Care of LGBTQ Patients in the Emergency Care Setting

Toolkit

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Demographics, Common Health Concerns, and Barriers for LGBTQ Patients

It is estimated that 3.5% of the adult population in the United States identifies as lesbian, gay, or bisexual, and 0.3% of the adult population identifies as transgender, which accounts for approximately 9 million individuals in the United States.¹ In addition, a national survey of 15- to 44-year-old adults found that 12.5% of women and 5.2% of men reported a history of same-sex sexual contact.¹

Common healthcare concerns among the LGBTQ population include:

- **Behavioral Health**
  - Depression
  - Substance abuse
  - Suicidal tendencies

- **Access to Care**
  - Few resources for LGBTQ health
  - Lack of insurance or insurance coverage
  - Lack of dedicated LGBTQ health providers

- **Sexually Transmitted Infections (STIs)**
  - HIV
  - Hepatitis B
  - Hepatitis C
  - Gonorrhea
  - Chlamydia
  - Syphilis
  - HPV

Common barriers to healthcare within the LGBTQ population include:

- **Education**
  - Patients, family members and healthcare professionals may lack education on LGBTQ health issues. This can impact knowledge of available resources and follow-up care for patients and family members. For healthcare professionals, this can impact patient safety and patient outcomes.

- **Health Insurance Barriers**
  - An increasing number of healthcare insurance plans such as Medicaid are now covering the costs of LGBTQ preventative care, medications and surgeries in certain states. However, many other healthcare insurance plans do not, causing a significant barrier to accessing specialized providers or needed medications and surgeries, which are costly without insurance coverage.

- **Economic Barriers**
  - Lack of healthcare insurance or having a healthcare plan that does not cover LGBTQ health needs can be a significant and costly barrier to accessing healthcare. Although an increasing number of healthcare insurance plans are now including coverage of LGBTQ health needs, there are others that do not.

- **Provider Knowledge Gaps**
  - Lack of knowledge of LGBTQ health needs by a provider can delay needed care, put the patient at risk, and increase the anxiety level of the patient. One study showed that approximately 54% of transgender patients reported having to educate their providers “some” or “a lot” regarding transgender issues.²

This toolkit will further address the common health concerns of LGBTQ individuals, and the many barriers that may prevent them from seeking the healthcare they need. Resources are also provided throughout to assist emergency nurses in their commitment to quality and safety in care of LGBTQ people.

Care of LGBTQ Patients in the Emergency Care Setting Toolkit

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Section 1 | Introduction
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Dear Healthcare Partners:

In upholding ENA’s values of inclusion and diversity, the ENA LGBTQ Toolkit for Emergency Care Settings seeks to guide the culturally safe provision of emergency nursing care to members of the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) community. The toolkit builds on the work of the ENA Topic Brief, Care of the Gender Expansive and Transgender Patient in the Emergency Care Setting,¹ and responds to a request from the 2017 ENA General Assembly to develop an educational toolkit for emergency nurses that speaks to the unique needs of the LGBTQ population.²

Patient’s experience: My last trip to emergency was for bronchitis... a bad cough of some kind. I had to go in for an x-ray of my chest and a nurse explained that I would have to remove any bra I might be wearing. I had no problem with that, but the nurse got sort of awkward and sheepish around me during that conversation. I felt that my breasts were being sexualized which was especially bothersome for me because I find dysphoria in having them. I felt that I was being sexualized as a woman and thereforegendered. A recommendation that I would like to bring forward is this: When one enters emergency, they are already asked if their home address and phone number is up to date. This is a perfect opportunity to also ask if their listed sex corresponds with how they choose to be addressed. For example, “Your ID card shows ‘Male.’ Is this up to date? What are your pronouns?”

– Kennedy Healey
The toolkit is divided into eight sections, each of which speaks to unique considerations of emergency nursing in providing care to LGBTQ patients.

Depending on learning needs, one may opt to read the toolkit in its entirety or focus on particular sections.

Stories of LGBTQ patients in the emergency department are woven throughout, with a case study section at the end.

**Toolkit Sections**

- **Section 1: Introduction, Toolkit Overview, and Terminology**
- **Section 2: The Emergency Department Environment** includes implicit/unconscious bias and impacts on LGBTQ health, communication, sexual orientation inquiry for electronic medical record, physical environment of the ED, LGBTQ-related legal and regulatory requirements, staff training, and family considerations
- **Section 3: Health Disparities and Conditions** contains recommended health tools, review of systems and physical examination, ordering labs/tests, discharge teaching, HIV education/screening/prevention, sexual health information, screenings, sexual orientation and gender identity collection and electronic medical records, and differential diagnosis items for consideration
- **Section 4: Transgender Health** explores dimensions of transition including legal, social, and medical
- **Section 5: Pediatric and Adolescent Patients** considers developmental stages and bullying
- **Section 6: Behavioral Health** outlines high rates of suicide and depression, strategies for overcoming extended holds for transgender patients, searching patients, and alcohol/substance abuse
- **Section 7: Transgender Surgical Procedures and Post-Operative Complications**
- **Section 8: Case Studies** presents the unique experiences of members of the LGBTQ community and their intersections with emergency department care

**Appendix**
Terminology

In starting a dialogue about culturally safe nursing care for LGBTQ patients in the emergency department, we begin with a review of the various terms used to describe the community. It is important to note that the acronym “LGBTQ” fails to recognize all of the unique and varied gender identities, gender expressions, sexual orientations, and emotional and romantic attractions that exist, so readers may be familiar with longer, shorter, and/or varied versions of this acronym, including “LGBTQ+”. Additionally, use of the term “gay community” is generally discouraged as it is not inclusive of the many other identities which fall under the umbrella of “LGBTQ” or “queer” communities.³

Lesbian (adj., noun) A sexual orientation that describes female-identified individuals who are emotionally, romantically, and/or sexually attracted to other female-identified individuals.⁴,⁵

Gay (adj.) A sexual orientation that describes individuals who are emotionally, romantically, and/or sexually attracted to individuals of the same sex and/or gender.⁴,⁶ It should be noted that not all individuals who engage in same-sex behavior identify as gay, and so the term should be used with caution.⁵ Lastly, the term “homosexual” should not be used interchangeably with “gay” as it is considered outdated and offensive to many community members.³

Bisexual (adj.) A sexual orientation that describes individuals who are emotionally, romantically, and/or sexually attracted to people of their own and other sexes and/or genders.⁴,⁶

Transgender (adj.) Describes individuals whose gender identity and/or expression is incongruent with the societal norms of their sex assigned at birth.³ Often used interchangeably with “trans,” this can be an umbrella term which defines a wide range of gender identities and expressions that fall outside of the binary “female” and “male.”

Non-binary (adj.) Sometimes referred to as “genderqueer,” describes individuals whose gender identity and/or expression falls between or entirely outside the binary classifications of male or female. It should be noted that this term is not synonymous with transgender.³

Queer (adj.) An umbrella term used to describe a broad spectrum of sexes, gender identities, and attractions that fall outside of conventional norms. Historically derogatory, this term is neither reclaimed nor used by all members of the community.⁴,⁶

Questioning (adj.) A term used to describe individuals who are in the process of exploring their gender identity and/or sexual orientation.⁴

Two-Spirit (adj.) Refers to an individual who embodies both the masculine and the feminine spirit. It is a culturally specific term used amongst some indigenous peoples who may identify solely as Two-Spirit or in addition to being LGBTQ.⁴,⁶

Sexual orientation (noun) Sometimes referred to as “attraction,” it describes an individual’s emotional, romantic, and/or sexual attraction to others, often based on sex and/or gender.⁴-⁶ It should be noted that sexual experience is not required to know sexual orientation, and that the term “sexual preference” should not be used as it implies choice.³

Gender identity (noun) An individual’s inherent sense and experience of gender.⁶ This may include identification with being female, male, another gender, or no gender, and may or may not align with cultural expectations surrounding an individual’s sex assigned at birth.⁴,⁶ Because gender identity is internal, it is not visible to others.⁶

Gender expression (noun) Also known as “gender presentation” or “gender performance,” describes the myriad ways in which individuals communicate their gender within a social context.⁶ “Gender can be expressed through clothing, speech, body language, hairstyle, voice, and/or the emphasis or de-emphasis of bodily characteristics or behaviors, which are often associated with masculinity and femininity.”⁶

Sex assigned at birth (noun) Refers to the medical assignment of a child’s sex at birth based on external anatomy.⁴ Sex assigned at birth generally falls into the categories of male, female, or intersex; however, it is important to note that sex is a combination of characteristics (i.e. chromosomes, hormones, internal reproductive organs, secondary sexual characteristics, etc.) and not merely based on genitalia.⁵,⁶
Intersex (adj.) Intersex is an umbrella term describing a community of people who are born with differences in sexual development/sexual characteristics and a range of body variations that do not align with the male/female binary. For some people, anatomical variations are visible at birth, whereas others may not have intersex traits present until puberty. Still others may have chromosomal intersex variations that are not apparent at all. Being intersex relates to sexual development and characteristics, and is distinguishable from sexual orientation and gender identity. Intersex individuals may constitute up to 1.7% of the general population and may identify their sexual orientation as gay, lesbian, bisexual, asexual or straight. They may also identify as male, female, agender, or non-binary.

Cisgender (adj.) Sometimes referred to as “cis,” the Latin prefix for “on the same side as,” it refers to individuals whose gender identity and sex assigned at birth correspond. Cisgender refers to non-transgender people and is the socially prevailing experience of gender identity relative to sex assigned at birth.

Transition (noun) Sometimes referred to as “gender affirmation process,” a term used to describe the various social, legal, and/or medical processes undertaken to affirm and express one’s gender identity. This may include a change in one’s name, pronouns, and gender expression; the alteration of sex or gender on legal documents (i.e. passport, driver’s license, birth certificate); and/or accessing counselling/support, hormone therapy, and/or gender affirming surgery. The process is specific to individuals and varies based on what an individual deems necessary and what is accessible to them.

Gender affirming surgery (GAS) (noun) Various medical surgeries used in the process of transition to alter one’s body to be more congruent with one’s gender identity. May also be referred to as “gender confirming surgery” (GCS) or “sex reassignment surgery” (SRS); however, the terms “sex change operation,” “pre-operation,” and “post-operation” should be avoided as they suggest that surgery is necessary in order to transition.

Gender affirming devices (noun) Devices used by members of the transgender community to affirm their gender identity. Often these devices are used to conceal or enhance the appearance of secondary sex characteristics (i.e. breast forms, chest binders, gaffs, packers, stand-to-pee (STP) devices, etc.).

Genderqueer or gender queer (adj.) Refers to individuals whose gender identity and/or expression may not align with societal expectations of male and female. Sometimes referred to as gender variant, gender expansive, or non-binary, genderqueer individuals may move “between or beyond genders” or identify as a combination of both.

Gender Fluid (adj.) Used to describe an individual who may move between gender identities and/or expressions of male and female and/or a combination of both.

While this list is far from exhaustive, it does provide a starting point from which care providers can begin to understand LGBTQ patients’ unique identities. For a more exhaustive list, please see The National LGBT Health Education Center’s “Glossary of LGBT Terms for Health Care Teams.”

Terminology

Appendices

Section 1

Overview of Toolkit Materials
Section 1 | References

Implicit/Unconscious Bias and its Impact on LGBTQ Health

Implicit/Unconscious Bias

Everyone has bias. Implicit or unconscious bias is a normal human survival mechanism that helps the brain process and filter the millions of bits of information that bombard us daily. It is the product of our cultures (plural because none of us are members of a single culture), identity, training, experience, beliefs, and attitudes.¹

Emergency nurses know that creating an effective nurse-patient relationship involves the cultural interaction of the nurse, the patient, the patient’s family, and the environment. For our part, it’s essential to be introspective and understand how our unconscious biases — which reflect our cultures, beliefs, and values — impact the delivery of safe, supportive, respectful and effective care.²

Six ways to recognize and mitigate unconscious bias:¹³

1. Acknowledge you have bias

It is OK – you are only human!

2. Engagement with others

You have to talk to people who do not look like you, think like you, or have your experience or worldview.

3. Get feedback

Ask others for their perspectives or reactions to your opinions, words, and actions and accept the responses in a non-defensive manner.

4. Experience awkwardness and discomfort

You have to get comfortable with being uncomfortable. Engaging with the LGBTQ patient potentially can challenge some deeply rooted and long-held assumptions or beliefs about sex, gender, and sexuality.

5. Challenge your own certainty

Once upon a time, people knew the world was flat. However, evidence proved that it is not. As emergency nurses, we must be open to new ideas or perspectives based on science and evidence. Embracing evidence-based change is essential to our professional growth and our ability to provide quality care of all of our patients. To reject evidence and science to hold on to unsupported opinions is willful ignorance, which can ultimately be harmful to our patients.

6. Introspection

Look inward. Ask yourself why or how you came to a decision or acted in a certain way in a given situation or in interacting with other people.
Myths and Stereotypes about LGBTQ People

In the 50 years since the Stonewall Riots of 1969, which many cite as the beginning of the fight for LGBTQ rights in the United States, lesbian, gay, and bisexual people have become more visible in society. However, it is much more recent that transgender and gender-non-conforming people have been included in public debate, popular culture, and the media. By 2016, 87% of Americans knew someone who was gay or lesbian, but only 30% knew someone who was transgender. The lack of familiarity combined with persistent willful ignorance and bigotry lead to many stereotypes about LGBTQ people that are not valid and not supported by evidence-based medicine.

Here are some myths and stereotypes about LGBTQ people:

- Being gay, lesbian, bisexual, or transgender is a choice
- Being lesbian, gay, bisexual, or transgender = mental illness
- Gender identity = sexual orientation
- All trans people have surgery
- Many transgender people regret transitioning
- Children cannot be transgender
- Same-sex parents harm children
- Gay men molest children at a higher rate than heterosexual men

A Real Barrier: “Trans Broken Arm Syndrome”

A pernicious situation that many transgender patients experience in emergency settings is the “trans broken arm syndrome.” This occurs when practitioners discover that a patient is transgender and, no matter what their presenting complaint, the practitioners state they lack the competency to care for a transgender patient, or that a cause of the patient’s illness or injury is either the fact that they are transgender or because of their masculinizing or feminizing hormone therapy. It also manifests as an inordinate interest and focus on the status of transition, particularly any gender-affirming genital surgery, before addressing the presenting complaint. Too often, this is accompanied by a knee-jerk reaction to tell the patient to stop their hormone therapy. This approach is generally not evidence-based, and in fact can be harmful to the patient’s physical and psychological health.

Health Disparities Facing the LGBTQ Community

In HealthyPeople 2020, the U.S. government – for the first time ever – included LGBTQ health matters in its report on health topics. With many contributing factors, including social stigma and a lack of healthcare practitioner education and training, the following negative health impacts exist for the LGBTQ community:

- Increased risk of suicide
- Increased risk of violence
- Increased risk of HIV/STD infection
- Increased substance abuse
- Increased mental health concerns
- Decreased insurance coverage
Communication: How to Talk to LGBTQ Patients

Like most other patients, LGBTQ patients do not start their day by wanting to come to the emergency department. Layer on top of being in distress or crisis, they have an understandable anxiety about being harassed, verbally abused, or denied care because of their sexual orientation or gender identity. Past negative interactions with the healthcare system often lead LGBTQ people to avoid seeking healthcare until they are in extremis and wind up in the ED.

Knowing this, it is incumbent on ED staff and clinicians to set an environment that is safe, welcoming, and respectful. Crucial to setting this environment and establishing the foundation for a trusting nurse-patient relationship is language.

Language Skills
Here are three practical language techniques that are effective in establishing a respectful and supportive environment:

1. Use the patient’s correct name and pronouns
   - Many transgender people do not have identification that aligns with their chosen name or gender marker reflective of their gender identity. More than half have faced some form of harassment or discrimination when showing non-matching ID.
   - Do not make assumptions about gender identity based on how someone sounds or how someone looks. Avoid using “sir/ma’am” or calling a patient “Mr./Ms.” until you have had the chance to ask them about their name and pronoun. Using the wrong terminology can be embarrassing (for both you and the patient), and a patient or visitor could consider it offensive.
   - Using the non-chosen name for a transgender person (often their former name that might still be on their ID) is called dead-naming. Beyond being embarrassing or offensive, it can be psychologically harmful to the patient (if it is a trigger for their gender dysphoria) or potentially dangerous (if it outs them as a transgender person to others who may be transphobic. [Remember that the lifetime probability of a transgender person being the victim of a physical or sexual assault because of their gender identity is 50%].)
   - Asking for the name – some inclusive examples:
     - “Hi, my name is [your name] and I’m going to be your nurse. My pronouns are she/her. How would you like me to address you? What pronouns do you use?” (See Appendix A)
     - “Could your chart be listed under another name?”
     - Call out for “Patient Smith”

Avoid “What is your real name?” as many people find that offensive. If you have to ask for the name for registration or billing purposes, ask, “What is the name listed on your insurance card or ID?”

   - Patient safety/two-identifier checks for labs/medication administration/diagnostics
   - Explain to the patient about the use of identifiers for patient safety and that, if required to use a dead name, it is not meant to be disrespectful. A good way to approach this is to tell the patient, “I am going to ask you to tell me the name listed on your record or wristband and what is your date of birth.” This language does not force the patient to “own” that former name.
2. Use the proper terminology
Please refer to the toolkit glossary for specific definitions.
“Transgender” is an umbrella term that encompasses multiple subgroups when referring to the community. When referring to a person or a group of people, transgender is an adjective. It is NOT a noun or a verb.
Correct: There is a transgender patient in exam room 6.
Incorrect: There are two transgenders out in the waiting room.
Correct: The transgender patient in the trauma bay is transitioning.
Incorrect: The patient in the trauma bay is transgndering from male to female.
The word is “transgender” NOT “transgendered” - there is no “ed” at the end!
(No one gets straightened, or gayed, or lesbianed. Transgender people do not get transgendered.)
Avoid using outdated language.

3. Ask appropriate questions in an appropriate manner at the appropriate time
It is always important to ensure questions are clinically relevant. When gathering a history or conducting a physical examination, the questions should relate the presenting complaint. Not all patients want to participate in educating the staff — avoid asking questions merely to satisfy curiosity due to a lack of exposure to LGBTQ patients.
When conducting a physical exam, ask the patient what terms they use to refer to their anatomy, and then use them.
Avoid asking a question in a manner that implies it is based on a myth or stereotype
Examples to avoid:
• “Are you pre-op or post-op?”
• “What is your sexual preference?”
• “When did you choose to be transgender/gay/lesbian/bisexual?”
• “Have you had ‘the surgery’?”
• “Which one of you is the wife/husband?”
(When speaking to a same-sex couple)
4. If you start a sentence with “I don’t mean any disrespect, but …” think twice before finishing.

The Bottom Line... As always, treat patients the way you would want yourself or your loved ones to be treated.

You will make mistakes
When you misgender someone or ask a question in a clumsy way (because you are human!):
• Apologize in a heartfelt, genuine manner
• Pay attention and do not make the same mistake twice
Sexual Orientation and Gender Identity (SOGI) Collection and the Electronic Medical Record
Paula M. Neira, JD, MSN, RN, CEN

Emergency nurses are committed to providing care to all patients in a safe, respectful, supportive environment focused on patient- and family-centered care.² Owing to the nature of our environment, we quickly have to establish patient-nurse trust to be able to deliver high quality care and contribute to our patient's long-term health.¹⁵ However, it is very difficult to deliver patient- and family-centered care if we do not know who our patients and their loved ones are because we did not bother to ask.

Historically, emergency departments (and health providers in general) have not asked patients about their sexual orientation or gender identity. Increasing the difficulty in obtaining this information is a long-standing and often well-founded fear by patients of discrimination that results when sexual orientation or gender identity information is shared. At least 33% of transgender individuals reported a negative experience when seeking healthcare.¹² However, the EQUALITY Study, which looked at the best methods to collect SOGI data in EDs, found a stunning mismatch of perspectives. Almost 78% of ED practitioners thought patients would be offended if asked about their sexual orientation, and around 80% thought patients would refuse to answer if asked. Yet almost 90% of patients would share the information about their sexual orientation if asked during an ED visit.¹⁶

Accordingly, we should be asking.

Sexual Orientation

SOGI information can be obtained as part of the registration process or by a clinician when conducting a health history. There are several ways to phrase the question about sexual orientation. You should use the one that is most inclusive and allows patients to describe their sexual orientation in their own language while also offering some options. Examples of how to phrase the question may include: “What is your sexual orientation?”, “How do you describe your sexual orientation?”, or “Regarding sexual orientation, do you describe yourself as [offer options]?”. Options can include straight/heterosexual, gay, lesbian, bisexual, pansexual, asexual, as well as a free text, decline to answer, and an “I don’t know” option.¹⁷

Gender Identity

The recommended manner to obtain gender identity information is to ask a two-step question.¹⁸ First, ask the patient in the most inclusive way about gender identity. Examples of how to ask this question are “What is your gender identity?”, “How would you describe your gender identity?”, or “Regarding your gender identity, do you describe yourself as [provide options]?”. Options can include female, male, transgender female, transgender male, genderqueer, non-binary, gender fluid, agender, as well as a free text, decline to answer, and an “I don’t know” option.¹⁸ Next, ask about the sex assigned at birth/sex listed on their original birth certificate. It is important to ask the second question to help identify transgender patients because some individuals who are living as their authentic selves may identify only as male or female rather than as transgender. In addition, to capture gender identity information fully, it is recommended to document chosen/preferred name and pronoun.¹⁸

Resources


Appendices

Terminology

Appendices
EMR challenges
Note that no electronic medical record system was originally designed with LGBTQ patients in mind. However, many systems have included upgrades to capture a chosen name, chosen pronoun, and SOGI information either in demographics or in the clinicians’ documentation as a form or part of a patient’s health history. Yet many issues remain when attempting to document or place orders within an electronic medical record. ED nurses should work with their informaticists to identify options within their setting’s EMR and advocate for changes to improve the ability to document LGBTQ patients. Some issues include:

- **Documenting chosen name/pronoun:** many systems still do not allow for easy documentation. In addition, many systems do not display the information for clinicians to view if it is present.

- **Gender marker restrictions on gender-specific labs:** it may not be possible to order a urine/serum pregnancy test through the lab-ordering interface in the EMR for a transgender male patient whose gender marker has been updated. Conversely, you may not be able to order a PSA level for a transgender female. You might have to order these on paper requisition forms/order slips.

- **Lab reference ranges:** most systems create references ranges based on the gender marker entered into the record. This marker often correlates to the sex assigned at birth or the gender marker on the patient’s identification documents. There is little research into the appropriate reference ranges for transgender patients.

- **Best practice advisories:** some of these advisories are also gender-specific and may be restricted based on the gender marker in the chart.

ED physical environment
Another essential aspect of creating a welcoming, safe, and supportive environment for LGBTQ patients is the physical space in which ED nurses deliver care. Administrators and staff should try to ensure that the optics and facilities of the ED are inclusive and that they send a clear message of acceptance and welcome.

**Signage/Waiting Area**
- Include signage or marketing materials that include visuals of LGBTQ patients and families
- Participate in Safe Zone training and post items that indicate support for the LGBTQ community
- If there are television screens in public areas, ensure that they are broadcasting neutral or non-offensive content. Some networks have a strong anti-LGBTQ reputation and, if on the waiting room television, send a negative message.
- Include LGBTQ-focused magazines or newspapers in the waiting areas
  - Many hospitals rely on donated reading material for waiting areas because of budgetary constraints. Nurses can help solicit donations from members of the local LGBTQ community or media. Often, LGBTQ local papers are free. Get the word out that such material is wanted and welcome.

**Bathrooms**
- Any single-stall bathroom in the ED should be labelled as gender-neutral
- If multi-stall bathrooms are present, there should be clear policy that individuals can use the bathroom aligned with their gender identity
- If another patient or visitor complains about a transgender person using a bathroom aligned with their gender identity, it is the person who is complaining who should be offered an alternative, not the transgender person
Room Assignments

- Ideally, transgender and gender-expansive patients should be assigned a private room if one is available.
- If a private room is not available, transgender patients should be assigned in accordance with their gender identity.

Security

- Any searches of patients and their belongings for safety and security should be conducted with professionalism, dignity, and respect for the patients and their belongings.
- Security personnel should be trained on interacting with the LGBTQ community. Part of that training should be awareness of personal items that transgender individuals may have to support their gender identity such as wigs, breast forms/padding, binders, or packers.
- Unless there are exigent circumstances, patients requiring a safety or security search should be asked if they have a preference as to the gender of the security officer carrying out the search. The request should be honored if feasible.
- As a default, the officer conducting the search should align with the patient’s gender identity.

Business Continuity

- While EMR issues are addressed elsewhere in the toolkit, administrators must address the challenges of ensuring paper forms, often used during periods when business continuity plans are enacted, are inclusive for LGBTQ patients.
  - Forms should avoid gendered terms (e.g., “mother/father”) and use gender-neutral language instead (e.g., “parents”).
  - Images used to document injuries/areas of pain should be gender neutral.
  - Include questions that collect sexual orientation and gender identity information with appropriate options that reflect maximum inclusivity.
  - Add options to list chosen name/pronouns beside just “name”.
  - Add options for gender beyond “male” or “female”.

Resources


LGBTQ-related Legal and Regulatory Requirements

Elizabeth Brennan, EdD, MSN, MEd, BS, RN, CEN

The care of LGBTQ patients and the patient care environment are directed by compliance with federal and state laws, adherence to regulatory agency regulations and requirements, established organizational policies, and professional quality care standards and guidelines.

While revisions are always possible, the following is a list of the primary laws, standards, guidelines, and organizational policies directing and supporting the care and environment of care for LGBTQ patients.

State Laws and Federal Laws

In 2012, California was the first state to ban the widespread insurance practice of exclusions for transition-related care. States have not been progressive in addressing the healthcare needs of LGBTQ and especially transgender people. The only states that ban insurance exclusion for transgender care and support state employees with inclusive transgender healthcare are California, Connecticut, Delaware, District of Columbia, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington. The other states that ban insurance exclusion are Colorado, Hawaii, Illinois, and Pennsylvania. In federal law, Section 1557 of the Affordable Care Act of 2010 overrides the lack of anti-discrimination LGBT state laws and offers protection for LGBTQ people who experience discrimination in healthcare. However, interpretation of these ACA protections may change if there is future determination by the Supreme Court that civil rights laws do not protect LGBTQ people from discrimination.
In the United States, there have been key federal laws that have addressed discrimination in the healthcare environment. From the Title VI of the Civil Rights Act of 1964 to the Affordable Care Act of 2010, these laws have addressed discrimination. The Joint Commission has provided an excellent resource regarding the history of these federal laws.24

The key federal laws that impact on LGBTQ care in the emergency department environment are:

**Emergency Medical Treatment and Labor Act (EMTALA)** requires that Medicare-participating hospitals with dedicated emergency departments provide a medical screening examination to any individual who comes to the emergency department requesting an examination. The emergency department is prohibited from refusing to examine and treat an individual with a medical condition or childbirth labor. This medical screening must be provided regardless of an individual’s ability to pay or insurance status.24

**Section 1557 of the Affordable Care Act (ACA) of 2010** provides that an individual shall not be excluded from participation, denied insurance benefits, or subjected to discrimination based on race, color, national origin, age, disability or sex, the latter including gender identity and sex stereotyping.23 This pertains to preventative, routine, and emergency care. This rule also protects gender nonconforming, non-binary, and inter-sex people from discrimination in healthcare.24 In June 2016, the Centers for Medicare and Medicaid further supported a nondiscrimination rule. These provisions also pertain to Medicare, Medicaid, Children’s Health Insurance (CHIP), and any state or federal Health Marketplace.

**Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990** were important for older LGBTQ patients and especially those patients with HIV/AIDS.24

**Health Insurance Portability and Accountability Act (HIPAA) of 1996** is a law supported by the U.S. Department of Health and Human Services that implemented privacy laws. This law addresses two significant issues: demographic information for sexual orientation and gender identity, and how that information is safeguarded.24 The role of the patient-designated healthcare representative was also defined in this law. This representative could be a close friend, relative, or any other person designated by the patient.24 This permits patients to select the individual who would represent them.

**The Centers for Medicare and Medicaid Services (CMS) Ensure Visitation Rights for All Patients as Patient Representatives** provides for visitation rights policies that support reasonable visiting policies and permits each patient to designate visitors (same-sex domestic partner, spouse, etc.). Unique healthcare situations involving the designation of a healthcare representative or healthcare power of attorney who may make medical decisions upon incapacitation of the patient, is also addressed. These decisions include medical decisions and end-of-life decisions. This patient designation of healthcare representative is protected by CMS for all patients and individuals. This supports the LGBTQ patient’s ability to select individuals who will support the patient’s living will or advance directive.25

**The Centers for Medicare and Medicaid Services: Same Sex Partners and Medicaid Liens, Transfer of Assets, and Estate Recovery** protects same-sex spouses from having their assets attached in providing care for the disabled or LGBTQ long-term care. Previously, the same sex spouse had not been protected.
Organizational Policies and Standards for LGBTQ Care

Federal and state laws, The Joint Commission, Office of Civil Rights (OCR), and U.S. Department of Health and Human Services (HHS) issue regulations that prohibit discrimination based on gender identity and gender expression. Policy recommendations involve:

1. Gender identity and gender expression anti-discrimination
2. Patient Bill of Rights
3. Access to hormone therapy
4. Protocols for interaction with transgender patients
5. Room assignments
6. Access to restrooms
7. Access to personal items that assist gender presentation
8. Admitting/registration records collection of gender identity data
9. Issuance coverage and benefits

An excellent resource for additional information and recommendations for healthcare organizations is provided by Lambda Legal.

Resources


Staff Training and Education

Elizabeth Brennan, EdD, MSN, MEd, BS, RN, CEN

The ED may be the first point of care for the LGBTQ patient, placing ED staff in a unique position to help decrease health disparities. Additional measures include training in sensitivity and cultural competency to improve communication and increase understanding. In competency training, a review of common health concerns of the transgender population would make the staff better able to anticipate potential health concerns.

Training specific to the LGBTQ population is offered by several nationally recognized health education centers on a range of LGBTQ topics: creating an affirmed environment; cultural competencies; LGBTQ terminology; behavioral healthcare; sexual and reproductive health; LGBTQ and transgender clinical care, including older adults, youth, and parents.

The online, easily accessible, and free LGBTQ health education centers that provide relevant and valuable education and resources for emergency department staff are:
1. **Fenway Health:**
   http://fenwayhealth.org/
   Fenway Health, based in Boston, MA, is a Federally Qualified Health Center, and one of the largest LGBTQ-focused health centers.

2. **Fenway Institute:**
   http://fenwayhealth.org/the-fenway-institute/
   The Fenway Institute at Fenway Health works to make life healthier for LGBTQ people and people living with HIV. The Fenway Institute focuses on research, training, education, and policy development.

3. **National LGBT Health Education Center:**
   https://www.lgbthealtheducation.org/
   The National LGBT Health Education Center is part of the Fenway Institute and provides educational programming and consultations for healthcare organizations with the goal of eliminating health disparities among LGBT people. Resources and training material include:
   - **Publications:** The topics include a glossary of LGBT terms for staff, creating an inclusive environment, clinical assessments of LGBT patients, best practices for affirmative care, and understanding the health needs of LGBT patients.
     https://www.lgbthealtheducation.org/lgbt-education/publications/
   - **Learning modules:** To access the free learning modules, you will have to register and log-in. Learning modules feature interactive presentations, slideshows, and evaluation surveys. The modules offer information and instruction on health equality, transgender health, LGBT youth, senior adults, and HIV screening, treatment, and prevention.
     https://www.lgbthealtheducation.org/lgbt-education/learning-modules/
   - **Webinars:** The free webinars are live and on-demand. The webinars are available on-demand within 48 hours. Topics include an introduction to LGBT health, LGBT health disparities and medical and clinical information, and social issues regarding LGBT health.
     https://www.lgbthealtheducation.org/lgbt-education/webinars/

4. **Human Rights Campaign:**
   https://www.hrc.org/
   The Human Rights Campaign is the largest non-profit national lesbian, gay, bisexual, transgender, and queer civil rights organization working to achieve LGBTQ equality.

5. **Health Equality Index** (Published by the Human Rights Campaign):
   https://www.hrc.org/hei
   In 2018, the Human Rights Campaign released the 11th edition of its annual Healthcare Equality Index which scores healthcare facilities on policies and practices dedicated to inclusive and equitable treatment of LGBTQ patients, visitors, and employees.

6. **Veterans Affairs Training Programs:**
   https://www.patientcare.va.gov/LGBT/LGBT_Veteran_Training.asp
   Veterans Affairs strives to provide information, guidance, and education to VHA providers about LGBT health issues, best practices, and creating an inclusive environment.

   The education programs include:
   - **Do Ask, Do Tell** series of internal presentations and external, on-demand presentations on transgender health
   - **LGBT Veteran Health Care Fact Sheets:** These are easy to read and provide information for the care of LGBT patients and their healthcare needs
     - Transgender male healthcare fact sheet:
     - Transgender female healthcare fact sheet:
     - Gay and bisexual male healthcare fact sheet:
     - Lesbian and bisexual female healthcare fact sheet:

   The training and education of ED frontline staff is important to create a patient care environment inclusive and welcoming, and to be able to provide the highest quality patient care. The online resources are free, comprehensive, and easily accessible for all staff members to improve their ability to provide quality care.
Defining Families

Emergency nurses have a commitment to provide a safe, compassionate environment for patients; however, care encompasses not only the patients, but their families as well. To build a trusting relationship, emergency nurses should recognize the diversity of modern families. Although families have always been as unique as their members, the definition of family has only quite recently become more expansive, both socially and legally. Currently, statistics show that 80% of households in the United States do not subscribe to the 1950s definition of family: mother, father, and children. Historically, the biological and legal bonds of the traditional nuclear family provided a sense of security when navigating the complex issues surrounding healthcare in the form of decisions and visitation. Because LGBTQ families were not recognized legally, many of these protections were denied.

Now that same-sex marriage is recognized across the United States, legal protection is more available to LGBTQ individuals and their loved ones. Further challenging the definition of family, LGBTQ communities, among others in non-traditional households, have accepted the concept of “chosen family.” A chosen family describes non-biological bonds formed exclusively through love, support, and circumstance. In recent studies, 42% of LGBTQ adults said that, even without legal provisions, they would rely on chosen family members over biological or legal family members, as opposed to 25% of the general population.
The following are some of the LGBTQ family structures that nurses in the emergency department might encounter:

- Same-sex spouses
- Unmarried partners
- Single parent or two same-sex parents raising children
  - Conception through donor
  - Surrogate
  - Joint parent adoption
  - Second parent adoption
  - Foster parenting
  - Stepparenting/blended families with children from previous relationships
  - De facto parenting – someone who has formed a parental bond by being a primary caregiver
  - Those with parentage judgments – full legal parentage ruled by a court
- Families with transgender or non-binary parents or children

The Joint Commission has urged hospital leadership to consolidate a comprehensive definition of family into new policies written to protect LGBTQ communities. The Joint Commission also urges policies to include any support member “who plays a significant role in the patient’s life in the form of spouses, domestic partners, significant others (of different sex and same sex), and other individuals not legally related to the patient.”

History Collection

It is well known that a thorough patient history assists medical providers to make decisions for individualized healthcare plans. Obtaining a complete biological and social history is important for patient- and family-centered care (see the SOGI collection section of this toolkit for obtaining inclusive patient information). When collecting a complete history, it is customary to obtain information on family structure and other support persons. There are many ways Emergency Departments can be inclusive of all types of familial structures; one way to do this is by changing to registration forms and language that do not exclude the LGBTQ community. The Gay & Lesbian Medical Association suggests using language of inclusivity (see Table 2).

Table 2

<table>
<thead>
<tr>
<th>Instead of:</th>
<th>Replace with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Partner or Significant Other</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Relationship Status:</td>
</tr>
<tr>
<td></td>
<td>- Single</td>
</tr>
<tr>
<td></td>
<td>- Married</td>
</tr>
<tr>
<td></td>
<td>- Domestic Partnership/Civil Union</td>
</tr>
<tr>
<td></td>
<td>- Partnered</td>
</tr>
<tr>
<td></td>
<td>- Involved with multiple partners</td>
</tr>
<tr>
<td></td>
<td>- Separated from spouse/partner</td>
</tr>
<tr>
<td></td>
<td>- Divorced/permanently separated from spouse/partner</td>
</tr>
<tr>
<td></td>
<td>- Other</td>
</tr>
<tr>
<td>Living Situation</td>
<td>Living Situation:</td>
</tr>
<tr>
<td></td>
<td>- Live alone</td>
</tr>
<tr>
<td></td>
<td>- Live with spouse or partner(s)</td>
</tr>
<tr>
<td></td>
<td>- Live with roommates</td>
</tr>
<tr>
<td></td>
<td>- Live with parents or other family members</td>
</tr>
<tr>
<td></td>
<td>- Other</td>
</tr>
<tr>
<td>Mother’s Name or Father’s Name</td>
<td>Parent(s) Name(s)</td>
</tr>
<tr>
<td>(of minor patients)</td>
<td></td>
</tr>
<tr>
<td>List of Mother/Father/Paternal/Maternal Grandparents in Biological Family History Conditions or Disease Processes</td>
<td>Emergency Departments can include a “Specify Who” instruction in the list of biological options.</td>
</tr>
</tbody>
</table>
Visitation Policies

In 2010–2011, President Obama wrote a presidential memorandum on hospital visitation rights, specifically acknowledging LGBTQ families and their loved ones. This memorandum elicited a response and revision of policies by the Centers for Medicare and Medicaid Services (CMS) as well as The Joint Commission. The policies “require covered facilities to not restrict, limit or deny visitation privileges based on sexual orientation or gender identity.” The policy changes the president put forth are regulated by Health and Human Services on a national level; however, some states have changed laws guaranteeing equal visitation specifically for LGBTQ family members.

Emergency Departments should have their visitation policies well documented and accessible to patients. One way to reduce anxiety when medical care is necessary is to communicate the Emergency Department’s (or the Hospital’s) equal visitation policy. The policy could be listed in several ways: online, on a patient’s bill of rights poster, in a brochure explaining LGBTQ advocacy given to patients during registration, on a placard in patient rooms, or posted in waiting rooms. Communicating an all-inclusive visitation stance is just as important as having the policy itself because it helps create a safe and trusting space for LGBTQ families.

Decision Making

If patients are no longer able to communicate because of a medical condition or traumatic event, it is important to determine if they have any medical directives. Medical directives will designate what healthcare professions should do in the event patients are incapable of voicing their desires. If medical wishes were not written, providers can turn to legal relatives to make these decisions for them. In some states, biological or legal bonds are necessary for a family member to express a patient’s wishes or make decisions of care based on knowledge of what the loved one wanted. Medical directives help ensure LGBTQ families continue their support at times when patients cannot voice their wishes. Two of the most well-known directives in healthcare are living wills and durable power of attorney for healthcare/proxy (see the legal section of this toolkit). Other directives an LGBTQ family might have in place are:

- Nomination of Guardian enabling a parent of a minor child who becomes unable to provide care to give custody to another adult (same-sex partner, different-sex partner, grandparent, aunt, uncle, etc.)
- Parenting Agreement determining the rights and responsibilities of each person sharing childrearing of a minor
- Authorization to Consent to Medical Treatment of a Minor Child giving permission for a child’s legal parent to designate someone other than a legal parent to make medical decisions for a minor (same-sex partner, different-sex partner, grandparent, aunt, uncle, etc.)

In any family, crisis can be difficult and stressful. Family members may feel ineffective, helpless, and scared. This can be especially true for LGBTQ families because parental and legal recognition laws can vary widely, leading to fear and vulnerability. The American Hospital Association (AHA) recommends raising awareness surrounding medical directives. In the words of the AHA, they “encourage everyone to talk with their family, their friends, their doctor. Know the options. Decide what’s right for you. And put it in writing.” Emergency department nurses can assist these families with education and guidance regarding medical directives and, at the very least, inquire if patients have these forms in place.
Section 2 | References


Health Disparities
A health disparity is defined as a type of health difference that is closely associated with social, economic, and/or environmental disadvantage. It is essential for emergency nurses to understand these disparities without assuming that LGBTQ patients have the same predisposition to health risks.

As Providers and emergency department nursing staff initiate their care for LGBTQ patients, a thorough physical assessment of the patients and their clinical needs will support the development of an appropriate ED plan of care and treatment. Those health disparities include:

- Higher rates of sexually transmitted diseases (syphilis, gonorrhea, human papillomavirus (HPV), genital herpes, and trichomonas)
- Lower rates of mammography and Papanicolaou (Pap) smear screening resulting in higher rates of cervical and breast cancer
- Higher rates of HIV and hepatitis (A, B, and C)
- Higher rates of substance abuse (alcohol and drugs)
- Higher rates of unhealthy weight control and eating disorders
- Higher rates of depression, anxiety, and suicide - especially among adolescents
- Higher rates of smoking
- Higher rates of violence, victimization, and intimate partner violence abuse

Recommended Health Tools, Screenings, and Diagnostic Tests
Based on patient interviews, evaluation of presenting symptoms, and discussion of medical and sexual history, the following laboratory tests and clinical screenings are recommended health tools for ED providers and nurses directing care of LGBTQ patients:

**Hepatitis A, B, and C Laboratory Tests**
Hepatitis types A, B, and C are viral infections that cause liver inflammation and damage. Chronic infections can lead to serious complications including cirrhosis and liver cancer. Gay, bisexual, or other men who have sex with men (MSM) have a higher incidence of contracting hepatitis A and B. While safe and effective vaccinations are available, many men have not been vaccinated. Hepatitis C is also a risk for gay, bisexual, and MSM if they are involved in high-risk behaviors, such as intravenous drug use and needle sharing. In the ED, it is important to screen for vaccination status and also promote vaccination against these serious and preventable diseases.

**Sexually Transmitted Disease (STD): HPV (Human Papillomavirus), Syphilis, Gonorrhea, Genital Herpes Evaluation and Tests**
Besides the presenting clinical symptoms, the patient’s sexual history and previous STDs are key for additional discussions with the patient and the ordering of diagnostic testing and treatments. Men who have sex with men account for 75% of primary and secondary syphilis infections and more than one third of gonorrhea infections. Rates of HPV-associated anal cancers among MSM are seventeen times that of heterosexual men.

**HIV Evaluation and Tests**
Higher rates of HIV are reported for MSM and transgender women. MSM account for more than two thirds of all people diagnosed with HIV each year. HIV is prevalent in 28% of transgender women. The CDC recommends that the use of antiretroviral treatment following sexual exposure to HIV must begin within 72 hours. The emergency department is often able to provide this service.
Mammograms, Papanicolaou, and Pregnancy Testing

While mammograms and Paps are not emergent tests, the information is valuable to include in patient discharge education or referrals for post-emergency-department care. Lesbian and bisexual women are less likely than heterosexual women to be screened for cervical and breast cancer, even though their risks are similar. Also, many transgender men retain a cervix and require cervical cancer screenings.

Mammography is recommended for male-to-female transgender patients over the age of 50 who have taken feminizing hormones for more than five years, and could be discussed and included in ED discharge instructions. Pregnancy testing should also be considered for female-to-male patients transitioning, and other considerations based on sexual history.

The standard review of systems and physical assessment have additional considerations for the LGBTQ patient.

Sexual Health History and Information

A routine sexual history should be obtained from all adolescent and adult patients, regardless of gender, race, ethnicity, socioeconomic status, sexual orientation, and gender identity. In an ED environment, sexual history interview and assessment often involves the presentation of symptoms of sexually transmitted disease (STD) or intimate sexual violence.

Regardless of sexual history, all patients should also be asked if they have any concerns about keeping themselves sexually safe and healthy. The CDC developed a simple categorization of sexual history questions based on “Five P’s” to help guide providers or other members of the clinical care team on which topics to cover:

- **Partners**: single or multiple partners - men, women, or both
- **Practices**: types of sexual practices
- **Protection from STDs**: current types of sexual protection used
- **Past protection** from STDs
- **Past history** of STDs

Some patients may not be comfortable talking about their sexual history, sex partners, or sexual practices. Try to put patients at ease and let them know that taking a sexual history is an important part of your medical exam and/or physical history. Recommended dialogue includes:

*I am going to ask you a few questions about your sexual health and sexual practices. I understand that these questions are very personal, but they are important for your overall health.*

Ordering diagnostic tests

An appropriate clinical patient exam and interview is important regarding gender-specific issues impacting clinical tests. The appropriateness of the interview and discussion with the ancillary departments (laboratory, radiology, and pharmacy) can assist in eliminating errors in results.

Gender-specific laboratory tests may also have discrepancies in their reference range. A major challenge for laboratory staff in reporting clinical laboratory or surgical pathology results for the transgender patient is the lack of a standardized definition of “normal” laboratory values for this population. Laboratory tests that have sex-specific reference ranges, such as tests for liver enzymes, creatinine, and hematocrit levels, are especially complicated to interpret.

Discussion between the ED providers and clinical lab pathologists regarding the transgender patient and possible discrepancies are important for safe care of LGBTQ patients.
Special Considerations for Additional Tests or Treatment

In the care of the ED patient, safety screenings conducted by trained staff could help identify at-risk patients that require additional resources or care. Hormone therapy can assist those transitioning or seeking to have an external appearance closer to that of their desired sex. On average, it takes 3–6 months to see any physical effects, with full effects taking up to 5 years. The purpose of hormone therapy is to suppress the existing secondary sexual characteristics and enhance the desired ones. There are several important clinical considerations when caring for patients receiving hormone therapy. Those participating in male-to-female transitions who are over 40 years old are at an increased risk for thromboembolism due to estrogen use. Estrogen also increases the risk of weight gain, hyperprolactinemia, cholelithiasis, cholecystectomy, and type 2 diabetes mellitus.

Individuals being treated for female-to-male transition may be prescribed spironolactone to reduce balding, which may put them at risk for hyperkalemia. Testosterone use may increase the risk of psychotic symptoms in individuals who are predisposed, and can contribute to acne, alopecia, weight gain, sleep apnea, and type 2 diabetes mellitus. Post-operative complications of gender-identity-confirming surgery may be a common presenting concern for transgender patients, with the issues to some extent depending on the direction of the transition. Complications include hemorrhage, necrosis, infection, pulmonary embolism, recto-vaginal fistula, prolapse, urethral strictures, nerve damage, and tissue loss. Tissue in these particular areas may be delicate, and excessive manipulation can cause additional damage to blood vessels, nerves, and tissue. Extra efforts should be made to help reduce stress and anxiety for the patient.¹

Intimate Partner Violence Screening

Sexual violence affects every demographic and every community, including the LGBTQ population. Lesbian, gay, and bisexual people experience sexual violence at similar or higher rates than heterosexuals.⁷ Nearly half of all transgender people and bisexual women will experience sexual violence at some point in their lifetimes.⁸ Due to the discrimination they often face surrounding their identities, LGBTQ survivors of sexual assault are often hesitant to seek help from police, hospitals, shelters or rape crisis centers - the very resources that are supposed to help them.⁸ Screening all patients for IPV in the ED promotes safety and gender inclusivity. A screening tool for intimate partner violence is available on the CDC website.⁹

Sexual Exploitation Assessment and Screening

Human trafficking is most prevalent among vulnerable populations, such as minors and runaways; lesbian, gay, bisexual, transgender, questioning or queer (LGBTQ); homeless youth; foreign nationals; and victims of domestic violence. Victims may present with traumatic injuries from sexual or physical assaults, sexually and non-sexually transmitted infections, pregnancy, and chronic pain, complications of substance abuse, malnutrition, and exhaustion. These patients may also present with depression, suicidal ideation and attempts, self-harm, and post-traumatic stress symptoms.¹⁰,¹¹

Emergency nurses are in a unique position to recognize and intervene on behalf of victims of human trafficking, a hard-to-reach population at risk for injuries similar to those of victims of domestic violence and sexual assault. Nurses are generally held in a position of trust and may often be the only individuals trafficking victims will confide in. However, detection of human trafficking among emergency professionals can be a factor when a victim does not disclose. In one study, 98 U.S.-born females who were sex trafficking survivors were interviewed, and it was found that 87.8% of them had encountered a healthcare professional during captivity without their plight being recognized. Of those surveyed, 63.3% were specifically seen in an emergency department. In a more recent study, 173 U.S. victims of human trafficking were surveyed—68% had presented to a healthcare provider at least once while being trafficked—most frequently to an emergency or urgent care provider.¹⁰
Suicide Screening
Suicide screening for ED patients is a targeted screening based on a behavioral health or psychiatric presentation. The vulnerable population of LGBTQ patients, both adult and youth, are at risk for anxiety, depression, and suicide ideation. Transgender people are more likely than the general population to experience discrimination in housing, employment, and healthcare. Many are verbally and physically victimized, starting at a young age. Abuse related to gender-minority status has a dose-response relationship with major depressive disorder and suicidality among transgender adolescents. Daily experiences of anti-transgender stigma, prejudice, and discrimination become internalized and ultimately affect psychological health. An estimated 40% of all transgender people have attempted suicide in their lifetimes.12 LGBTQ youth are also 2 to 3 times more likely to attempt suicide.13

Substance Abuse Screening
According to a 2015 Substance Abuse and Mental Health Services Administration survey,14 LGBTQ men and women across all age brackets were significantly more likely to have misused prescription pain relievers in the preceding year compared with heterosexual adults, and had almost three times greater risk of opioid use disorder compared with heterosexual adults. The higher prevalence of opioid use disorder among LGBTQ people can best be understood within the framework of minority stress. Starting at a young age, LGBTQ people live with everyday discrimination, marginalization, and victimization based on their status as a sexual and gender minority. The stress caused by such high levels of external stigma can disrupt an individual’s psychological processes, such as the ability to cope adaptively, regulate emotions, and achieve positive interpersonal relationships.

External stigma can become internalized, leading to identity concealment, self-hate, feelings of worthlessness, and fear of rejection. To escape or mute these challenging emotions, some LGBTQ people turn to opioids and other substances that provide a sense of euphoria or relief. These behavioral coping mechanisms can lead to worse mental and physical health outcomes, such as physiologic dependence and addiction; depression and other mental health disorders; and HIV and other sexually and intravenously transmitted infectious diseases.15

Obesity, Eating Disorders, and Body Dissatisfaction Screening
Lesbian and bisexual females are more likely to be overweight or obese.13 Eating disorders and body image disorders maybe be more common among gay and bisexual men. Plus, high school students who have same sex partners engage in unhealthy eating disorders more commonly than those with opposite sex partners.4

Disparities in body image, weight, and eating disorders among LGBTQ youth can best be understood within the framework of minority stress. This framework explains how daily experiences of stigma, discrimination, and victimization create stressors that significantly impact behavioral and physical health.

Schools present challenges for LGBTQ youth as well. Even though bullying is present among all school-age children, bullying and marginalization of LGBTQ youth are disproportionately greater. Gender-specific school restrooms can be a traumatic stressor for LGBTQ youth because they may experience harassment while using restrooms that align with their gender identity. Many LGBTQ youth will forego eating or drinking to avoid being tempted to use the restroom. The need to continuously manage these and other ongoing stressors can lead to the development of behavioral health issues, including non-adaptive coping behaviors like substance use, sexual risk-taking, disordered eating, weight, and shape control, and body dysmorphia.16

Discharge Teaching and Instructions
An important part of discharge instruction and teaching is providing information or access to information for follow-up care. There are websites that would direct the patients to educational resource information and future care.
Sexual Health Information

- HIV education/screening/prevention\(^1^7\)
- Getting tested for HIV, STD, and hepatitis\(^1^8\)
- Fact sheets for many STDs: bacterial vaginosis, chlamydia, gonorrhea, genital herpes, hepatitis A, B, and C, HIV, STD, HPV- Human Papillomavirus, PID - pelvic inflammatory disease, syphilis, and trichomonas\(^1^9\)
- National LGBT Health Education Center\(^2^0\)

Resources


Differential Diagnosis

Matthew Wall, BSN, RN, CPEN, NREMT-P

Understanding the healthcare needs of LGBTQ people is an important step to formulating an appropriate differential diagnosis in the emergency department. LGBTQ individuals experience a combination of societal, social, and physical stressors that create both risk factors and unique health disparities. The Office of Disease Prevention and Health Promotion has identified these LGBTQ health disparities in their national framework, Healthy People 2020, highlighting their significance in the role of LGBTQ health.\(^2^1\)

Caution should be used when developing a differential diagnosis. Ensure the diagnosis is based on evidence and not assumptions. It would be incorrect, for example, to assume an LGBTQ individual's depression is a direct result of sexual orientation simply because LGBTQ people have higher rates of depression.

Cancer

LGBTQ people suffer a disproportionate rate of cancer in the United States owing to poor prevention measures, healthcare avoidance, and other unique risk factors.\(^2^2\)

Additionally, the LGBTQ population suffers more late stage cancer diagnoses than the general population. As mentioned by the Office on Women’s Health,\(^2^3\) lesbians and bisexual women, for example, are less likely to get routine cancer screening such as Pap smears and mammograms, which leads to delayed cancer diagnoses. Lesbian and bisexual women experience higher rates of breast, lung, cervical, and endometrial cancer.\(^2^4\)

Within the LGBTQ community, barriers exist to openness and trust of the medical community due to a history of stigmatization and discrimination. Although progress has been made to rebuild this trust, the emergency department may be a place where LGBTQ individuals are more hesitant to open up about their sexuality and gender status. Knowing a health and sexual history can help guide treatment in the emergency department, possibly leading to earlier cancer diagnosis and treatment.

Human Papillomavirus (HPV)

According to the CDC,\(^2^5\) nearly all sexually active people who do not get the HPV vaccine will be infected with HPV at some point in their lives. Contracting HPV is concerning because it increases your cancer risk. In the United States, approximately 17,500 women and 9,300 men are affected by HPV-related cancers every year. Depending on the location of the infection, HPV can cause cervical, penile, anal, or throat cancer.\(^2^5\)

Men who have anal sex with men (MSM) are significantly more likely to contract anal HPV and develop anal cancer. For this reason, the CDC recommends that MSM, especially those under the age of 26, be vaccinated against HPV as a means of prevention. Anal cancer should be placed at a higher index of suspicion for MSM presenting with anal-related complaints. MSM can also be referred back to their primary care physicians to have an anal Pap smear, which can be used as a routine cancer-screening tool for this population.\(^2^5\)
Sexually Transmitted Diseases

The risk for gay and bisexual men of contracting a sexually transmitted disease (STD) is higher than for any other demographic. Many times, STDs have no symptoms and can be transmitted unknowingly by the carrier. Testing and prevention are crucial steps to break this chain. It is a misconception that lesbian and bisexual women are not at risk for contracting STDs. Body fluids containing the virus or bacteria can be exchanged by skin-to-skin and mouth-to-genital contact, putting women who have sex with women also at risk for STDs. STD testing should be offered to all members of the LGBTQ community.

It is common practice in most emergency departments to test for gonorrhea and chlamydia by a urine sample. For gay and bisexual men and any individual practicing anal or oral sex, this may be inadequate as it will not assess rectal or throat infections. Additionally, rates of shigellosis (Shigella infections) have been noted to be higher in gay and bisexual men than in the general population and should be considered as part of the standard battery testing for STDs.

HIV

The rate of HIV infection has decreased since the 1980s; however, the number of infected individuals remains high. According to the CDC, there were 39,782 new HIV infections reported in 2016, with gay and bisexual men accounting for 70% of new HIV infection in the United States. The threat of HIV and AIDS is still very real in America, and emergency departments are uniquely positioned to help stop the cycle of infection. It is estimated that 1 in 6 gay men living with HIV are unaware they have it, making HIV testing critical to preventing the spread of HIV.

Suicide

Mental health is a multi-faceted problem in the LGBTQ community with one of the most alarming issues being suicide. The two subpopulations most affected by suicide are LGB youth and transgender people. LGB youth are 3 to 4 times more likely to report a suicide attempt; 40% of transgender adults have reported a suicide attempt. Conducting suicide screening in the emergency department can help provide nick-of-time resources to patients in need. One study showed that 10% of suicide victims visited an emergency department within 6 weeks of their death, which shows the potential impact emergency department screening could have on preventing suicide for the LGBTQ community.

Hormone Therapy Risks

Transgender individuals may choose to begin hormone therapy to modify their secondary sexual characteristics to better match their gender identity. This has the positive effects of improving both quality of life and mental health. Hormone therapy does, however, have risks, and knowing these risks can be useful in the emergency department when caring for a transgender person (see Table 3).

Table 3

<table>
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<td>Estrogen</td>
<td>Venous thrombosis, pulmonary embolism, and cholelithiasis</td>
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<tr>
<td>Spironolactone</td>
<td>Hyperkalemia, renal insufficiency, and hypotension</td>
</tr>
<tr>
<td>Progestins</td>
<td>Coronary heart disease, stroke, pulmonary embolism, and breast cancer</td>
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Table 3. (Compiled with information from Dahl et al., 2006)
Section 3 | References


Legal Dimensions of Transition

Legal transition refers to the ability of transgender individuals to update their identification documents to reflect their chosen name and appropriate gender marker. Only 11% of transgender people have both their name and their gender marker updated on all of their documentation; 68% have none of their documents updated with their name and gender marker. When presenting identification that did not match, 52% of transgender people were victims of discrimination, including harassment, denial of service, expulsion from premises, or physical assault.¹ Some transgender people may update their name and/or gender marker on some documents but not on others because of legalities as well as insurance coverage concerns. A pragmatic issue concerning insurance is that the name and gender marker on the insurance card should match the name and gender marker contained somewhere in the chart. If not, a billing mismatch can occur, with insurance denial and the patient receiving a bill for services.²

Name Change

To update the name on identification documents such as birth certificates, driver’s licenses, passports, military identification cards, government-issued identification cards, and Social Security cards, transgender people generally must obtain a court order to do so. In most, but not all, jurisdictions, the procedures for updating one’s name are the same for both transgender and cisgender people.

As a rule, unless the name is being changed for the purpose of fraud or to avoid a legal obligation, name change requests are routinely granted by the courts. However, there have been cases where judges have refused to grant a request for a name change for transgender applicants because of bias. Of transgender people who have sought court orders, 88% have been successful.¹ Some of the barriers that transgender people encounter are prohibitively costly attorney, court, and publication fees as well as the bureaucratic process. In many jurisdictions, notice of a name change must be published in the local paper. Some transgender people may feel that to do so will place them at risk for violence or harassment. However, individuals can ask the court to waive the requirement (and save on the publication costs).

Gender Marker Change

The laws governing updating the gender marker on various identification documents vary greatly across the states and at the federal level. While some countries allow the gender marker to be changed simply by self-determination, the majority require some type of medical documentation. In the United States, some states require surgery and others simply an affidavit from a healthcare provider that the necessary care has been received and the gender marker should be updated.³
In most jurisdictions, updating the gender marker is still a binary process. Oregon, Washington, New York, California, and Washington, DC provide for a non-binary gender marker on documents such as a driver’s license. Maryland has also recently made this change. California, Oregon, and Washington allow a non-binary gender marker on a birth certificate. Globally, ten countries allow a non-binary gender marker on passports: Australia, Bangladesh, Canada, Denmark, Germany, India, Malta, Nepal, New Zealand, and Pakistan. The most common non-binary gender marker in use is “X” because it is recognized by the UN agency, the International Commercial Aviation Organization (ICAO), that establishes international travel documentation standards.

**Resources**

The National Center for Transgender Equality (NCTE) maintains a web page with U.S. state-specific information on the requirements for name and gender marker changes: https://transequality.org/documents

The Transgender Law Center maintains a state-specific list with information on updating the gender marker on birth certificates: https://transgenderlawcenter.org/resources/id/state-by-state-overview-changing-gender-markers-on-birth-certificates

The United States Department of State maintains guidance on updating passports: https://travel.state.gov/content/travel/en/passports/apply-renew-passport/gender.html


**Social Dimensions of Transition**

For transgender people, transitioning means going from living aligned with the sex assigned at birth to living aligned with their gender identity. Every person’s transition is unique, and there is no one way to transition. That said, most people will have several dimensions to their transition: social, legal, and medical. Arguably, while not every transgender person may seek to have their identification changed on legal documents (legal transition) or seek medical treatment (medical transition), everyone will have a social transition to some degree.

Social transition is that realignment of interactions with others in social situations to reflect one’s gender identity. Social transition generally entails a change in the social use of a chosen name and appropriate pronouns, a change in gender expression (haircuts, clothing styles, mannerisms, voice), and using gendered facilities that align with the new gender identity (restrooms and locker facilities). For many transgender people, social transition is the first step in their journey.

Transgender people undertake their social transition at varying rates based on their situation. Many will come out to family and close friends before coming out at school or work. Some may change their gender expression in private before venturing out publicly. Owing to fear of estrangement from family or friends, expulsion from social or faith groups, discrimination, harassment or violence, people may socially transition in some areas of their life while remaining closeted in others.

By the very nature of emergent illness or injury, transgender patients may present in the emergency department in a manner aligned with their gender identity but they may not be at the point where they are public about their social transition. They may be terrified about being outed. It is incumbent on emergency nurses to establish a safe environment and communicate clearly by their words and actions that they will maintain the patients’ privacy and the confidentiality of their information.
Medical Necessity and Standard of Care for Transition

Justin Milici, MSN, RN, CEN, CPEN, CCRN, TCRN, FAEN

Provision of consistent quality healthcare for patients going through transition includes a requirement for respect and compassion. Patients receiving hormone therapy or going through reassignment surgery may be at risk for additional complications related to acute illness or injury. Regardless of the situation, all patients are to be treated with dignity and respect.

Hormone Therapy

Patients are often on hormone therapy during or after transitioning to help promote male or female characteristics. The two most common hormones, estrogen and testosterone, can place patients at risk for complications, especially if the patient still has male or female reproductive organs. Common complications include:

**Estrogen**
- Non-reversible sterility
- Breast cancer
- Thromboembolic disease
- Gallstones
- Weight gain
- Hyperlipidemia

**Testosterone**
- Polycythemia
- Hypertension
- Cardiovascular disease
- Stroke
- Thromboembolic disease
- Sleep apnea

Other Medications

**Spironolactone (Aldactone)**
- Diuretic
- Used in transgender females
- Blocks testosterone
- Prevents hair loss
- Decreases male pattern body hair
- Induces breast development
- Prevents spontaneous erections

**Lupron**
- Used in young children
- Delays puberty
- Used until formal hormone therapy begins
- Breakthrough vaginal bleeding is common during the first 2 months of therapy
- Can cause decreased sexual drive and impotence

Resources


Section 4 | References


Pediatric and adolescent patients present a unique challenge to the emergency department nurse. In addition to having knowledge of anatomic, physiological, and developmental differences of the pediatric patient, the nurse must also consider the following:

• Effects of hormonal therapy (estrogen, testosterone)
• History of reassignment surgery
• Preferred pronouns

Pediatric and adolescent patients in the LGBTQ population are at an increased risk for discrimination, bullying, parental rejection, depression, and suicide.

According to the CDC’s 2017 “Youth Risk Behavior Surveillance” survey:³
Pediatric Transgender Patients
Matthew Wall, BSN, RN, CPEN, NREMT-P

Patient’s experience: I recently went to the Emergency Department because I was having pain with urination. The doctor quickly figured out that I had a sexually transmitted infection. The doctor was nice, but seemed in a hurry. He did a quick exam and asked if I was sexually active. I said, “Yes,” but I didn’t mention anything about being bisexual. I didn’t say anything about it because I wasn’t sure how the doctor would react and I felt uncomfortable bringing it up. I didn’t see any signs or rainbow stickers that would make me think this was a safe place. I know I’m at a higher risk for contracting HIV and I really wanted to know my status. I left without finding out. Maybe next time I’ll have the courage to speak up.

Early Concepts of Gender
Children begin to understand the concepts of gender from as young as 3 years of age, and gender roles begin to solidify for some children around 5 to 6 years of age. This means that some parents may notice their child expressing gender non-conforming behaviors from a young age. Healthy childhood development incorporates exploration of gender expression, which may see children acting outside of strict gender roles: for example, girls playing with trucks and boys playing with dolls. When children are consistent, insistent, and persistent about a gender identity different than the one matching their assigned sex at birth it may indicate a transgender identity.

The Power of Pronouns
Children who identify as transgender or are gender non-conforming may begin to dress in a way that matches their gender identity and go by a different name and pronouns. Using the child’s chosen name and pronouns can have a powerful influence on their mental health. A study in the Journal of Adolescent Health has shown that use of preferred names in transgender youth is linked to a significant reduction in depression, anxiety and suicide risk.

Puberty Blockers
As transgender children approach puberty, they may choose to take medications known as “puberty blockers” such as gonadotropin-releasing hormone (GnRH) agonists to stop the development of secondary sex characteristics. This medication may be an injection or implant. This is a reversible step that allows children to have more time to explore their gender identity. It is not until later in adolescence that hormones are considered as an option to affirm the child’s gender identity.

Family Support and Resources
Encouraging family support is critically important for transgender youth. Transgender youth who describe having strong parental support are 72% more likely to report overall life satisfaction and show a 93% decrease in suicide. If possible, incorporate family into the child’s plan of care and refer the family to providers that have experience with the transgender population.
Section 5 | References


According to the National Alliance on Mental Illness, individuals within the LGBTQ population are 3 times more likely than others to experience a behavioral health condition.¹ In addition, transgender youth are more likely to experience attention-deficit disorders, depression, and anxiety than their non-transgender counterparts.²

**Depression and Suicide**
- Individuals within the LGBTQ population are at a higher risk for depression and suicide, typically due to discrimination, prejudice, lack of peer support, and family rejection. “For LGBTQ people aged 10–24, suicide is one of the leading causes of death. LGBTQ youth and questioning youth are, respectively, 4 and 3 times more likely to attempt suicide, experience suicidal thoughts, or engage in self-harm than straight people. Between 38–65% of transgender individuals experience suicidal ideation.”¹

**Alcohol and Substance Abuse**
- The rate of substance and alcohol abuse is higher in the LGBTQ population than non-LGBTQ individuals because of prejudice, discrimination, lack of peer support, and family rejection. “An estimated 20–30% of LGBTQ people abuse substances, compared to about 9% of the general population.”¹ “25% of LGBT people abuse alcohol, compared to 5–10% of the general population.”¹

**Emergency Department Psychiatric Holds**
- Emergency departments are frequently challenged with increasing numbers of lengthy psychiatric holds. Long dwell times in the ED for LGBTQ patients with behavioral health issues can delay and affect the consistency of psychiatric care as well as increase existing stress and anxiety for the patient.

**Searching and Stripping Patients**
- Having to remove clothes and be physically searched by law enforcement officers can be a devastating and humiliating experience for the transgender individual. Strip searches are frequently performed on patients placed on emergency detention because of the risk of harm to themselves or others. In the transgender individual, devices such as a chest binder may be viewed as a ligature risk if the patient is suicidal.
Section 6 | References


Section 7 | Transgender Surgical Procedures and Post-Operative Complications
Meg Bergeson, DNP, ACNP-BC, FNP-BC

Types of Gender-Confirming/Affirming Surgeries

Male to Female (MtF) surgeries

Breast augmentation: Creation of larger breasts through saline or silicone implants. Complications of this surgery are typically skin infection, which can easily be handled with antibiotics. Deeper-seat surgical infections will most likely require implant removal and a return to the surgeon who placed the implant. Rupture after blunt trauma will also require removal of the implant.

Tracheal shave: Reduction of Adams’s apple. This is a procedure where some of the cartilage is removed from the neck region. Swelling may be noted for a few days after this procedure. Skin infections may occur, and oral antibiotics can be prescribed. Airway compromise is typically never an issue.

Vaginoplasty: The intended results are a natural appearing vagina with normal sensation and adequate depth for sexual intercourse. A penile inversion technique is employed. The testicles and the erectile tissue of the penis are removed. A vaginal space is created below the urethra (urinary tube). The clitoris is formed from the glans of the penis, keeping the nerves that supply it intact, thereby creating a sensate clitoris and labia. A small portion of scrotum is used to fashion the labia. Cotton packing is placed in the vagina at the end of the procedure. The stent stays in place for six days until it is removed for dilation. Rarely, the vaginal graft will expulse. If this occurs, it is best to notify the surgeon who performed the vaginoplasty. Occasionally, the native urethra will bleed post-surgery. The best method for tamponade is to place a size 18 French or greater Foley catheter in the urethra. If needed, a few size 3.0 monofilament synthetic absorbable sutures can be used to stop the bleeding around the urethra after the catheter has been placed.

Labiaplasty: This is to create thinner inner labia, to provide some hooding to the clitoris, and to improve the overall aesthetic result. Additional urethral revisions and other minor revisions to the vaginoplasty can be accomplished in this stage. Not all patients have this second procedure. Skin infections, swelling, and ecchymosis are sometimes seen in this surgery. Antibiotics can be used for soft tissue infection, and rest and ice are recommended.
Vaginal deepening/widening: A secondary attempt to create more depth and/or width through skin grafts. Bleeding and loss of skin graft may be seen with this surgery and it is best to call the surgeon with any issues.

Orchiectomy: Removal of testicles through a midline incision. This may be done to decrease the production of testosterone. Swelling and occasionally hematomas are seen. Ice and rest are recommended.

Body contouring:
- Liposuction
- Gluteal augmentation (buttock implants)
- Abdominoplasty (tummy tuck)

Facial feminization: Below are the multiple facial procedures a patient may undergo. Any of these may give rise to soft tissue swelling that typically does not pose a problem. Soft tissue infection is rare.
- Brow contouring ( forehead feminization)
- Scalp advancement (hairline advancement)
- Genioplasty (chin augmentation or contouring)
- Rhinoplasty (nose feminization)
- Mandibular contouring (jaw contouring)
- Cheek lift with/without implants
- Facelift
- Blepharoplasty (eyelid correction)

Female to Male (FtM) surgeries

Metoidioplasty: The procedure results in a normal appearing but very small penis. The suspensory ligament is released to allow more functional length, and the labial ligaments are divided to allow the penis to come forward for unrestricted natural erections. The skin surrounding the shaft and glans is elevated and wrapped around the shaft of the penis, and the ligaments and dorsal suspensory tissue is used to thicken up the shaft of the penis. Bleeding, swelling, and soft tissue infections may be seen in these surgeries.

Urethral lengthening: A urethral lengthening involves the formation of an extended urethra through the neophallus to allow the patient to stand to urinate. A primary urethral lengthening is done with a metoidioplasty (or pre-meta preparation for a phalloplasty) and an extended radial forearm urethral lengthening can be done after a phalloplasty. In most cases, a patient will have a suprapubic Foley catheter to drain the bladder and a urethral Foley catheter to stent the extended urethra. It is important to ensure that the suprapubic catheter is draining so there is no backflow or pressure on the bladder. Urinary tract infections may occur, and some hematuria is not uncommon in the beginning.

Phalloplasty

Pedicle groin flap: The creation of a phallus using skin harvested from either flank area and forming a tube that is slowly released from the patient’s body. This is a staged procedure that creates a penis of adequate size but without erogenous sensation.

Radial forearm free flap: The creation of a phallus using skin, nerves, and vessels from the forearm. This is a microsurgical procedure that creates a sensate penis of adequate size for intercourse. With these procedures, patients typically stay in the town where the surgeon operates for an extended period of time to ensure there are no complications. Any concerns should be called to the operating physician.

Scrotoplasty with or with implants: Creation of a scrotum followed by possible placement of tissue expanders and then permanent testicular implants. Tissue expanders may get infected and need to come out, necessitating a call to the provider. On occasion, the scrotum (formed from the labia) may open up and the testicular implant can extrude. It is best to remove the implant and let the area close up until another implant can be placed.

Erectile device placement: For functional sexual intercourse. These devices can become infected. Most are MRI compatible.

Resources

University of California San Francisco, Center of Excellence for Transgender Health. [http://transhealth.ucsf.edu/](http://transhealth.ucsf.edu/)


Case Study 1

A 23-year-old male is brought into the ED by EMS following an aggravated assault. The patient is quiet and appears withdrawn. Multiple abrasions are noted to his face and left arm. His left orbital area appears swollen. The patient is taken to one of the trauma bays.

The patient reports that he was at a club with his friends and was attacked by two men when he left. The patient states the two men were shouting “faggot” and other cuss words during the attack, and were threatening his life. The patient appears scared and teary-eyed during the assessment.

- What is the nurse’s first priority?
  - Stabilization of the patient’s airway, breathing, and circulation is always the first priority for any patient
  - Continuous psychosocial support during this time is crucial in this situation
- Based on the information given, would it be appropriate to ask the patient what his sexual orientation is? Is that information needed at this time?
  - Information about sexual orientation is probably not needed for this patient’s immediate medical needs. However, this information may be necessary to address his psychosocial needs, both presently and long-term.

The patient tells the nurse he is gay and has a boyfriend who is in the waiting room. He asks if his boyfriend can come back to the treatment area to see him.

- Should the nurse inquire further about the patient’s sexual orientation at this time? Would it be appropriate for the boyfriend to come and see the patient?
  - Unless the information regarding sexual orientation is going to impact the patient’s care, further inquiry is not needed at this time. Once the patient is stabilized, it would be very appropriate to have the boyfriend come back and see the patient. Patient privacy should be respected and maintained.

Case Study 2

A 19-year-old transgender male presents to the ED with a chief complaint of right lower quadrant abdominal pain for the past several hours. During the triage assessment, the nurse notes that the patient’s electronic medical record indicates two prior ED visits under a different name and gender. The patient reports that he is currently in the process of legally changing his name, but nothing has been finalized.

- How should the nurse proceed?
  - The nurse should ask the patient how he wants to be addressed and what pronouns to use
  - The nurse should explain to the patient that for legal purposes and his own safety, his legal name (or that on his insurance card/ID/medical record) and date of birth will be used prior to any diagnostic testing, procedures, or consents since his name has not yet legally changed.
A urine pregnancy test is ordered. When the nurse explains to the patient why a urine sample is needed, the patient states, “Why? I am obviously not pregnant.”

- What would be the nurse’s best course of action?
  - During the assessment, the nurse should ask the patient if he still has female parts (uterus, fallopian tubes, ovaries) that may be the cause of his abdominal pain. The nurse should further explain that until the parts are removed, pregnancy can still occur.

Case Study 3

A 17-year-old transgender female presents to the ED with her mother. The patient is noted to be limping and states she twisted her left ankle while playing basketball.

**Patient’s Experience**

I went out on a date with someone I recently met. She invited me over to her place for dinner. Normally, I wouldn’t go to someone’s home on the first date, but we had been talking on the phone over the course of a few months and I felt completely safe. Once there, we had dinner and two drinks, tops. The events become blurry. All I know is I woke up in her bed without my clothes, unable to recall anything after the second drink, anything at all. I lay there wondering what happened. I stood up to walk to the bathroom and my legs would not support me. I was unable to walk and I became terrified. After a few nerve-wracking hours, I was able to drive, still unable to recall events. I made it to the nearest Emergency Department. I was ashamed and completely alone. Had I drunk that much? Why had this happened? I had never felt this way before.

When I spoke to the nurse at the front, I told her that I thought I had been drugged and sexually assaulted and needed to be seen. The nurse asked if I knew “him.” When I explained that it was a woman, she stopped writing, looked at me and asked, “Why would a woman sexually assault you? How would that even work?” After she took my blood pressure and temperature, she told me to go back to the waiting room. I sat there for a few minutes before I walked out the door. I was never seen or treated for the event. I felt like it was my fault. I still hold shame, and now I will never have the answers to my questions.

– Kelly S.
Appendix A | Gender Pronouns

It is always a good idea to ask the patient what pronouns they use and then follow their lead. Many transgender people who identify as non-binary (and may use self-identification terms such as non-binary, genderqueer, or two-spirit, among others) may use gender neutral pronouns. Some examples (not exhaustive) are:

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Reference:
Appendix B | Fact Sheets

Affordable Care Act Fact Sheet
https://transgenderlawcenter.org/resources/health/aca-fact-sheet

Frequently Asked Questions: Lesbian and Bisexual Health

Intersex Fact Sheet

Sexually Transmitted Diseases (STDs) Fact Sheets
https://www.cdc.gov/std/healthcomm/fact_sheets.htm

Veteran’s Affairs Fact Sheets
• VA Health Care for Transgender Men
• VA Health Care for Transgender Women
• VA Health Care for Gay and Bisexual Men
• VA Health Care for Lesbian and Bisexual Women

Viral Hepatitis: Information for Gay and Bisexual Men Fact Sheet
https://www.cdc.gov/hepatitis/Populations/PDFs/HepGay-FactSheet.pdf

LGBTQ Family Fact Sheet
https://www2.census.gov/cac/nac/meetings/2017-11/LGBTQ-families-factsheet.pdf

Non-binary Gender Identities Fact Sheet

Mental Health and the LGBTQ Community Fact Sheet
Appendix C | Resources

Family Equality Council
https://www.familyequality.org

Fenway Health
http://fenwayhealth.org/

Fenway Institute
http://fenwayhealth.org/the-fenway-institute

Gay and Lesbian Alliance Against Defamation (GLAAD)
https://www.glaad.org/

Human Rights Campaign
https://www.hrc.org/

Lambda Legal
https://www.lambdalegal.org/

National Center for Transgender Equality
https://transequality.org/

National LGBT Health Education Center
https://www.lgbthealtheducation.org/

The Transgender Law Center
https://transgenderlawcenter.org/

Veterans Affairs Training Programs
https://www.patientcare.va.gov/LGBT/index.asp
Appendix D | LGBTQ Research

LGBTQ-related Studies Referenced in this Toolkit


Appendix E | LGBTQ Community Resource Template

This template (next page) allows emergency departments to note LGBTQ resources established in the community. Connecting patients to these resources can be a critical step in the process of getting them the support they need.

Attempt to incorporate each member of the LGBTQ community, rather than just one sub-group, when determining which local resources should be included. You may not have local resources for each of the sections, which is OK. The resources should grow and be updated over time.
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