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CORRIGENDUM

Corrigendum to: Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) Communities and the Coronavirus Disease 2019 Pandemic: A Call to Break the Cycle of Structural Barriers

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Within the article, "The LGBTQ+ communities and the COVID-19 pandemic: a call to break the cycle of structural barriers" [*The Journal of Infectious Diseases* 2021, https://doi.org/10.1093/infdis/jiab392], the companion essay "The roles and challenges of LGBTQ+ providers in the Infectious Diseases workforce" was mistakenly submitted to the journal as a supplemental file and now appears as an appendix. The author of this essay, Thomas Fekete, has also been added to the author list.

THE ROLES AND CHALLENGES OF LGBTQ+ PROVIDERS IN THE INFECTIOUS DISEASES WORKFORCE

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The 5 June 1981 issue of the *Morbidity and Mortality Weekly Report* (*MMWR*) described 5 gay men with pneumocystis pneumonia and other unusual opportunistic infections. This began the first public reckoning with the AIDS pandemic, which has to date killed >30 000 000 people worldwide and continues to kill more than half a million people a year. For those of us who specialize in the care of people with infectious diseases (ID), this changed everything. The early years of the HIV era were challenging because the cause was unknown, it was highly lethal, early diagnosis was impossible, there were no effective treatments, and it preferentially affected minority and marginalized communities. The year 1981 was also pivotal for gay men worldwide since this new infection spread quickly and resulted not only in excess death but also increased stigma.

Even before 1981, a mysterious disease affecting gay men had been rumored for a few years. This was known to clinicians with many gay men in their practice, and some of these doctors were, themselves, gay. Even prior to the discovery of HIV infection, there were clinics around the US, sometimes open in the evenings, that largely served gay men. These clinics varied in their mission, but they were usually geared to screening for and treating sexually transmitted infections. These clinics were often staffed by volunteers including medical students and residents who were members of the local gay community. In some instances, these doctors pursued training in ID. It is impossible to know how many LGBTQ providers were members or fellows of the Infectious Diseases Society of America (IDSA)/HIV Medicine Association (HIVMA) before the 1980s, but there was clearly a mutually beneficial relationship for LGBTQ providers and the organization.

It was clear from the beginning that treatment of people with HIV would require an openness to understanding sexuality. For many LGBTQ physicians, it was helpful to be open about their own orientation to maintain credibility with their patients and to advocate for resources and compassion within the larger medical community. This stance could be a threat to their practices since some patients felt threatened by even a visit to a potentially HIV-infected provider. It is hard to conceive that it took 4 years from the 1981 *MMWR* announcement to have a blood test for HIV.

Much of organized medicine was slow to accept the care of patients with HIV. In some parts of the country, especially remote rural areas, there were few providers willing or able to provide even basic HIV medical care. Fear of contagion was widespread. As an example, even in our urban HIV clinic, a patient with

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AIDS brought a homemade cake to clinic and there was an uncomfortable conversation about whether clinic staff would be willing to eat it. A network of clinicians including primary care providers and specialists formed the HIVMA under the umbrella of the IDSA. IDSA/HIVMA (hereafter "IDSA") was also in dialogue with the public on matters relevant to testing and treatment of HIV, trying to deal with fear and stigma and provide scientifically sound screening and treatment. IDSA was welcoming to members and fellows of sexual minority communities. This is not to say that the ID medical community was fully "woke" in the 1980s, but an important set of steps was taken to protect our members and the public. In some medical centers, the need to care for patients with complications of HIV was contrasted with a concern about being seen as an institution that might accidentally expose other patients or providers to infection. To some extent the sympathy of "innocent victims" such as Ryan White and the establishment of national studies of HIV treatment such as the AIDS Clinical Trials Group CTG and Community Programs for Clinical Research on AIDS in prestigious medical centers were keys to reducing institutional stigma. But the uncomfortable reality is that many patients struggled to find compassionate and competent care, especially in the era before reliable HIV suppressive medications.

Being willing to practice in communities where HIV was prevalent was frightening for some providers, and seeing IDSA members use the best science to protect themselves while advocating for their patients set a powerful example, as discretion and a nonjudgmental approach have always been vital attributes of ID clinicians. In the 1980s and 1990s, ID doctors were often approached by their friends or colleagues regarding their anxiety about HIV and personal concerns about sexually transmitted infection, highlighting, again, the role of ID doc as the "clinician's clinician."

The larger social backdrop for the early years of the HIV pandemic is relevant since the US government had become more conservative with the election of Ronald Reagan. While Reagan offered assurance of vaccine development, his administration was reluctant to advance policies that could have diminished the spread of HIV. For gay people who lived through the 1980s, this lack of leadership is still unforgiveable. Currently there is a strong healthcare infrastructure around HIV and sexually transmitted infections, and this is well aligned with the needs of the LGBTQ community. But there is also a demand for primary care and specialty services for LGBTQ individuals, especially in rural areas where there may not be a wide range of providers. In the realm of medical education, it is important to remember these needs and not to present LGBTQ folks only through the lens of ID.

Things are much better now for most but not all people. Anyone attending an IDSA meeting would be unlikely to find overt homophobia. In fact, many young people ask, why focus on equity issues for LGBTQ people when there is still work to be done in other areas of inclusion and diversity? However even in 2021, there are several reasons why IDSA should continue to address and review its stance on LGBTQ issues, as follows.

First, even now, many young health professionals are worried about being open in their sexuality as they enter medical school, residency, or the job market. For many LGBTQ people, the battles are over, but some still experience discrimination. It may be hard to find someone who admits to being homophobic, but there can be uncomfortable conversations or jokes that make the workplace unsafe or, at least, awkward. This behavior can also come from nonphysicians or from patients, enhancing the vulnerability of the LGBTQ provider. This can make being "out" at work more difficult and that, in turn, can lead to stress and burnout.

Second, politics can be tribal. This makes it potentially awkward to try to work closely with or trust people of different backgrounds. Keeping political discourse out of the workplace is nigh impossible. In some contexts, it is necessary to keep defending one's right to exist and to have a normal personal and family life. This is a problem for many minorities, but the ability to hide sexual orientation is a double-edged sword in this setting. LGBTQ people who cannot or choose not to be subtle about their identity should have access to all privileges that are available, but it is hard to determine if this ideal is being met. Implicit discrimination and even internalized homophobia can still be present and powerful.

Third, acceptance for various parts of the LGBTQ community can be variable. Even in liberal areas, there is prejudice and violence against transgender people. For transgender people of color, this problem is magnified further. When popular figures such as J. K. Rowling openly question the existence of trans identity, there is cover for further discrimination. Pennsylvania's Secretary of Health, Dr Rachel Levine, is a transgender woman who has conducted herself in an exemplary and professional manner and has been nominated as US Assistant Secretary of Health. But this does not stop regular manifestations of disrespect that flow from her status, including one from a Pennsylvania state legislator in January 2021. So even professional accomplishment is not protective.

Fourth, some LGBTQ people face rejection and discrimination from within their families. This can lead to homelessness and suicidality in gay youth, but it can also be a lifelong stress for many adults. Having a safe harbor in professional life can mitigate that stress, but a hostile work environment can aggravate it.

Since 1981, there have been many aspects of the "culture wars" that have called into question the equality and humanity of LGBTQ people. The long fight for marriage equality in the US was debated again and again in legislatures before being narrowly settled by the Supreme Court. There is ample reason to believe that the current state of affairs could be reversed by a less accepting Court. In the meantime, LGBTQ people had to structure complicated financial instruments to achieve a

simulacrum of marriage and often were not allowed to visit partners in the hospital or to get custody of children after the death of a partner, etc. But as awful as these things are for individuals, it was clear that many referenda on marriage equality were designed to mobilize conservative forces. This was used to advance an agenda hostile to reproductive freedom and personal expression and often ran counter to the ideals of inclusion and diversity in general. It is hard to decide which is worse: an animus against LGBTQ individuals or the cynical manipulation of homophobia to advance a political agenda.

Being against discrimination is easy and yet it is still very important for organizations to make explicit their promise to evaluate people based only on their qualifications. On a personal level, I have never experienced any sense of rejection or inequality by my colleagues at work or by the IDSA. I have had occasion to see other LGBTQ people embraced by the Society, and to have their partners and/or spouses warmly welcomed as was mine. But there are still subtle barriers out there. When traveling internationally, it can still be hard for same-sex couples to get equal treatment. This is especially a concern when one of the partners is not American and thus subject to even greater scrutiny when reentering the country.

IDSA and IDSA Foundation are inclusive and accepting organizations. This is vital for people to know before they join so they can be free to be themselves. It is also important for our organizations to reach out and advocate for acceptance and nondiscrimination for all minority groups since all have been under some degree of attack, rejection, or marginalization since the US was founded. The 14th, 15th, 19th, 24th, and 26th amendments to the US Constitution all address the right to vote, and it was just over 100 years ago that women won the right to vote! But voting, as important as it is, does not reflect the speed bumps that affect day-to-day life. No one person can speak for the LGBTQ community, and like other minority communities its needs and priorities are subject to change. But I believe that as a matter of policy, the IDSA and IDSA Foundation should be vocal in support of human rights in the US and abroad, that they should strive for LGBTQ nondiscrimination, and that they create safe spaces for members of sexual minorities—especially those without or with limited protection. My pride in IDSA is strong and I know that the needs of sexual minorities are valued, as are those of other underrepresented minorities (and of course, women) in all aspects of the organization. I believe that our overall success will be judged by a commitment to fairness across the board even when it is not easy or convenient. IDSA can provide leadership and set an example as it has for years with complete representation in growing a diverse and healthy ID workforce to better serve the people and public health of the nation.