The Joint Commission

This example is part of a series that illustrate encounters of implicit bias, health inequity, and disparity in the provision of health care.

Case Example #6 — Part 1
Call me by my name: A case of transgender health inequity

See added safety strategies on page 2

CASE EXAMPLE

A transgender woman arrived at a hospital's emergency department with complaints of acute abdominal pain and nausea. At first reluctant to seek health care for fear of discrimination, the pain increased throughout the day and she was no longer able to delay care. At the ED's reception, she underwent the triage process where others in the waiting area could hear.

After an hour of waiting, she was escorted to a patient room to be seen by a physician. The physician entered the room and began to discuss her condition and initiate the exam. As the physician began to palpate the abdomen, the patient disclosed her status as a transgender woman as she wanted there to be no confusion as to the configuration of her reproductive organs. There was a pause and the physician asked, "So, you're genetically male, then?" The patient replied affirmatively to which the physician stated in a tone of surprise, "Oh, you look like a woman," and then asked whether she was going to pursue surgery.

The physician completed the physical examination and went to the computer station to enter information into the electronic medical record and remarked that the EMR stated the patient was female. With a growing sense of discomfort, the patient replied, "Yes, my legal sex is female." After further documentation, the physician communicated the need for a bedside ultrasound and left the room momentarily. Upon return, the physician was accompanied by additional health care providers ostensibly for training purposes around transgender patients, disempowering the patient and increasing her unease.

The abdominal ultrasound was performed, and a CT was indicated. As the patient awaited her CT scan, she noticed her patient information wristband read "male" – a change in medical record information from the initial ED assessment. The physician had altered the medical record to reflect the patient's sex assigned at birth rather than the sex listed on her insurance and legal documents. This change to the medical record affected her subsequent patient encounters. She was referred to other providers for follow-up care, and staff who called to set up appointments misgendered her by using the term "Mr." Until the record could be corrected, she was forced to discuss her transgender status in each interaction when such discussion would otherwise not be necessary.

Having experienced discrimination in the past, the exposed area and public process of triage generated feelings of embarrassment and fear of being outed, stigmatized, and mistreated.

Transgender individuals can experience specific health inequities of stigma, discrimination, and denial of care in addition to other intersectional social, economic, and political disparities.[1,2,9] This includes within health care settings.

Transgender patients have reported experiencing and observing both passive and active discrimination, leading to mistrust and avoidance of health care, which can further the gap in disparity and health outcomes.[3,6]

Implicit bias and cultural incompetence led to the insensitive and gratuitous inclusion of others without first asking the patient.

Transgender patients have reported health care encounters in which other unnecessary health care staff were present out of curiosity or novelty of the situation. Such experiences can embarrass, alienate, and disempower the patient leading to further mistrust.[3,7,8,13]

The provider's lack of experience, knowledge and cultural competence regarding gender identity and transgender health resulted in harmful and unnecessary questions that were not medically relevant to the patient's chief complaint.

Stigmatization, scarcity in trans-competent providers, and discrimination are prominent barriers to transgender patients receiving quality care, which can result in avoidance and/or delay in seeking care.[4,6]

The EMR system was designed such that the patient's birth sex and legal gender must align for the chart to be closed. Providers would change the field to match – misgendering the patient as male. The EMR also lacked the capacity to enter the name and pronouns used by the patient, requiring the patient to reassert her gender and name until the record could be corrected. This structural disconnect led to further mistrust and loss of confidence in the ability to receive patient-centered, quality care.

Inconsistencies in how to include structured collection of sexual orientation and gender identity (SOGI) data within electronic health systems has led to transgender patient experiences rife with uncoordinated documentation and reiterative questioning. Using a name or pronoun that is not the patient's preference or does not match the patient's current identity can be hurtful, stigmatizing and generate a hostile patient experience that can lead to a patient's distrust and avoidance in seeking future care.[7,9,13]

Accurately documenting both current gender identity and assigned sex at birth is critical to the support of clinical processes and understanding of a patient's unique health needs, as well as enhancing meaningful dialogue between provider and patient.[6,7]

Disclaimer: This case example is aggregated and is not representative of a single report or incident. Any likeness to an actual event is purely coincidental.

The Joint Commission

This example is part of a series that illustrate encounters of implicit bias, health inequity, and disparity in the provision of health care.

A look at safety strategies

Case Example #6 — Part 2
Safety Strategies
Call me by my name: A case of transgender health inequity

SAFETY STRATEGIES

A transgender woman arrived at a hospital's emergency department with complaints of acute abdominal pain and nausea. At first reluctant to seek health care for fear of discrimination, the pain increased throughout the day and she was no longer able to delay care. At the ED's reception, she underwent the triage process where others in the waiting area could hear.

After an hour of waiting, she was escorted to a patient room to be seen by a physician. The physician entered the room and began to discuss her condition and initiate the exam. As the physician began to palpate the abdomen, the patient disclosed her status as a transgender woman as she wanted there to be no confusion as to the configuration of her reproductive organs. There was a pause and the physician asked, "So, you're genetically male, then?" The patient replied affirmatively to which the physician stated in a tone of surprise, "Oh, you look like a woman," and then asked whether she was going to pursue surgery.

The physician completed the physical examination and went to the computer station to enter information into the electronic medical record and remarked that the EMR stated the patient was female. With a growing sense of discomfort, the patient replied, "Yes, my legal sex is female." After further documentation, the physician communicated the need for a bedside ultrasound and left the room momentarily. Upon return, the physician was accompanied by additional health care providers ostensibly for training purposes around transgender patients, disempowering the patient and increasing her unease.

The abdominal ultrasound was performed, and a CT was indicated. As the patient awaited her CT scan, she noticed her patient information wristband read "male" – a change in medical record information from the initial ED assessment. The physician had altered the medical record to reflect the patient's sex assigned at birth rather than the sex listed on her insurance and legal documents. This change to the medical record affected her subsequent patient encounters. She was referred to other providers for follow-up care, and staff who called to set up appointments misgendered her by using the term "Mr." Until the record could be corrected, she was forced to discuss her transgender status in each interaction when such discussion would otherwise not be necessary.

The organization performed a self-assessment to understand existing barriers to the access, provision of care, and treatment of transgender patients.[9]

The ED incorporated LGBT-affirming signs and stickers to make the waiting room more welcoming and communicate inclusivity. It established a more private area at the triage desk, developed a workflow for how and when to capture SOGI data, and incorporated tools to facilitate a patient's self-reporting of sensitive information.[3,4,6,7,9,11,13]

The organization established an advisory group focused on LGBT health care and disparities and included members from the community. It embarked on revising policies to ensure equitable, patient-centered care for LGBT patients, as well as policies addressing discrimination and inappropriate conduct.[7,9]

The organization instituted mandatory cultural competence training annually for staff and providers. The training includes content on health disparities, terminology, implicit bias awareness, and cultural competency skills regarding the transgender and LGBT community. Staff were trained in perspective taking and interacting with LGBT patients in a culturally responsive, respectful, and affirming manner.[5,6,7,8,9,10]

An IT workgroup identified a means to support a two-step process for capturing sex at birth as well as current gender identity within the EHR.[1,6,7,10,12] This facilitated more accurate collection, capture, and reporting of SOGI data within the EHR to facilitate clinical decision-making and communication specific to a patient's unique health care needs. It also enabled printing of wristband labels with the name the patient uses and current gender identity.[3,7]

The IT workgroup standardized the interface display with inclusion of one's legal name and name and pronouns used by the patient within the EHR. It also ensured this can be viewed throughout the EHR system, helping to minimize misgendering a patient and repeated questioning.

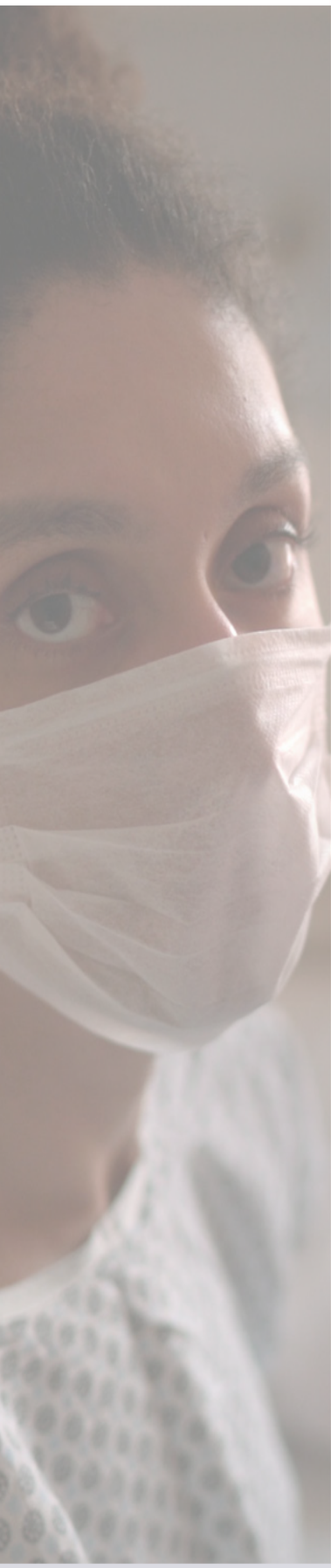
LGBT-specific questions were added to patient experience surveys to obtain feedback on areas of exemplary service as well as opportunities for improvement.[7,9]

Disclaimer: This case example is aggregated and is not representative of a single report or incident. Any likeness to an actual event is purely coincidental.

The Joint Commission

Case Example #6 — Resources

Call me by my name: A case of transgender health inequity



RESOURCES

1. Reisner SL, Poteat T, Keatley J, et al. Global Health Burden and Needs of Transgender Populations: A Review. *Lancet*. 2016;388(10042):412-436. doi:10.1016/S0140-6736(16)00684-X
2. Teti M, Kerr S, Bauerband LA, et al. A Qualitative Scoping Review of Transgender and Gender Non-conforming People's Physical Healthcare Experiences and Needs. *Front Public Health*. 2021;9:598455. doi:10.3389/fpubh.2021.598455
3. Samuels EA, Tape C, Garber N, et al. "Sometimes You Feel Like the Freak Show": A Qualitative Assessment of Emergency Care Experiences Among Transgender and Gender-Nonconforming Patients. *Annals of Emergency Medicine*. 2018;71(2):170-182.e1. doi:10.1016/j.annemergmed.2017.05.002
4. Zatloff JP, von Esenwein SA, Cook SC, et al. Transgender-Competent Health Care: Lessons from the Community. *Southern Medical Journal*. 2021;114(6):334-338. doi:10.14423/SMJ.0000000000001261
5. Furness BW, Goldhammer H, Montalvo W, et al. Transforming Primary Care for Lesbian, Gay, Bisexual, and Transgender People: A Collaborative Quality Improvement Initiative. *Annals of Family Medicine*. 2020;18(4):292-302. doi:10.1370/afm.2542
6. Ding JM, Ehrenfeld JM, Edmiston EK, et al. A Model for Improving Health Care Quality for Transgender and Gender Nonconforming Patients. *Joint Commission Journal on Quality and Patient Safety*. 2020;46(1):37-43. doi:10.1016/j.jcjq.2019.09.005
7. Do Ask, Do Tell: A Toolkit for Collecting Sexual Orientation and Gender Identity Information in Clinical Settings. Toolkit was created by Sean Cahill, PhD, Director of Health Policy Research at The Fenway Institute; Kellan Baker, MPH, MA, Senior Fellow at the Center for American Progress; and Harvey Makadon, MD, Director of Education and Training at The Fenway Institute and Professor of Medicine at Harvard Medical School.
8. Morris M, Cooper RL, Ramesh A, et al. Training to Reduce LGBTQ-Related Bias Among Medical, Nursing, and Dental Students and Providers: A Systematic Review. *BMC Medical Education*. 2019;19(1):325. Published 2019 Aug. 30. doi:10.1186/s12909-019-1727-3
9. The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. Oak Brook, IL, Oct. 2011.
10. Healthy People 2020. Lesbian, Gay, Bisexual, and Transgender Health.
11. Blagev DP, Barton N, Grissom CK, et al. On the Journey Toward Health Equity: Data, Culture Change, and the First Step. *NEJM Catalyst* – Innovations in Care Delivery. 2021; 07. doi.org/10.1056/CAT.21.0118
12. Rosendale N, Fishman A, Goldman S, et al. Systematic Collection of Sexual Orientation and Gender Identity in a Public Health System: The San Francisco Health Network SO/GI Systems-Change Initiative. *Joint Commission Journal on Quality and Patient Safety*. 2020;46(10):549-557. doi:10.1016/j.jcjq.2020.02.008
13. National LGBT Health Education Center. Ready, Set, Go! A Guide for Collecting Data on Sexual Orientation and Gender Identity. Updated 2020.

August 2021