Attitudes, behaviour, and comfort of Canadian emergency medicine residents and physicians in caring for 2SLGBTQI+ patients

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Abstract

Objectives Physicians working in the emergency department (ED) will interact with two-spirited, lesbian, gay, bisexual, transgender, queer/questioning and intersex (2SLGBTQI+) persons as colleagues and patients. These patients have unique healthcare needs and encounter negative experiences when seeking medical care, leading to poorer health outcomes and inequities. This study aims to explore the attitudes, behaviour, and comfort of Canadian emergency medicine (EM) physicians in caring for 2SLGBTQI+ patients.

Methods An anonymous survey was distributed to EM staff physicians and residents through the Canadian Association of Emergency Physicians (CAEP) network and social media channels. Demographic information was collected, and participants were asked about their comfort, current knowledge, and desire to gain new knowledge in caring for 2SLGBTQI+ patients. Personal perceptions and practice patterns in treating cisgender heterosexual (cis-het) and 2SLGBTQI+ patients were analysed using five-point Likert scales. Residents were asked additional questions regarding availability of learning experiences during training.

Results 266 surveys were included in the final analysis consisting of 229 (86%) staff physicians and 37 (14%) residents. 97% ($n=258$) of all respondents believed 2SLGBTQI+ patients deserve the same quality care from medical institutions as other patients. Further, 83% ($n=221$) respondents agreed that they would like to increase their knowledge in taking care of 2SLGBTQI+ patients, while 34% ($n=91$) agreed that performing physical examinations on transgender or intersex patients was more challenging than on cis-het patients. Among resident respondents, 46% indicated a lack of didactic teaching devoted to 2SLGBTQI+ care during residency ($n=17/37$), while 38% encountered discrimination towards 2SLGBTQI+ patients, with most comments from senior faculty and nursing staff.

Conclusions This study suggests that Canadian EM physicians feel that 2SLGBTQI+ patients deserve equitable care when compared to cis-het patients. Future work should focus on educational needs and curricular enhancements in residency programs and continuing professional development for physicians to improve care for 2SLGBTQI+ patients in the ED.

Keywords 2SLGBTQI+ · Emergency medicine · Health equity

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Résumé

Objectifs Les médecins travaillant dans les services d'urgence interagissent avec des personnes bispirituelles, lesbiennes, gaies, bisexuelles, transgenres, queer/en questionnement et intersexes (2SLGBTQI+) en tant que collègues et patients. Ces patients ont des besoins uniques en matière de soins de santé et vivent des expériences négatives lorsqu'ils cherchent à obtenir des soins médicaux, ce qui entraîne des résultats moins bons en matière de santé et des inégalités. Cette étude vise à explorer les attitudes, les comportements et le confort des médecins d'urgence canadiens dans la prise en charge des patients 2SLGBTQI+.

Méthodes Un sondage anonyme a été distribué aux médecins membres du personnel d'urgence et aux résidents par l'intermédiaire du réseau de l'Association canadienne des médecins d'urgence et des canaux de médias sociaux. Des informations démographiques ont été recueillies, et les participants ont été interrogés sur leur confort, leurs connaissances actuelles et leur désir d'acquérir de nouvelles connaissances sur la prise en charge des patients 2SLGBTQI+. Les perceptions personnelles et les modèles de pratique dans le traitement des patients cisgenre-hétérosexuels (cis-het) et 2SLGBTQI+ ont été analysés à l'aide d'échelles de Likert à cinq points. Des questions supplémentaires ont été posées aux résidents concernant la disponibilité des expériences d'apprentissage pendant la formation.

Résultats 266 sondages ont été inclus dans l'analyse finale consistant en 229 (86 %) médecins du personnel et 37 (14 %) résidents. 97 % ($n = 258$) de tous les répondants pensent que les patients 2SLGBTQI+ méritent la même qualité de soins de la part des institutions médicales que les autres patients. En outre, 83 % ($n = 221$) des répondants ont convenu qu'ils aimeraient améliorer leurs connaissances dans la prise en charge des patients 2SLGBTQI+, tandis que 34 % ($n = 91$) ont convenu que la réalisation d'examen physiques sur des patients transgenres ou intersexes était plus difficile que sur des patients cis-het. Parmi les répondants résidents, 46 % ont indiqué un manque d'enseignement didactique consacré aux soins 2SLGBTQI+ pendant la résidence ($n = 17/37$), tandis que 38 % ont été victimes de discrimination à l'égard des patients 2SLGBTQI+, la plupart des commentaires provenant du corps professoral supérieur et du personnel infirmier.

Conclusions Cette étude suggère que les médecins d'urgence canadiens estiment que les patients 2SLGBTQI+ méritent des soins équitables par rapport aux patients cis-het. Les travaux futurs devraient se concentrer sur les besoins éducatifs et l'amélioration des programmes d'études dans les programmes de résidence et le développement professionnel continu des médecins afin d'améliorer les soins aux patients 2SLGBTQI+ dans les urgences.

CJEM Capsule

What is known about this topic?

2SLGBTQI+ patients face significant challenges and potential stigmatisation exists when they are cared for in the ED.

What did this study ask?

What are the attitudes, behaviour, and comfort of ED staff physicians and residents towards caring for 2SLGBTQI+ patients in Canada?

What did this study find?

Both ED attending physicians and resident expressed some challenges in their clinical approach in caring for 2SLGBTQI+ patients.

What does this study matter to clinicians?

Improving the knowledge and comfort of EM practitioners caring for 2SLGBTQI+ patients could lead to improved healthcare outcomes.

Introduction

An estimated 1.5% of the Canadian population identifies as homosexual or bisexual [1]. Studies show that two-spirited, lesbian, gay, bisexual, transgender, queer/questioning, and intersex (2SLGBTQI+) patients have healthcare needs and risk factors that lead to worsened health outcomes compared to their heterosexual counterparts. These include an increased prevalence of mental health and addiction disorders, higher rates of sexually transmitted infections, lower rates of preventative screening, and poorer access to healthcare [2–4]. They frequently encounter discrimination when seeking medical attention, leading to negative impressions and avoidance of the healthcare system [5–7]. A recent study on transgender patients in Canada showed that 12% of patients avoided emergency departments (EDs) as a result of perceptions of discrimination and poorer care when compared to the general population [8].

Despite the regularity with which ED physicians provide care to 2SLGBTQI+ persons, studies suggest that an average of 5 h of instruction is provided on this topic during undergraduate medical training [9]. In the US, only 33% of emergency medicine (EM) program directors indicated that their programs teach about 2SLGBTQI+ health topics, and, of these, most had less than an hour of teaching throughout

the entire residency [10]. These factors may contribute to why EM residents in the US found that caring for transgender patients was more challenging than heterosexual patients when discussing sexual behaviour and conducting physical and genitourinary examinations [11]. The aim of this study was to examine the attitudes, behaviour, and comfort of EM staff physicians and residents towards the care of 2SLGBTQI+ patients in Canada.

Methods

Study procedure

A detailed survey was distributed to Canadian ED physicians and residents between October 5 and November 2, 2020. Participants were recruited through the Canadian Association of Emergency Physicians (CAEP) database. The initial survey email was followed by another email two weeks later, as per the modified Dillman approach [12]. Social media channels, including Facebook, Twitter, TimedRight, and the Society of Rural Physicians of Canada members database were used for further distribution. Inclusion criteria were staff or resident physicians in the CAEP member database who opted into receiving surveys, and any physician who self-identified as an EM provider in Canada. The number of certified emergency physicians in Canada is estimated to be 6635 [13]. However, the number of CAEP members who consented to survey distribution is 1280.

Measures

A questionnaire was administered to solicit demographic information. Data pertaining to the participants' comfort, current knowledge, and desire to gain new knowledge in caring for 2SLGBTQI+ patients were collected via survey responses based on previous work by Moll et al., with modifications to fit the Canadian context [10, 11]. Permission for using these surveys was obtained from the journal publisher. Residents were asked additional questions regarding the availability of learning experiences during their training program. A pilot survey was distributed to several participants at the host institution, and feedback was sought from the CAEP 2SLGBTQI+ committee prior to final survey dissemination. The survey can be found as Supplement A.

Data analysis

Descriptive statistics were run on all data. Questions that were answered on a five-point Likert scale were converted to a 1–5 continuous scale (strongly disagree = 1; strongly agree = 5). Independent-sample *t*-tests and the Mann–Whitney *U* test were performed to determine if a statistically

significant difference was detected in ordinal Likert scale responses between the ED attending and resident groups. Statistical analyses were performed using IBM SPSS version 26.

Results

266 of 324 surveys were completed in entirety and included in the final analysis. Based on CAEP membership, this resulted in a 20.8% response rate ($n = 266/1280$). Table 1 displays demographical information, with practicing physicians comprising 86% ($n = 229$) of responses. Most respondents were Caucasian, from Ontario, and heterosexual. There were even numbers of men and women. None of the respondents identified as non-binary or two-spirited, and 38 participants self-identified as bisexual, homosexual, or other.

Table 2 shows survey questions regarding the perceptions of patients; overall, 67.2% of respondents were somewhat or extremely comfortable taking care of these patients. During clinical encounters with self-identified 2SLGBTQI+ patients, 73% ($n = 195$) of physicians admitted to misidentifying their relationship with their support person, and 45% ($n = 120$) avoided questions about sexual behaviour at least some of the time. 83% ($n = 221$) agreed that they would like to increase their knowledge in taking care of 2SLGBTQI+ patients. A lack of time and availability of learning resources were ranked as the most important barriers to doing so. Free text responses indicated that some participants did not feel that there were any barriers or were already comfortable with caring for these patients. For example, one respondent stated they “feel adequately trained already” and “I already feel very informed and work to consciously recognise the barriers my patients face”. However, others noted “constantly changing definitions and acronyms” and “competing priorities—at this point, learning about racism is a higher priority for my practice setting”.

Table 3 shows the survey questions regarding history taking and physical examination of 2SLGBTQI+ patients. 15.6% ($n = 41$) of all physicians stated that they were more likely to screen for sexually transmitted infections at least half the time with 2SLGBTQI+ patients compared to cis-gender heterosexual (cis-het) ones. 17% ($n = 45$) would spend more time discussing sexual behaviour with 2SLGBTQI+ patients at least half of the time. 21% ($n = 56$) described having less eye contact with the patient at least some of the time. ED residents were statistically more likely to perform fewer procedures to avoid physical contact compared to staff ($p = 0.006$). Table 4 shows that 34.3% ($n = 91$) and 62.5% ($n = 165$) of all physicians agreed that it was more challenging to conduct either a physical or genitourinary exam on transgender or intersex patients, respectively.

Table 1 Demographic information of survey participants

	Number of participants (<i>n</i> = 266)
Staff physicians	226
Residents	37
Province/Territory	
Alberta	21
British Columbia	32
Manitoba	17
New Brunswick	5
Newfoundland and Labrador	6
Northwest Territories	1
Nova Scotia	11
Nunavut	0
Ontario	158
Prince Edward Island	1
Quebec	9
Saskatchewan	5
Yukon	0
Age	
25–34	78
35–44	90
45–54	60
55–64	32
Over 65	6
Ethnicity	
Black or African American	3
East Asian (Chinese, Japanese, Korean, Taiwanese, etc.)	18
Indigenous	0
Latin American	1
Middle Eastern	5
Other/Mixed	13
South Asian (Indian, Sri Lankan, Nepalese, Pakistani, Bangladeshi, etc.)	29
White (Caucasian)	197
Sexual orientation	
Bisexual	14
Heterosexual	224
Homosexual	19
Other	5
Prefer not to say/blank	4
Gender identity	
Man	134
Woman	128
Non-binary	0
Two-spirit	0
Prefer not to say	4

Table 5 shows that 97% (*n* = 258) of respondents agreed that 2SLGBTQI+ patients deserve the same level of quality care from medical institutions as other patients. 54% of respondents (*n* = 144) agreed that they

have observed discriminatory or inappropriate comments about 2SLGBTQI+ patients or staff, and 96% (*n* = 255) agreed that they were comfortable working alongside 2SLGBTQI+ physicians.

Table 2 Percentage of participant responses to questions regarding perceptions of 2SLGBTQI+ patients

Perceptions of 2SLGBTQI+ patients	
Overall, how comfortable are you addressing the needs of your 2SLGBTQI+ patients?	Total (<i>n</i> = 253)
Extremely uncomfortable	0.4
Somewhat uncomfortable	8.7
Neither comfortable nor uncomfortable	23.7
Somewhat comfortable	49.4
Extremely comfortable	17.8
When taking a sexual history, how often do you ask about the gender(s) of a patient's sexual partner(s)?	Total (<i>n</i> = 266)
Never	4.9
Sometimes	33.5
About half the time	9.8
Most of the time	27.1
Always	24.8
During your clinical encounters with self-identified 2SLGBTQI+ patients, how often did the following events occur?	Total (<i>n</i> = 265)
Avoided questions about sexual behaviour	
Never	54.5
Sometimes	38.7
About half the time	3.0
Most of the time	2.6
Always	0.8
Misidentified their relationship with their support person (e.g. assumed support person was a friend or relative instead of partner)	Total (<i>n</i> = 265)
Never	27.7
Sometimes	66.8
About half the time	7.9
Most of the time	2.4
Always	0

Of the resident respondents, 54% (*n* = 20) indicated that they had no didactic teaching devoted to 2SLGBTQI+ care during residency (Supplement B). Of the residents that had didactic teaching during training, most wanted between 3 and 4 h, which was more than was provided by programs. 38% of all residents (*n* = 14) encountered at least one episode of discrimination towards 2SLGBTQI+ patients, most commonly from senior faculty and nursing staff (Fig. 1). Many residents noted multiple groups that displayed these behaviours.

Discussion

Interpretation

Our study demonstrates that physicians believe 2SLGBTQI+ patients deserve equitable care, and that there is a desire to improve knowledge in this area. Most physicians felt comfortable in addressing the needs of 2SLGBTQI+ patients, though some expressed challenges with history taking and performing physical examinations.

Unfamiliarity with anatomical differences i.e. gender-affirming surgeries and elements of stigma may be contributing factors. Many residents in our study did not have 2SLGBTQI+ specific learning during residency. While didactic teaching may not encompass all facets of learning in medical education, the curricular time dedicated to this topic could be considered a marker of its importance to residency programs. Mentorship and direct role modelling by staff are other modalities for teaching residents about these issues. Most residents in our study desire more instruction related to 2SLGBTQI+ health, thus creating a curriculum development opportunity for training programs. Finally, over half of respondents observed discrimination in our survey. Resident trainees identified senior faculty and nursing staff as the groups who appeared to be making undesirable remarks.

Previous studies

The results of our study support previous work by Moll et al., which highlights a need for progressive change to our medical education systems [10, 11]. Our study results are in keeping

Table 3 Percentage of participant responses to questions regarding history taking and physical examination of 2SLGBTQI+ patients

History taking and physical examination of 2SLGBTQI+ patients			
Compared to patients who do not self-identify as 2SLGBTQI+, how often do you believe you have treated the 2SLGBTQI+ population differently in respect to the following?			
Less eye contact			
	Total (n = 265)		
Never	78.9		
Sometimes	18.1		
About half the time	2.6		
Most of the time	0.4		
Always	0		
Fewer procedures to avoid physical contact*			
	Total (n = 264)	Staff physicians (n = 227)	Residents (n = 37)
Never	89.0	90.8	75.7
Sometimes	9.5	8.3	16.2
About half the time	1.5	0.9	8.1
Most of the time	0	0	0
Always	0	0	0
Spent more time discussing sexual behaviour			
	Total (n = 264)		
Never	46.6		
Sometimes	36.4		
About half the time	10.2		
Most of the time	6.4		
Always	0.4		
More likely to screen for STIs			
	Total (n = 264)		
Never	47.7		
Sometimes	36.7		
About half the time	9.1		
Most of the time	6.1		
Always	0.4		

*Statistically significant difference observed between staff physicians and residents ($p = 0.006$)

with their conclusions that conducting a genitourinary exam on transgender or intersex patients is particularly challenging for ED physicians. Further, a minority of respondents (6%) disagreed that 2SLGBTQI+ patients deserve the same care as all patients. Their study was conducted in 2018 and in the United States, which may not be comparable to a Canadian population [11]. While many ED physicians do treat 2SLGBTQI+ patients like the general population, the difference in medical history taking and physical examination requires some exploration. This is not unique to emergency medicine; for example, a recent Canadian study that interviewed residents in family medicine, endocrinology, psychiatry, and urology noted that there was a lack of comfort and knowledge when caring for transgender patients [14].

While we did not survey 2SLGBTQI+ patients directly, our finding that physician respondents have heard

discrimination directed towards these patients complements previous research indicating that these individuals feel discriminated against by healthcare professionals [6, 8]. These previous studies elucidated multiple themes that affected transgender and gender-nonconforming patients, including an emergency system that is not designed for safe gender disclosure and a lack of care competency by providers. Experiences such as patients being disrespected by staff were described as well. This is clearly an area that continues to be an issue despite years of progress in 2SLGBTQI+ rights.

Strengths and limitations

To our knowledge, our study is the first of its kind conducted in Canada. The survey collected input from physicians from most provinces and territories in Canada. We were also able

Table 4 Percentage of participant responses to questions regarding the challenges in caring for 2SLGBTQI+ patients

Challenges in caring for 2SLGBTQI+ patients	
It is more challenging to gather a history from self-identified 2SLGBTQI+ patients than from other patients	
	Total (<i>n</i> = 263)
Strongly disagree	32.7
Somewhat disagree	32.3
Neither agree nor disagree	16.9
Somewhat agree	15.4
Strongly agree	1.5
It is more challenging to conduct a physical exam on self-identified 2SLGBTQI+ patients than on other patients	
	Total (<i>n</i> = 263)
Strongly disagree	42.3
Somewhat disagree	29.2
Neither agree nor disagree	20.6
Somewhat agree	11.5
Strongly agree	0.4
It is more challenging to conduct a physical exam on transgender or intersex patients than on other patients	
	Total (<i>n</i> = 263)
Strongly disagree	22.3
Somewhat disagree	22.3
Neither agree nor disagree	20.4
Somewhat agree	29.8
Strongly agree	4.5
It is more challenging to conduct a genitourinary exam on transgender or intersex patients than on other patients	
	Total (<i>n</i> = 264)
Strongly disagree	12.1
Somewhat disagree	12.5
Neither agree nor disagree	12.9
Somewhat agree	50.4
Strongly agree	12.1
It is more challenging to discuss sexual behaviour with self-identified 2SLGBTQI+ patients than with other patients	
	Total (<i>n</i> = 264)
Strongly disagree	29.5
Somewhat disagree	27.7
Neither agree nor disagree	19.7
Somewhat agree	22.0
Strongly agree	1.1

to collect important demographic data describing EM providers which has not previously been documented.

The generalizability of our results to the EM community in Canada is limited by our ability to effectively reach all practicing staff physicians and residents across the country. Our method of using the CAEP mailout and social media channels may bias our results towards academic physicians and those who have an interest in 2SLGBTQI+ issues. To the best of our knowledge, there is no national database of emergency physicians to allow for distribution of a survey to all applicable parties. Our survey was available in English

only, which limits participation from physicians in French-speaking regions. Most of our respondents also practice in Ontario, which limits generalisation to other provinces, although our survey was distributed nationwide. The province or territory in which a physician practices may have differing levels of societal acceptance of 2SLGBTQI+ patients, which would affect our results. However, that is beyond the scope of our study and could possibly be an area of future research.

Table 5 Percentage of participant responses to questions regarding 2SLGBTQI+ patients and the healthcare system

2SLGBTQI+ patients and the healthcare system	
2SLGBTQI+ patients deserve the same level of quality care from medical institutions as other patients	
	Total (<i>n</i> = 264)
Strongly disagree	0.4
Somewhat disagree	0
Neither agree nor disagree	1.5
Somewhat agree	2.3
Strongly agree	95.5
I am comfortable working alongside 2SLGBTQI+ physicians	
	Total (<i>n</i> = 263)
Strongly disagree	0.4
Somewhat disagree	0
Neither agree nor disagree	2.7
Somewhat agree	4.9
Strongly agree	91.7
I have observed other healthcare workers (physicians, nurses, etc.) make discriminatory or inappropriate comments about 2SLGBTQI+ patients or staff	
	Total (<i>n</i> = 264)
Strongly disagree	18.6
Somewhat disagree	14.0
Neither agree nor disagree	12.9
Somewhat agree	37.1
Strongly agree	17.4

Fig. 1 Groups that made derogatory remarks, displayed discrimination, or exhibited biases towards 2SLGBTQI+ patients as noted by resident physicians (*n* = 37). Residents may have noted remarks from more than one group

Clinical implications

Our research highlights potential areas for improvement in caring for 2SLGBTQI+ patients in the ED. First, while misidentifying a support person may not necessarily cause negative clinical outcomes, it may lead to a poorer ED experience for the patient, along with feelings of stigmatisation

that may contribute to avoiding ED use. This issue can be addressed by asking patients what their relationship is with the person whom they presented to the ED with, rather than verbalising assumptions.

History taking and physical examination of 2SLGBTQI+ patients was described as more challenging compared to cis-het patients. In our training, we develop approaches to

chief complaints that differ depending on biological sex, medication usage, and other factors. It is possible that respondents found it more challenging with 2SLGBTQI+ patients because they are uncertain how their approach changes when examining non-cis-het patients. As patients become more comfortable expressing their gender and sexual identities, physicians need to be educated on issues that are unique to this patient population. In the ED, physicians will encounter complications of gender-affirming surgeries, hormonal therapies, physical and sexual abuse, and a myriad of mental health concerns that are more frequent in 2LGBTQI+ patients. Specific training should be provided: e.g. phrasing sensitive questions and vocabulary to avoid heteronormative language. Specific checklists of issues and how to obtain information on sexual health have been described in the literature; educators may find utility in incorporating these into their clinical skills training [14]. It is important that institutions have policies in place for promoting an environment of inclusivity and diversity, especially in a setting with vulnerable persons who may already suffer from stigmatisation. Staff physicians should try to role model positive behaviours to learners and bring attention to discriminatory interactions when possible.

Research implications

The results of our study suggest that continuing professional development opportunities and curricular enhancements are the next logical step in enhancing care for 2SLGBTQI+ patients in the ED. Medical teachers with experience in equity, diversity, and inclusion should be recruited to develop best practices guidelines and educational sessions. Future work should seek consultation from 2SLGBTQI+ persons to ensure their perspectives are included in the planning of both educational content and equitable care delivery in the ED.

Conclusions

Emergency physicians and residents in Canada will care for 2SLGBTQI+ patients in their clinical work. They believe that this patient population deserves equitable care when compared to cis-het patients, and there is a desire to improve knowledge in being able to do so. Future work should focus on education in residency programs and continuing professional development for staff physicians to improve care for 2SLGBTQI+ patients in the ED. Discrimination towards 2SLGBTQI+ patients still occurs, and our profession should move towards adopting policies to advocate for patients and to encourage appropriate mentorship and role modelling among ED physicians.

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1007/s43678-021-00160-5>.

Author contributions KL and VN were responsible for project design, data analysis and manuscript writeup. BV was responsible for data analysis and manuscript editing.

Declarations

Conflict of interest The authors declare that they have no conflict of interest.

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