

LETTERS

IMPORTANT CONSIDERATIONS FOR ADDRESSING LGBT HEALTH CARE COMPETENCY

Many lesbian, gay, bisexual, or transgender (LGBT) patients have difficulty identifying physicians that understand their unique health needs, and the recent article by Khalili et al.¹ emphasizes how health care institutions exacerbate this problem. The authors report that few US academic health centers have procedures or policies to refer to, identify, or list LGBT-competent physicians. Furthermore, few institutions offer comprehensive LGBT competency training.¹ While these provisions are important to optimizing LGBT patient care, they also reveal several problems about the general nature of such measures.

Physician self-identification as LGBT-competent is a thematic problem in the few institutions that have referral lists. Not every patient will feel comfortable with every provider, so LGBT patients may feel that their options are limited to the provider list, which could paradoxically further restrict patient access. More importantly, however, the lists of these self-identified physicians are often problematic considering that they do not use

objective methods to verify competency in treating LGBT patients. Instead, local LGBT patient communities have longstanding word-of-mouth referral networks, particularly among the transgender population, to facilitate health care access by capitalizing on existing community knowledge.

These issues stress the need for comprehensive training programs to ensure and verify competency, but the programs that do exist across academic medicine today contain inconsistent content and implementation procedures. Moreover, while training programs are titled LGBT, this umbrella term often ignores the unique health differences of each individual group, despite the numerous, published guidelines on LGBT health to help standardize education for medical students and professionals.²⁻⁵ However, while these guidelines provide content consistency to new and existing training programs, they do nothing to promote their implementation; thus, we propose a call for the establishment of national standards for all health care professionals around LGBT health in their continuing education.

Finally, while some providers may be LGBT friendly, they might not be knowledgeable of the specific health needs of LGBT patients, further emphasizing the need for competency. Thankfully, more US academic health centers have implemented LGBT competency trainings⁶ since Khalili et al.'s initial 2012 survey. In fact, we expect that a follow-up survey performed today would likely find increased numbers. However, the aforementioned problems still remain. While the current proceedings are necessary for now, they are not sufficient. Future endeavors should focus on highlighting identity group differences as well as other intersecting identities (e.g., gender expression, race, and socioeconomic status) that contribute to health care access. ■

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This letter was accepted August 7, 2015.
doi:10.2105/AJPH.2015.302864

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J. T. Jann contributed to the conceptualization and design of the work, and drafted and revised the letter. E. K. Edmiston and J. M. Ehrenfeld contributed to the conceptualization and design of the work, reviewed the draft article, and provided revisions. All of the authors approved the final article for publication.

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