What do physicians need to know about their patients? And, once they receive medical and other pertinent information about patients, how should those facts be interpreted to provide the best possible care?

The answers to these questions, according to the expert panelists in a recent education session, very much depend on particular factors shaping a patients’ life, including gender, gender identity, race, ethnic background, sexual orientation and economic class.

Physicians should explore how all of these variables work together as social determinants of health to optimally meet patients’ needs, the panelists concurred. That, they said, is what physicians should understand as intersectionality: the various overlapping and interdependent identities of people who have been historically oppressed and marginalized.

“To be intersectional, you have to be comprehensive and interdisciplinary,” said panelist David Ernesto Munar, president and CEO of Howard Brown Health, a leading provider of health care for Chicago’s LGBTQ community.

Munar was one of several experts to speak during “Health equity and the intersectionality of LBTQ and minority health,” an education session at the 2017 AMA Annual Meeting. The session was co-sponsored by the AMA’s Advisory Committee on LGBTQ Issues, Minority Affairs Section and the Medical Student Section’s Minority Issues Committee.

That means, for instance, delving beneath the surface to see how race, economic circumstances and gender identity have played a role in shaping patients’ health. Have they been able to afford basic care for themselves or their children? Affordability aside, have patients resisted coming in for regular check-ups because they they feared discrimination based on their race or gender identity, or because they have experienced overt prejudice?

These are not hypothetical questions, said panelist Kim Hunt, executive director of Pride Action
Tank, a project of the AIDS Foundation of Chicago that focuses on improving outcomes for the LGBTQ community. She spoke of a lesbian patient who was told by a health professional that she did not have to worry about taking precautions as a sexually active adult because “lesbian sex is not real sex.” Feeling diminished and misunderstood, the patient did not return for needed follow-up treatment, Hunt noted.

This is particularly dangerous, panelists agreed, because lesbians suffer from a higher rate of gynecologic cancer than women as a whole. Experts agree that one of the causes is the misapprehension that women who do not engage in heterosexual intercourse do not need cervical cancer screening.

In an even more egregious case that Hunt shared, a patient identifying as a transgender woman was contradicted by both her physician and nurse, who refused to acknowledge her gender identity. In anger, the nurse lifted the patient’s gown, groped her genitalia and then checked off “male” on the patient’s medical record form.

It is unsurprising, Hunt said, that one-third of transgender patients report having been subjected to overt discrimination in health care settings.

Psychiatrist Frank A. Clark, MD, chair of the Minority Affairs Section Governing Council, moderated the second part of the session. He noted that such prejudice has had an impact on the life expectancies of LGBTQ individuals, as indicated in a June 2013 study in *Social Science & Medicine*.

What, then, can physicians do to enhance care for LGBTQ patients, particularly those who, in addition to having suffered discrimination because of their sexual orientation or gender identity, have also experienced prejudice due to their race, economic class, religion, national heritage or ethnic background? Among the many recommendations the panelists offered were these.

**Examine biases.** The point is not to be bias-free, but to be aware of your prejudices and keep them in check so that patient care is not compromised. That includes sensitivity to body language and facial expressions, which can indicate either a receptiveness to patients’ concerns (eye contact and a nodding of your head) or a fear or lack of interest in them (crossed arms and lack of smile).

**Avoid assumptions about patients’ interests.** Munar of Howard Brown spoke of a health workshop designed for transgender women of color. What the workshop’s participants wanted to talk about—“getting out of sex work and staying safe on the street,” he said—were not “the things we wanted them to think about.”
Be sensitive to context when offering advice. Panelist Maxx Boykin, the community advocacy and social justice manager at AIDS Foundation of Chicago, noted that saying, “You have to eat better,” to a patient at risk for hunger is ineffectual and insensitive.

Keep in mind how social and psychological well-being affect physical health. It is with this notion in mind, said panelist Abbas Hyderi, MD, MPH, associate professor of clinical medicine at the University of Illinois College of Medicine at Chicago, that his school has undertaken a sweeping transformation of its curriculum. The changes will enable students to learn about the ways in which structural determinants of health—poverty, race, discrimination and community problems such as drugs and violence affect patients at the most basic level.

Advocate on behalf of patients and communities. As respected members of the community, physicians are in a powerful position to influence others and shape policy. “Be deft and tactful” in challenging statements that might be off the mark, said Dr. Hyderi.

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