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REVIEW

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

Raul Macias Gil,[1] Tracey L. Freeman,[2] Trini Mathew,[3] Ravina Kullar,[4] Thomas Fekete,[5] Anais Ovalle,[6] Don Nguyen,[2] Angélica Kottkamp,[7] Jin Poon,[8] Jasmine R. Marcelin,[9] and Talia H. Swartz[10]; for the Inclusion, Diversity, Access, and Equity Task Force of the Infectious Diseases Society of America

[1]Department of Infectious Diseases, Kaiser Permanente Northern California, Napa/Solano, California, USA, [2]Medical Scientist Training Program, University of Pittsburgh-Carnegie Mellon University, Pittsburgh, Pennsylvania, USA, [3]Division of Infectious Diseases and International Medicine, Beaumont Hospital, Royal Oak, Michigan, USA, [4]Expert Stewardship, Inc, Newport Beach, California, USA, [5]Department of Medicine, Temple University Lewis Katz School of Medicine, Philadelphia, Pennsylvania, USA, [6]Division of Infectious Diseases, Dartmouth Hitchcock Medical Center, Dartmouth, New Hampshire, USA, [7]Division of Infectious Diseases, New York University Grossman School of Medicine, New York, New York, USA, [8]Department of Family Medicine, Kaiser Permanente Northern California, Vallejo, California, USA, [9]Division of Infectious Diseases, University of Nebraska Medical Center, Omaha, Nebraska, USA, and [10]Division of Infectious Diseases, Department of Medicine, Icahn School of Medicine at Mount Sinai, New York, New York, USA

The coronavirus disease 2019 (COVID-19) pandemic has disproportionately impacted lesbian, gay, bisexual, transgender, and queer (LGBTQ+) communities. Many disparities mirror those of the human immunodeficiency virus (HIV)/AIDS epidemic. These health inequities have repeated throughout history due to the structural oppression of LGBTQ+ people. We aim to demonstrate that the familiar patterns of LGBTQ+ health disparities reflect a perpetuating, deeply rooted cycle of injustice imposed on LGBTQ+ people. Here, we contextualize COVID-19 inequities through the history of the HIV/AIDS crisis, describe manifestations of LGBTQ+ structural oppression exacerbated by the pandemic, and provide recommendations for medical professionals and institutions seeking to reduce health inequities.

Keywords. LGBTQ+; COVID-19; health disparities; HIV/AIDS.

The coronavirus disease 2019 (COVID-19) pandemic has disproportionately impacted lesbian, gay, bisexual, transgender, and queer (LGBTQ+) communities. The Movement Advancement Project is an independent nonprofit advocacy group committed to health equity. It summarized critical findings from a poll evaluating the impact of COVID-19 in United States (US) households [1], finding that LGBTQ+ families have less secure access to financial, medical, and educational resources than non-LGBTQ+ populations. Sixty-four percent of LGBTQ+ individuals stated they or a household member experienced employment loss compared to 45% of non-LGBTQ+ individuals. Additionally, 47% of LGBTQ+ individuals indicated severe concerns about severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) acquisition at work, compared with 28% of non-LGBTQ+ individuals. One in 4 LGBTQ+ households experienced challenges affording medical coverage, and 2 in 5 LGBTQ+ households experienced barriers to medical care, compared with 19% of non-LGBTQ+ households.

Few studies have highlighted disparities in LGBTQ+ communities during the COVID-19 pandemic. This population has long been subject to medical oppression and deprivation, as reflected by the human immunodeficiency virus (HIV)/AIDS crisis. This is the result of structural oppression. To call oppression *structural* is to recognize that disparities faced by a marginalized group are woven into the very fabric and systems core to our society. This includes access to healthcare, economic stability, social safety, and physical sovereignty. LGBTQ+ communities mobilized to disseminate this information and ignited biomedical innovation and healthcare activism that defined the national HIV response beginning in the 1980s. Here, we provide a history of the HIV/AIDS crisis, elucidate mechanisms by which LGBTQ+ health inequities occur, and describe recommendations for fostering LGBTQ+ health equity in the COVID-19 pandemic.

HISTORY OF THE HIV/AIDS CRISIS AND COVID-19: THE MARGINALIZED AND ENERGIZING LGBTQ+ POPULATIONS

The HIV epidemic has spanned 4 decades and provides rich historical context for the COVID-19 pandemic [2]. During the early years of the HIV/AIDS epidemic, no drugs were available, and HIV infection had a nearly 100% mortality rate [2]. Today, biomedical advances have given us the optimism to foresee the end of the AIDS epidemic [3–5]. When HIV/AIDS was first described, it was referred to as the “gay

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Correspondence: Talia H. Swartz, MD, PhD, Department of Medicine, Division of Infectious Disease, Immunology Institute, One Gustave L. Levy Place, Box 1090, Mount Sinai School of Medicine, New York, NY 10029, USA (talia.swartz@mssm.edu).

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plague" [2]. Stigma resulted in public indifference and governmental inaction. Then-president Ronald Reagan did not publicly acknowledge the epidemic until 1985, 4 years after the deaths had begun.

Lack of governmental AIDS response galvanized LGBTQ+ communities to adopt mutual aid and community-driven action strategies to care for the dying and disabled [6]. AIDS activists in New York City formed the AIDS Coalition to Unleash Power (ACT UP), which disseminated the message "silence = death" through demonstrations, "die-ins," media campaigns, and protests at the Centers for Disease Control and Prevention, Food and Drug Administration (FDA), and National Institutes of Health [6–10].

Pushed by the tenacity of HIV/AIDS activists, scientific communities began to collaborate with activists by including people with HIV on clinical trial advisory boards, expediting therapeutic pipelines, and expanding access to emergency-use drugs [2]. HIV/AIDS advocacy radically transformed science and medicine in support of patient-centered care and highlighted the impact of structural racism and discrimination on healthcare and health outcomes [11, 12].

In contrast to the unseen HIV/AIDS pandemic, COVID-19 advocacy benefits from unprecedented international attention, leading to expeditious progress of clinical trials, therapeutics, and vaccine developments. One year into the pandemic, the FDA approved a drug for the treatment of COVID-19 and granted emergency use authorization for several therapeutics and 3 vaccines [13, 14]. The history of HIV/AIDS shows that far more sweeping changes are possible and necessary to eliminate the inequalities exacerbated by the COVID-19 pandemic [3, 15–17].

Activists have long stressed that community devastation from HIV/AIDS was not solely due to the unprecedented nature of the epidemic. Instead, injustices embedded within our social structures drove disparate morbidity, mortality, and the permanent public health crisis faced by minoritized communities [18, 19] during both the HIV/AIDS and COVID-19 pandemics [2]. COVID-19 is an opportunity to further activism in the HIV/AIDS movement and enact longitudinal change that uniformly addresses disparities and preventable consequences of infectious diseases.

LGBTQ+ HEALTH DISPARITIES

Despite LGBTQ+ health being understudied, there is evidence demonstrating worse health outcomes and barriers to medical care in this population compared with nonminority groups [20]. These factors predispose LGBTQ+ communities to severe COVID-19 disease and higher mortality than the general population [21, 22]. A survey of 13 562 people in 138 countries conducted during April–May 2020 demonstrated that COVID-19 has had "a devastating impact" globally on LGBTQ+ communities [23]. The pandemic has interrupted vital services upon which LGBTQ+ people rely [24]. More than 20% of people with HIV indicated limited access to healthcare, with 7% at risk of running out of antiretrovirals. Even with tangible access to medical care, many feel unsafe going to a medical facility. One in 6 LGBTQ+ people and nearly a quarter of transgender people avoid medical care because of fear of discrimination [25].

Testing for sexually transmitted infections (STIs), including HIV, gonorrhea, and chlamydia, decreased by 85% during the pandemic despite increased test positivity [26]. STI treatment, hormonal therapy, gender-affirming surgery, and HIV preventive care such as preexposure prophylaxis (PrEP), condoms, and self-testing have also decreased during the pandemic [27]. Such service cuts worsen preexisting healthcare inequities in Black, Latinx, transgender, gender-nonconforming, and nonbinary patient populations [28].

In both the HIV/AIDS and COVID-19 pandemics, income has determined an individual's ability to access needed therapeutics. Today, HIV PrEP is essential to end the ongoing epidemic, yet only 8% of US patients who could benefit from the drug receive it. Despite costing an estimated $6 per month to manufacture, PrEP is sold for prices as high as $2000 per month in the US [29]. Similar patterns exist in the manufacture and sale of COVID-19 drugs [30].

LGBTQ+ SOCIOECONOMIC AND WORKFORCE DISPARITIES

COVID-19 has increased unemployment and worsened housing instability [31], compounding LGBTQ+ socioeconomic disparities [9, 32, 33]. LGBTQ+ people earn less money on average and are subject to higher poverty rates than cisgender heterosexual people, with transgender men facing the highest poverty rates [34]. One in 5 LGBTQ+ adults lives in poverty. In California, >55% of LGBTQ+ adults live in poverty [35].

Unemployment rates are also higher within LGBTQ+ communities, translating to worse overall health outcomes, especially for those who receive care through employer health insurance plans [36]. LGBTQ+ people of color are more than twice as likely as white LGBTQ+ people to face discrimination in applying for jobs [25]. According to the Human Rights Campaign Foundation, up to 40% of LGBTQ+ people in the US work in industries affected by the pandemic, including healthcare, food service, education, and retail [37]. The high risk of COVID-19 exposure among front-line or essential workers has significantly increased physical, psychological, and financial burdens due to work, and health coverage loss. One in 3 LGBTQ+ adults reported a reduction in work hours due to the pandemic, compared to 1 in 5 non-LGBTQ+ adults [37, 38]. LGBTQ+ adults are less likely to have access to paid sick leave, which is not federally guaranteed in the US [39].

COVID-19 EXPOSURE AND THE LGBTQ+ HOMELESSNESS-INCARCERATION CYCLE

LGBTQ+ people are systematically denied access to the right to safe and adequate housing [40]. Shelters are often inaccessible to LGBTQ+ communities; this is particularly true for transgender people [41]. Beyond acceptance and respect, many have experienced violence, abuse, exploitation, and discrimination in shelters [42], aggravated by policy changes that allow sex-segregated shelters to discriminate against transgender people [43]. Up to 40% of homeless youth identify as LGBTQ+ [44]. In the COVID-19 pandemic, LGBTQ+ youth have navigated discrimination and violence without the schools, community centers, libraries, and shelters they rely on for physical and psychological safety [45, 46].

Homelessness and poverty among LGBTQ+ people are deeply intertwined with the mass incarceration of LGBTQ+ communities [40, 42]. People without housing are incarcerated at elevated rates, and many for crimes of existence, including sitting on the sidewalk, possessing an oversized cart, or rummaging through trash [43]. In tandem, people who have been incarcerated face stigma when applying for jobs and acceptance to academic institutions [47, 48]. Denials of employment and education create poverty and homelessness. This cycle demonstrates why oppression is *structural*. These oppressive constructs (homelessness and incarceration) are associated with poverty, food insecurity, healthcare deprivation, and social and cultural exclusion. These interconnected statuses form a web of oppressions from which it is nearly impossible to escape (Figure 1). These determinants of health are redundant and pervasive; this is why healthcare reform must be paired with sweeping changes to our social structures to achieve health equity.

Jails and prisons impose substantial risks to LGBTQ+ health. LGBTQ+ youth are overrepresented in the juvenile justice system, making up nearly 20% of the juvenile justice population [49]. The confined nature of carceral facilities, often with limited access to hygienic products and delayed medical care,

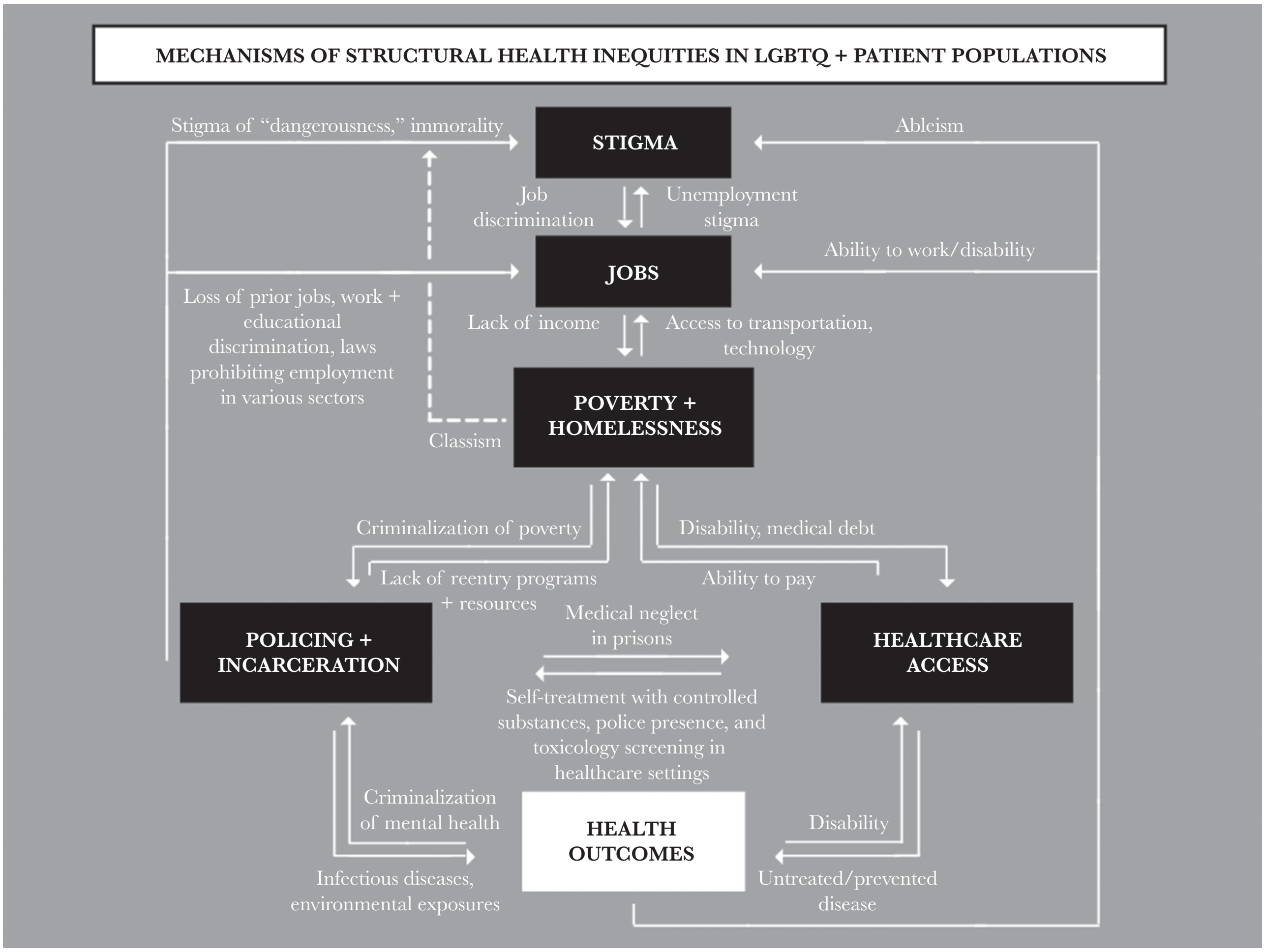

Figure 1. Mechanisms of structural health inequities in lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patient populations. Disparate health outcomes in the LGBTQ+ patient populations are fueled by structural inequities such as healthcare deprivation, policing, and criminalization of poverty and homelessness that are tied to employment instability and stigma. These forms of oppression are interconnected and redundant. Manifestations of these injustices include increased rates of untreated and preventable disease and disability, ultimately resulting in disparate health outcomes.

creates an environment highly permissive to disease spread [50, 51]. LGBTQ+ people are also overrepresented and disproportionately at risk of SARS-CoV-2 transmission because of the nature of mandated prison labor. Incarcerated people, for example, were required to dig graves for and bury the deceased of both the HIV/AIDS and COVID-19 pandemics in the nation's largest mass grave (Hart Island, New York) [52–54]. In response to COVID-19, incarcerated people have functioned as front-line workers, producing pandemic-related items such as hand sanitizer for wages between $0.16 and $0.65 per hour. Ironically, prisons cannot use these products to mitigate transmission risks, as products with alcohol content are banned within carceral facilities [53, 55–57].

Incarcerated people experience disproportionately high rates of HIV, tuberculosis, and hepatitis C [50, 51]. Incarcerated people with HIV often face delays in treatment, receive low-quality care, and do not receive treatment for preexisting conditions [57–61]. In addition to infectious diseases, incarcerated populations face higher rates of hypertension, asthma, arthritis, and cervical cancer [62].

Incarceration rates are 3 times higher for LGBTQ+ adults than the general population [63]. More than 40% of incarcerated women are lesbian or bisexual. Prisons and jails incarcerate 21% of transgender women [64]. Carceral violence against LGBTQ+ people of color is staggering: 47% of Black transgender people are incarcerated at least once [65]. Furthermore, transgender people, especially Black transgender people, are profoundly absent from medical professions [66]. It is for this reason that advocates must recognize how this structural oppression limits representation, advocacy, and prioritization in data collection. The lack of analyses on the medical impacts of incarceration limits our ability to understand the extent to which mass incarceration is detrimental to the health of LGBTQ+ communities, but it is clear that an urgent public health response is necessary.

The disparities in COVID-19 prison-related health risks and outcomes showcase the multifaceted ways in which LGBTQ+ people are subject to medical oppression. Within carceral facilities, mechanisms include acute illness, longitudinal effects from environmental exposures, and reduced accessibility of medical care during and following imprisonment. Models suggest that imprisonment and mortality exhibit a dose-dependent relationship in which each year of incarceration results in a 2-year reduction in an individual's life expectancy [67]. The growth of the incarceration rate has reduced the average US life expectancy by 1.79 years [68].

LGBTQ+ DATA COLLECTION: BENEFITS, METHODS, AND CAUTIONS

Difficulties understanding the demographics and mechanisms of LGBTQ+ health disparities extend beyond incarceration. Accurate health data in LGBTQ+ communities can be challenging due to the lack of uniform mechanisms to identify sexual orientation and gender identity (SOGI) in healthcare settings [25–28]. Further research and insights are needed to inform strategies to ensure equity in our COVID-19 response. SOGI data collection has garnered increasing support in identifying individuals at risk, as this may provide valuable information on social determinants of health [69–71].

There is also potential for harm in collecting SOGI data, and we must remain cognizant of patient safety. Unauthorized protected health information (PHI) disclosures are common; these breaches impacted approximately 112 million Americans in 2015 [72]. Privacy breaches place patients at social and societal risk including stigma, anti-LGBTQ+ violence, and job loss [73]. Even Health Insurance Portability and Accountability Act of 1996 (HIPAA)–compliant SOGI documentation can have devastating impacts on minoritized individuals. Patient medical records are frequently acquired by subpoena. SOGI and language describing patient behavior may endorse common anti-LGBTQ+ tropes ("noncompliant," "nonconforming," "difficult") and may contribute to court bias and worse outcomes for LGBTQ+ patients [65, 74, 75]. Documentation of a pediatric patient's SOGI, accessible to a child's parents/guardians, produces alarming youth abuse and homelessness risks. Risks of SOGI data must be contextualized by lessons from the HIV/AIDS epidemic, during which anti-LGBTQ+ sentiments were expressed in a *New York Times* op-ed calling for people with HIV to be tattooed for public identification [76, 77]. Violence and acceptance of violence against LGBTQ+ remain rampant in our society.

SOGI documentation may come at the expense of patient safety and comfort. In 2020, the US Supreme Court determined that it is permissible to discriminate against transgender people in offering health services, providing care consistent with their gender identity, and covering transition-related medicine [78]. In the National Transgender Discrimination Survey, 28% of transgender people reported being harassed in a medical setting, 19% were refused care, and 10% were sexually assaulted in a healthcare setting [79]. Anti-LGBTQ+ attitudes among providers are common, and there is a dearth of evidence to suggest that increased SOGI documentation would reduce provider discrimination.

When collecting SOGI data, medical professionals must provide an opt-in method in which LGBTQ+ patients may choose to disclose SOGI. Patients should dictate whether they consent to SOGI documentation in electronic health records and to whom this information is visible (eg, single practitioner, individual healthcare system, interinstitutional) [80]. In assessing COVID-19 LGBTQ+ health disparities, healthcare systems may wish to consider collecting anonymized aggregate patient SOGI data at the point of care when administering COVID-19 tests and vaccines for data collection.

SUMMARIZING MECHANISMS OF STRUCTURAL HEALTH INEQUITIES IN LGBTQ+ PATIENT POPULATIONS

Injustices faced by LGBTQ+ individuals define interconnected cycles of oppression involving stigma, job loss, poverty, homelessness, incarceration, and limited access to healthcare that impact health outcomes. Figure 1 describes these cycles that fuel each other. Stigma impacts jobs and education, causing poverty and homelessness, which feed incarceration and limited healthcare access. These result in untreated and preventable diseases that compromise health outcomes. Multilayered interventions will be necessary to break this cycle and improve how health outcomes can be improved in LGBTQ+ communities.

RECOMMENDATIONS TO REDUCE COVID-19 HEALTH DISPARITIES IN LGBTQ+ PATIENT POPULATIONS

Recommendation 1: Create Medical Environments Safe for LGBTQ+ Patient Populations

Creating safe environments requires recognizing and respecting patient pronouns, understanding gender as an identity distinct from sex assigned at birth, and being open to learning new LGBTQ+ identities and patient concerns. Providers should understand deep-rooted connections between LGBTQ+ identities and forms of structural violence (policing, prisons, denial of jobs, and social services) and consider how practices may affect patient comfort and safety in receiving medical care, including documentation of social/behavioral notes, ordering toxicology screens, and maintaining police presence in clinics and hospital settings. Health systems may benefit from partnerships with patient legal advocates [81].

Recommendation 2: Use Practice-Engaged, Patient-Centered Care to Better Understand How to Serve LGBTQ+ Patients

Large-scale COVID-19 testing and vaccination sites may offer exceptional opportunities to collect aggregated, anonymized SOGI data for health disparities analysis. SOGI survey questions should be indicated as optional and anonymized, as marginalized populations have cited individually identifiable data collection as a concern contributing to COVID-19 vaccine hesitancy [82–84]. Understanding LGBTQ+ health requires providers to encourage patients to discuss access barriers they have faced in seeking medical care. These discussions require providers to acknowledge their knowledge gaps and actively seek to learn from the patients they treat. LGBTQ+ care competency may require training and tools for providers and clinic staff.

Recommendation 3: Remove Access Barriers to COVID-19 Vaccination and Testing in Marginalized Communities

COVID-19 vaccines and routine SARS-CoV-2 testing must be offered in clinics and communities. Common appointment-only vaccine administration strategies are inaccessible to patients without the time or technological resources to schedule appointments. Community-based vaccination and testing sites are needed to remove transportation barriers. Elimination of proof-of-residency requirements to receive COVID-19 vaccination is required for vaccine access by undocumented LGBTQ+ immigrants. It is also essential for vaccine access by transgender, gender-nonconforming, and gender-nonbinary patients, who may lack government identification matching correct names, genders, and addresses. Sufficient medical care and resources must be provided to people in congregate living facilities, including those held in carceral institutions. Initiatives to reduce jail and prison populations to halt the spread of SARS-CoV-2 have garnered broad endorsement [55].

Recommendation 4: Ensure Access to Comprehensive Medical Care Regardless of Immigration Status, Insurance Coverage, or Financial Resources

The healthcare community needs to provide medical care for preexisting conditions to treat and prevent COVID-19 effectively. Populations with limited healthcare access have expressed concern that they will not be offered future treatment for side effects as they would free vaccination [82]. Encouraging vaccination among marginalized populations requires dedication to treating patients before, during, and following COVID-19 interventions. Administration of equitable and comprehensive medical care, including essential primary care, will enable providers to promote and provide personal protective equipment, social distancing, and vaccination. This will foster continuity of care, equitable health outcomes, and reason for patients to trust medical institutions.

Recommendation 5: Communicate Healthcare Information in Accessible Formats

Side effects and questions about the efficacy of COVID-19 vaccines have been cited as the primary reason for declining vaccination [85]. The Latinx community has voiced concern regarding whether vaccination outcomes may differ across demographics [82, 83, 86]. Lack of diversity in clinical trials has been a long-standing challenge [87–89] and was a paramount concern of HIV/AIDS activists in the 1980s–1990s [90]. This activism successfully increased racial and ethnic minorities' representation in HIV drug trials and set expectations for demographic diversity in future FDA trials [91]. Patients from marginalized groups should be provided information regarding subgroup-specific data on vaccine side effects and efficacies. To effectively disseminate this information, point-of-care locations must be equipped with language translators. Written communications and infographics should be offered in multiple languages. Availability of comprehensive medical care (see recommendation 4) should be communicated through community centers, schools, libraries, and social media platforms. Outreach and enrollment workers are a necessary and evidence-based strategy [92].

Our recommendations seek to ensure access to care, patient safety, and effective dissemination of medical information to understand patients' unique intersecting identities. Proposed areas of intervention are defined by the fundamental restructuring of healthcare provision to treat all patients comprehensively. We propose healthcare provider education and understanding of documented access barriers that have plagued LGBTQ+ communities for decades. These initiatives are limited in scope and insufficient to achieve equitable COVID-19 outcomes. Disproportionate job loss and workplace exposure, for example, will not be solved by these measures. We advocate for strengthened healthcare laws and policies to support LGBTQ+ individuals and families.

CONCLUSIONS

The HIV/AIDS epidemic illuminated failures of the medical community to care for LGBTQ+ patients adequately. COVID-19 has continued to expose medical and societal inequities that we have yet to acknowledge or mobilize resources to solve. It is crucial to note that these outcomes—including greater rates of COVID-19, underemployment, poverty, and adverse health outcomes—are akin to symptoms of an underlying disease.

Combating such systems of oppression is complex. Even when equipped with data, our efforts to achieve health equity are inhibited by a dire lack of representation of marginalized communities in medical careers and policy. This lack of representation renders data utility limited, as results are interpreted primarily by those without experience navigating core foundations of structural violence, including poverty, homelessness, incarceration, and medical neglect. Because of the extent to which diversity and representation are absent from medicine, perhaps the most crucial lesson to be learned from the HIV/AIDS epidemic is the activists' demand of "nothing about us without us" [93], that no policy should be decided without representation of the group impacted by that policy. Healthcare providers need education about medical disparities and social determinants of health that affect LGBTQ+ communities. Healthcare providers should empower patients for whom injustices are most pronounced to lead educational initiatives. When we seek to learn from patients, we must remain mindful of exacerbated barriers to health faced by those with additional marginalized identities; diversity in consulted patient groups is paramount. These forms of diversity include gender identity, sexual orientation, race, ethnicity, age, religion, immigration status, housing status, socioeconomic status, disability, geographic distribution, education, and parental status. Our responsibility is to encourage marginalized individuals to pursue medical careers and provide them with the necessary support.

We should aspire to earn the trust of our LGBTQ+ patients and the privilege of learning from them. This requires universal adoption of inclusive practices, including addressing patients by their correct names and pronouns, creating intake forms and an office environment that recognizes LGBTQ+ identities, provider knowledge of LGBTQ+-specific medical care, and provider comfort with diverse sexual and gender identities, orientations, practices, and opinions [94]. Actions by and disseminated messages from healthcare providers and the healthcare community should demonstrate that diverse patients are heard, are valued, and will uniformly receive the highest standard of care. Individuals, clinicians, and organizations must ensure equitable administration of medical care. In tandem, we must amplify our patients' voices, experiences, and guidance essential to understanding what it means to serve this patient population faithfully and what we must change to do so.

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

Thomas Fekete, MD, MACP, FIDSA

Chair, IDSA Foundation

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 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.

Notes

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