lesbian couples versus straight ones [13–16]. While same-sex couples are 4–6 times more likely to adopt [13], many options for family planning are utilized. It is never appropriate to ask questions about family planning for the purpose of curiosity. If relevant genetic information is required, questions should be phrased thoughtfully to avoid assumption and invalidation ("It's important for me to know about Mason's genetic history. Could I ask you two about his birth?"). On the contrary, asking a question such as "Who's the mom/dad?" is harmful in multiple ways. First, it wrongfully assumes that the child must have been conceived and birthed by one parent. In fact, both parents may have contributed genetically (in the case of reciprocal in-vitro fertilization or in a same-sex couple with one transgender partner) or neither, if the child is adopted. More importantly, regardless of intention, the underlying message is that the parent who did not give birth cannot be considered a "real" mother. It is common for each parent figure in a same-sex couple to have a particular name by which their child refers to them (for instance, "Dad" and "Papa"). Non-binary parents may use nicknames that depart from the traditional "Mom"/ "Dad" dichotomy. A general rule is to mirror the family's language and, when unsure, ask, "When speaking to your child, how should I address you?".

Finally, the electronic medical record (EMR) should be optimized to collect data on sexual orientation, gender identity, and organ inventory. These data enable appropriate care coordination and help to communicate correct names and pronouns, preventing misgendering or deadnaming in future encounters. SOGI data collection will also support future research about LGBTQIA + health disparities [17–19].

Trans, Non-binary, and Other Gender Minority Patients

The gender binary describes the classification of an individual's gender into one of two distinctly opposite, immutable, and biologically predetermined forms: feminine woman or masculine man. In reality, gender identity and expression are as varied as the individuals that embody them. Each one of us holds claim to a unique gender of our own. Beyond individual life experiences, gender is highly context-dependent, with rapidly shifting ideals across cultures and throughout time. It's important to note that the gender binary as we know it today is a largely colonial invention, as many indigenous and first nations communities acknowledged the existence of "third gender" or "two-spirit" people long before non-binary entered the lexicon. This is reflected in surveys showing that TGNB individuals are more likely to be non-White than cisgender individuals [20]. As society advances toward a greater appreciation for cultural diversity, simultaneous acknowledgement of GSD is necessary. Celebrating all forms of human diversity can only serve to unite us and enable us to provide better health care for our patients.

The transgender umbrella encompasses a wide range of gender identities and expressions with an overarching commonality: these individuals do not absolutely identify with the gender (and/or associated gendered expectations) they were assigned at birth. Initially, the medical community only validated trans people who reflected the narrative of a stable gender binary and stayed within its bounds ("I am a woman born into 'the wrong body'"). The early decades of transgender medicine were also marked by compulsory heterosexuality in order to receive appropriate medical and surgical care ("I am a straight woman born into 'the wrong body;' after 'reassignment,' I want to seek a husband"). Transgender patients have experienced communal trauma at the hands of the medical establishment, a phenomenon which unfortunately persists today. According to the most recent US Transgender Survey (USTS), 1 of every 3 respondents had "at least one negative [medical] experience related to being transgender, such as being verbally harassed or refused care" within the past year [10]. About 1 in 4 trans/non-binary patients admitted to not seeing a physician when they needed to due to "fear of being mistreated as a trans person" [10]. Non-binary people, in particular, face the unique challenge of many physicians' inability or refusal to see beyond the male/female dichotomy. These patients report even higher rates of mistreatment—including explicit identity invalidation, misgendering, and deadnaming—than their binary trans counterparts [11•].

TGNB people may seek gender-specific health care in the form of hormone therapy, counseling, and/or surgery (see gender affirmation, gender-affirming care, gender affirmation surgery, and [gender] transition) [21]. Although transgender patients may seek gender-specific care from an otolaryngologist, they may also present with any number of otolaryngologic complaints unrelated to gender identity. Regardless of chief complaint, we should provide the minimum standard of gender-affirming care by consistently using the patient's correct name and pronouns throughout interpersonal communication and documentation. Unless a patient is specifically seeking gender-affirming voice therapy, procedural interventions, or surgery, there is usually not a need to request details about transition. We should conscientiously avoid asking questions, even if well-intentioned, that may make patients feel like a medical curiosity or spectacle. For the vast majority of otolaryngologic complaints, simply treat TGNC patients with the same degree of care and respect as with any patient. Patient-reported information that varies from that on record (e.g., a name or gender marker) should be

promptly noted within the EMR unless otherwise requested. Intake forms can reduce both patient anxiety about being misgendered as well as physicians' fears of making mistakes. If and when a mistake is made, however, the best possible solution is to quickly acknowledge, apologize, and correct it—then move on. ("Mister—oh, sorry, I mean Miss Jones—what did you want to speak about today?") Dwelling on or overly apologizing for an error can have the opposite of intended effect for trans patients—it places patients in the awkward position of feeling obliged to comfort or reassure the physician. Similarly, patients should never be tasked with educating their doctor about gender-related care. If a patient offers information about their identity or transition, it is reasonable to ask clarifying questions that may facilitate better care. ("I see on your form that you're non-binary and hoping to discuss facial feminization. Since non-binary can mean many different things to patients, could you tell me more about what it means to you? Then we can talk about some goals of surgery.") It is *never* appropriate to request that patients explain the details of specific medical treatments or surgical procedures ("Oh, interesting, I've never heard of a metoidioplasty! What's that?"). Instead, when confronted with a question or topic we are unfamiliar with, it's appropriate to indicate as much. We should follow up with an enthusiastic promise to learn more and then reconvene—and keep that promise. ("I'll admit I don't know much about feminizing voice therapy or which speech language pathologists might be best for this referral. Let me do some research and then call you in a few days with what I find.") Too often when seeking gender-related care, trans patients have heard some iteration of "I'm uncomfortable with that" or "that's not my area of expertise." While these may be true statements, they are correctable with a little time and effort. What patients interpret, instead, is "I'm uncomfortable with you; I can't (or won't) help you."

Otolaryngologists interested in providing gender-related surgical care—particularly laryngologists and facial plastics subspecialists—will find a largely untapped patient pool. As indicated in the latest USTS, while 6% of trans women and AMAB non-binary people have undergone facial feminization procedures, 36% desire them. Less than 5% of these patients have undergone feminizing phonosurgery and thyroid chondroplasty, though these procedures are desired by 16% and 29%, respectively [10]. At this time, Medicaid in 27 states, Puerto Rico, and the District of Columbia covers transition-related medical and surgical treatment [22]. Twenty-two states, mostly concentrated along the continental coasts and Northern USA, explicitly ban private insurance exclusions [22]. There is a massive pre-existing gap between patient demand and the supply of surgical specialists who offer gender-affirming care. This is projected to continue widening as coverage becomes more inclusive and as Generation Z emerges into later adulthood.

Treating LGBTQIA + Youth

LGBTQIA + youth and their families face many challenges unique to childhood and adolescence. Although some of these issues may not seem relevant to otolaryngology at first glance, we include an overview here as they may affect the ability of patients to seek care. Moreover, many of the topics covered in this section may exacerbate other medical problems, including otolaryngologic conditions, that LGBTQIA + youth face. This discussion aims to equip the practicing otolaryngologist with the information needed to optimize care for queer youth.

As SGM youth develop, they are likely to experience (or at the very least, witness) stigma and discrimination against the LGBTQIA + community. These issues often start in school [23]. Queer children and adolescents report facing physical and emotional bullying at school more frequently than their cisgender, heterosexual peers, which caused one-third of SGM students to skip school because they felt unsafe [23–25]. This discrimination, however, was not exclusively from their peers—the majority of queer students reported that their schools had LGBTQIA-related discriminatory policies, a statistic that will only worsen as states pass "Don't Say Gay" laws that prohibit discussion of LGBTQIA + issues in the classroom [23, 26]. These issues are not limited to school, though. Only 1 in 3 SGM youth endorsed having an affirming household, and 30% reported facing food insecurity [24]. In particular, half of LGBTQIA + Native children and adolescents experienced food insecurity, a stark example of how the inequities facing SGM patients are substantially worse for those who are also racial minorities. Particularly for SGM youth whose families kick them out upon discovering their identities, many LGBTQIA + children and adolescents are more likely to experience housing insecurity, which can also affect their ability to access medical care.

This LGBTQIA + discrimination directly harms the mental health of queer youth. Many LGBTQIA + children and adolescents internalize this homophobia and transphobia, which can lead not only to emotional distress but also to anxiety, depression, and substance use disorders as they attempt to cope [4, 27–30]. Indeed, gender minority youth who face discrimination based on their gender identity had more than twice the odds of attempting suicide than those who did not experience this stigma [31]. Moreover, anti-LGBTQIA + policies and proposals, including those that target access to gender-affirming care and transgender people in sports, exacerbate stress and anxiety in all LGBTQIA + children and adolescents, which can in turn worsen their mental health [24]. Conversely, queer youth in areas with school policies that protect LGBTQIA + students from discrimination were less likely to report suicidal thoughts

in the past year compared to sexual and gender minority youth in cities and states with less protective climates [32].

Many of the best practices discussed previously also apply to optimizing care for LGBTQIA + children and adolescents. Although a patient's sexual and/or gender identity might not be directly relevant to their chief complaint, a queer patient might choose to confide in their physicians about their identity or difficulties faced at school or home. Responding with empathy and connecting them with resources can build that patient's trust not only in their care but also in the medical system. Unfortunately, our health care system has a history of harm perpetuated against the LGBTQIA + community through pathologizing LGBTQIA + identities in the DSM, discriminating against LGBTQIA + patients during medical visits, and more [33–35]. However, counteracting this trauma through affirming care and empathy can help rebuild trust in our health care system and makes the patient less likely to avoid or postpone seeking care [35, 36].

Treating LGBTQIA + Older Adults

As LGBTQIA + adults age, they face barriers to accessing care when compared to their cisgender, heterosexual counterparts. LGBTQIA + adults have higher rates of disability yet are less likely to utilize care resources due to fear of discrimination/mistreatment and lack of available culturally competent care [37–39]. In 1965, the Older Americans Act (OAA) became law and began providing funding and services that allowed older adults from vulnerable communities to age in their homes rather than long-term care facilities [40, 41]. Although people from racial and ethnic minority groups as well as those with disabilities were included, SGM adults were not. However, LGBTQIA + adults are more likely to face discrimination in the workplace, which leads to lower earnings and Social Security payments; thus, SGM older adults are less likely to be able to afford to pay for the assistance necessary to be able to age within their communities [42]. This forces LGBTQIA + adults to enter long-term care facilities for necessary support.

Unfortunately, once LGBTQIA + adults enter nursing homes and long-term care facilities, the power dynamic present between themselves and their caregivers can create unsafe environments for SGM adults. Many LGBTQIA + older adults report feeling the need to go back in the closet after entering these facilities because they did not feel safe to continue expressing their identities openly [43]. Indeed, some LGBTQIA + adults faced discrimination within nursing homes including separation from their partners [39]. Other SGM adults are ostracized from their families if they come out later in life, which leads to greater social isolation in a population already at risk. Moreover, moving into long-term care facilities necessitates leaving communities behind, which contributes to the significant social isolation that many SGM older adults report [42, 43]. These issues collectively contribute to complex support systems and discharge planning as LGBTQIA + adults try to find the safest way to receive support and care after leaving the hospital.

Conclusion

Regardless of one's area of expertise within otolaryngology—head and neck surgery, otolaryngologists will care for patients within the LGBTQIA + community. This review aims to provide an overview of best practices to use in the care of SGM patients while also illuminating some of the unique joys and challenges of serving this diverse population. Best practices should be shared with all clinic and operating room staff to ensure that LGBTQIA + patients feel safe and welcome at every step of their visits.

Glossary

AFAB/AMAB: *(noun)* stands for assigned female at birth (AFAB) and assigned male at birth (AMAB). Used among some members of the trans and intersex community to communicate their sex assigned at birth. Preferred over outdated alternatives such as female-to-male (FTM) or male-to-female (MTF).

Alliance signaling: *(verb)* the act of using visual cues and inclusive language to express support for the LGBTQIA + community.

Ally: *(noun)* a supporter of the LGBTQIA + community and their rights, one who allies themself with the cause. Someone who addresses heterosexism, cissexism, and monosexism when it occurs.

Androgynous: *(adjective)* someone whose gender presentation includes both masculine and feminine qualities.

Androgyne: *(noun)* someone with a gender that is both masculine and feminine.

Aromantic: *(adjective)* a romantic orientation characterized by low or absent romantic attraction. Often shortened to "aro."

Asexual: *(adjective)* a sexual orientation characterized by low or absent sexual attraction. Often shortened to "ace." Both aromantic and asexual orientations are on a spectrum with varying degrees of desire. Both aro and ace people may (and often do) have physical or emotional attractions to others.

Biphobia: *(noun)* oppression, fear, and discrimination towards the bisexual community. Can be perpetuated by both straight and gay people. *See related: monosexism.*

Bisexual: *(adjective, noun)* being attracted to more than one gender, often towards same and other genders. Often shortened to "bi." Represented by the B in LGBTQIA + .

Note: people may talk about the "bi umbrella," which is a group of sexual orientations that represent attraction to more than one gender and include pansexual, omnisexual, polysexual, and more.

Chosen family: *(noun)* a group of people that represents a core support system for someone, not necessarily from one's direct family lineage.

Cisgender/cis: *(adjective)* a gender identity that is largely or completely aligned with a person's sex assigned at birth (e.g., a woman who was assigned female at birth).

Cissexism: *(noun)* also known as genderism. The belief that gender is binary and limited only to men and women, and one's gender is inextricably tied to sex assigned at birth. This belief underlies transphobia and associated discrimination against the trans community.

In the closet/ "closeted": *(idiom, adjective)* a term/phrase used to describe those who do not share their sexual orientation or gender identity publicly. Note that some people are out in certain settings but closeted in others. For instance, someone could be out to their friends and family yet closeted at work. *Antonym: coming out/ "out."*

Coming out/ "out": *(idiom/adjective)* the act of revealing one's sexual orientation or gender identity to others or the world. This can happen in many ways and often happens many times. Many resources are available for those navigating coming out for the first time. *Antonym: in the closet/ "closeted."*

Deadname: *(noun, verb)* the former name of a trans, nonbinary, or gender nonconforming person; the name was used before they chose a name that better aligns with their gender identity. The act of using one's old name rather than their birth name, often done in an attempt to invalidate or demean a trans person's authentic gender. If you'd like to refer to a memory of a trans person that preceded their social transition, please use their current, chosen name rather than their deadname. You may mention that the event occurred prior to their transition if relevant to the story.

Demisexual: *(adjective, noun)* when one only experiences sexual attraction after developing a strong emotional connection with someone. Falls on the asexual spectrum.

Drag: *(noun)* a type of entertainment/performance art which involves the portrayal of exaggerated, stereotypical femininity (e.g., by drag queens) or masculinity (e.g., by drag kings). Although drag has its roots in the LGBTQIA + community, one's participation in drag is not necessarily reflective of their gender identity or sexual orientation. Drag queens and kings may or may not identify within the larger trans umbrella.

Female-to-male/FTM: *(noun, obsolete)* an outdated term for a transgender man.

Gay: *(adjective, noun)* often used to describe men who are attracted to other men, but this term can be used to describe anyone who is not strictly heterosexual.

Gender: *(noun)* a social construct that classifies people into various identities, such as man, woman, nonbinary, and more. These can include socially constructed behaviors, roles, and norms. Gender is separate and distinct from the sex one is assigned at birth.

Gender and sexual diversity (GSD): *(noun)* a term that encompasses the broad range of diversity of sexual and gender identities within the LGBTQIA + community. Presence of many different sexual and gender identities within a group.

Gender affirmation: *(noun)* social process of being recognized or affirmed in one's gender identity, expression, and/or role. Critical part of the health and well-being of gender-diverse people. Multidimensional with at least 4 core constructs:

1. Social affirmation: acknowledgment of name and pronoun
2. Psychological affirmation: internal sense of self-actualization; felt gender is respected and validated, resist internalized stigma and transphobia
3. Medical affirmation: puberty blockers, hormones, surgery, other body modification
4. Legal affirmation: name and gender marker change

Gender-affirming care: *(noun)* health care that holistically attends to the physical, mental, and social health needs and well-being of gender-diverse people while respectfully affirming their gender identity. ANY care that is sensitive, responsive, and affirming to a person's gender identity and/or expression (e.g., simply using the correct name and pronouns during your patient interaction). Can also be used to refer to gender-specific care used during transition (see below).

Gender affirmation surgery: *(noun)* a term that encompasses many possible procedures one can receive to affirm their gender, to make their appearance align better with their gender identity. People who pursue gender affirmation surgery will often have differing desires—not everyone who wants gender affirmation surgery will want every surgery available to affirm their gender. Gender-affirming care should thus be approached as a menu of possible procedures with each patient deciding which procedures are best for them.

Gender dysphoria: *(noun)* the negative feelings that arise when someone does not feel that their gender identity aligns with their sex assigned at birth, is often alleviated through transitioning in ways that are affirming to that person's gender. The elements and extent of transitioning necessary to mitigate gender dysphoria will be different for everyone. *See related: transition.*

Gender expansive: *(adjective)* an umbrella term that includes those who challenge/broaden society's traditional views on gender expression and other gender norms.

Gender expression: *(noun)* the way someone expresses their gender through their outward characteristics, such as appearance and behaviors.

Gender identity: *(noun)* the way someone understands their internal gender and who they are, which may or may not align with their sex assigned at birth and may or may not align with one's gender expression.

Gender minority: *(noun)* those who identify with genders outside of the societal norms of the time, often used to refer to those who are transgender, nonbinary, genderqueer, genderfluid, and otherwise outside the cisgender man/woman binary.

Gender presentation: *(noun)* see gender expression.

Gender-neutral bathrooms/all-gender bathrooms: *(noun)* bathrooms which are not designated for use by men or women only, are open to people of all genders.

Gender-non-conforming (GNC): *(adjective)* describing someone whose gender and/or gender expression is outside the gender binary. Can be written a number of ways including gender nonconforming, gender non-conforming, and more.

Genderfluid: *(adjective)* describing someone whose gender and/or gender expression shifts over time, someone who is not restricted to one gender/gender expression.

Genderqueer: *(adjective)* describing someone whose gender/gender expression is outside the gender binary. Someone who is genderqueer may relate to more than one gender and/or express more than one gender (or no gender at all).

Go back in the closet: *(idiom)* a phrase used to describe those who were once open about their sexual orientation and/or gender identity, but now choose to conceal it. Note that some people are out in certain settings but closeted in others. For instance, someone could be out to their friends and family yet closeted at work.

Hermaphrodite: *(noun, obsolete)* an outdated and offensive term that was used to refer to intersex people.

Heteronormativity: *(noun)* the belief and expectation that people will ascribe to a specific set of gender roles within the gender binary, including a man marrying a woman and vice versa and gender identities that align with sex assigned at birth.

Heterosexism: *(noun)* the belief that sexual attraction should be limited only between men and women, that everyone should be heterosexual. A form of privilege of heterosexual people over sexual minority people, such as lesbian, gay, bisexual, and queer people. This belief underlies homophobia and associated discrimination against the sexual minority community.

Heterosexual: *(adjective, noun)* being attracted to a gender other than one's own gender.

Homophobia: *(noun)* aversion to queer people, often used to justify hatred and discrimination against the LGBTQIA + community. *See related: heterosexism.*

Homosexual: *(adjective, noun, obsolete)* being attracted to someone of the same gender. Inherently suggests binary gender. Previously used to pathologize queer people particularly among the medical community and is now outdated. Consider using the specific identity (e.g. gay, lesbian) or a broader umbrella term (e.g. LGBTQIA +) to replace this term depending on what you are trying to convey.

Intersectionality: *(noun)* the way in which multiple marginalized identities intersect to form different experiences of oppression that are not simply the additive effects of two separate types of discrimination. Introduced by Kimberlé Crenshaw. *Example: to understand the experience of a Black trans woman, it is not enough to study only the Black experience or only the experiences of a trans woman; rather, you have to understand the experiences of Black trans women and how these are distinct from their peers.*

Intersex: *(adjective)* a sex that is neither strictly male or female, one that calls outside the biological gender binary. This can include a number of characteristics such as variations in internal and/or external sex characteristics, different chromosome combinations, and/or hormone levels that differ from what would be expected for a given sex assigned at birth. Many intersex infants underwent medical procedures to make their characteristics more stereotypically male or female, which can lead some intersex people to have discomfort or distrust with the medical establishment.

Lesbian: *(adjective, noun)* a woman or non-binary person who is sexually, romantically, and/or emotionally attracted to other women.

LGBTQIA + : *(adjective, noun)* an acronym used to encompass the breadth of the queer community, including all sexual and gender minorities. Stands for lesbian, gay, bisexual, transgender, queer (or questioning), intersex, asexual/aromantic/agender. The + indicates the expansion of the acronym to include the myriad other identities that fall under this community.

Marginalization: *(noun)* the systematic treatment of a minority individual or community as inferior, unimportant, and unempowered.

Misgender: *(verb)* to use terms/language to refer to someone that does not align with their identity. Can include using the wrong pronouns.

Monogamy: *(noun)* the practice of being in one intimate relationship at a time.

Monosexism: *(noun)* the belief that sexual/romantic attraction to one gender (monosexuality) is superior to sexual/romantic attraction to more than one gender. This concept underlies discrimination against the bi + community and can come not only from heterosexual people but also from gay and lesbian people. This leads to numerous health inequities for bi people that are often more severe than those for their gay and lesbian peers. *See related: biphobia.*

MLM: *(noun)* short for men-loving-man. Describes men who are attracted to other men. Does not necessarily imply behavior associated with this attraction.

MSM: *(noun)* short for men who have sex with men. This abbreviation is often used in medical literature to describe sexual behavior rather than sexual orientation. This includes men who have sex with men who do not necessarily consider themselves to be part of the queer community. *Note: although MSM has a role in describing behavior in research, some are encouraging moving away from this term as it can overemphasize focus on behavior while missing the societal and socioeconomic inequities that contribute to health disparities for gay and bisexual men.*

MTF/male-to-female: *(noun, obsolete)* an outdated term for a transgender woman.

Non-binary/nonbinary: *(adjective)* a person who does not identify as belonging within the binary of strictly man/strictly woman, regardless of their sex assigned at birth. Typically, but not always, identifies within the transgender umbrella.

Pansexual: *(adjective)* being attracted to all genders, considered part of the bi + umbrella.

Polyamory: *(noun)* the practice of being in multiple intimate relationships at once. Also sometimes shortened to "polyam" or "poly."

Preferred/chosen name/pronouns: *(noun)* the name and/or pronouns that someone chooses to use over the name and/or pronouns given at birth. Although people may refer to these as "preferred" or "chosen" names/pronouns, these should be respected the same way one should respect anyone's name and pronouns in use. *Synonym: name-in-use.*

Pronouns: *(noun)* a word that can take the place of a noun once it is referenced. Includes I, you, he, she, it, we, and they among many others. People will often ask that others use the pronouns that align with their gender identity, such as "she/her/hers" to refer to a woman. For those who use gender-neutral pronouns, they may choose to use among several options including they, ze, hir, and more.

Queer: *(adjective)* like gay, this term can be used as an umbrella term to describe anyone who is not strictly heterosexual. Queer can also be used to describe a sexual orientation on its own. The Q in the LGBTQIA + acronym. *Note: this term used to be a slur for LGBTQIA + people, but it has been reappropriated by the community. However, some who have trauma associated with this word do not use it the way others in the community do.*

Questioning: *(adjective)* those who are exploring their sexual orientation or gender identity.

Romantic orientation: *(noun)* a term describing one's romantic attraction to others, one's identity in regards to romantic attraction.

Same-gender-loving: *(adjective)* an umbrella term that refers to those who are attracted to and/or date people of the same gender. Historically used among Black gay and lesbian communities.

Sapphic: *(adjective)* an umbrella term that refers to women-loving-women, such as lesbian and bisexual women and nonbinary folks. This term came from the Greek poet Sappho, who wrote about her attraction to other women.

"Seen": *(idiom)* a term that indicates acceptance, someone feeling accepted. *Used in a sentence: That doctor used my name and pronouns throughout the entire visit. She made me feel so seen.*

Sex: *(noun)* a way to sort people based on biological attributes such as external genitalia, chromosomes, reproductive organs, and other characteristics. *Note: biological sex has classically been determined within a strict male/female binary, but many do not fall strictly within the binary. See related: intersex.*

Sex reassignment surgery/gender reassignment surgery: *(noun, obsolete)* an outdated term for gender affirmation surgery.

Sexuality: *(noun)* the components of one's identity that contribute to their sexual attraction towards others. This can include, but is not limited to, sexual orientation, gender identity, sexual practices, and more.

Sexual minority: *(noun)* those who identify with sexual orientations other than heterosexual.

Sexual orientation: *(noun)* a term describing one's sexual attraction to others, one's identity in regards to sexual attraction. Often, but not always, aligns with one's romantic orientation. *Note: some people use "sexual preference" instead of sexual orientation, but this is considered to invalidate the experiences and identities of sexual minorities and should not be used.*

SGM: *(noun)* short for sexual and gender minorities. Refers to those who fall under the LGBTQIA + umbrella, people of various sexual and gender identities.

SOGI: *(noun)* short for sexual orientation and gender identity, often seen as "SOGI data" when referring to collecting data about people's sexual orientations and gender identities in surveys, censuses, and studies.

Straight: *(adjective)* a synonym for heterosexual, which refers to people who are sexually attracted to people of the opposite sex (an annotation that assumes a gender binary).

TGNB: *(abbreviation)* short for transgender/non-binary (see definitions).

TGNC: *(abbreviation)* short for transgender and gender non-conforming (see definitions).

Third gender: see "two-spirit".

Trans: *(adjective)* short for transgender, see below.

Transgender: *(adjective)* identifying with a different gender than the one assigned at birth (e.g., a man who was assigned female at birth, a non-binary person who was assigned male at birth). *Note: this term should never be used as a noun.*

Transgender man: *(noun)* a man who was assigned female (or, rarely, intersex) at birth. Historically called "female-to-male" (FTM or FtM), although this term is now outdated.

Transgender woman: *(noun)* a woman who was assigned male (or, rarely, intersex) at birth. Historically called

"male-to-female" (MTF or MtF), although this term is now outdated.

[Gender] Transition: *(noun)* the process of moving from one gender presentation to another. Can include social, psychological, medical, and legal processes (*see related: gender affirmation*). This process is highly variable between individuals, who may elect for any combination of interventions (including none) and still remain trans.

Transphobia: *(noun)* aversion to trans, nonbinary, and/or gender non-conforming (TGNC) people, often used to justify hatred and discrimination against the TGNC community. *See related: cissexism.*

Transsexual: *(adjective, obsolete)* an outdated term that previously referred to transgender people, often specifically to those who had taken steps to medically and/or surgically transition. *Note: this term has fallen out of favor and generally should not be used. However, some members of the transgender community have reappropriated the term and may use it to describe themselves.*

Two-spirit: *(noun)* also written as two spirit. An umbrella term for Indigenous Native American gender and sexual diversity, often referring to a third gender role present within a tribe's culture. The specific term for this third gender and the accompanying definition varies by tribe. Two-spirit people are often included in the broader LGBTQIA + acronym as "2" or "2S" (e.g., LGBTQIA2S +).

WLW: *(noun)* short for women-loving-woman. Describes women who are attracted to other women. Does not necessarily imply behavior associated with this attraction. *See related: "sapphic."*

WSW: *(noun)* short for women who have sex with women. This abbreviation is often used in medical literature to describe sexual behavior rather than sexual orientation. This includes women who have sex with women who do not necessarily consider themselves to be part of the queer community. Although WSW has a role in describing behavior in research, some are encouraging moving away from this term as it can overemphasize focus on behavior while missing the societal and socioeconomic inequities that contribute to health disparities for sapphic women.

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- • Of importance
- •• Of major importance

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