



POLICY FOCUS:

WHY GATHER DATA ON
SEXUAL ORIENTATION
AND GENDER IDENTITY
IN CLINICAL SETTINGS

POLICY FOCUS:**Why gather data on sexual orientation and gender identity in clinical settings¹**

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Gathering sexual orientation and gender identity data from patients is essential to providing appropriate health care to lesbian, gay, bisexual and transgender (LGBT) people, who face significant documented health disparities. It also helps us to better understand these disparities. However, limited data indicate that most providers do not ask questions about sexual orientation, either during initial medical history or during annual exams.² Gathering LGBT data in electronic health records (EHR) is consistent with key recommendations in Healthy People 2020, the 2011 Institute of Medicine report on LGBT health issues and research gaps, and the federal government's implementation of the Patient Protection and Affordable Care Act, which expands access to health care to most Americans and enhances protections against discrimination in health coverage.

If LGBT patients are told why it is important to gather such information, and that such information will be kept private and confidential, most will be forthcoming with this information.³ Provider knowledge about their patients' sexual orientation and gender identity can facilitate optimal care.

By 2014, when the U.S. government hopes that Americans' health records will be fully computerized, data from intake/registration forms and data obtained in the course of provider-patient interactions should be merged into one data record. A second, related brief in this series provides best practices for gathering sexual orientation and gender identity data through both formats.⁴

WHY ASK THESE QUESTIONS?

Asking questions about sexual orientation and gender identity⁵ is important because there are significant documented health disparities affecting LGBT people.⁶ While we know about some disparities, there remain wide gaps in research on LGBT health. Gathering sexual orientation and gender identity data



in a standardized way will allow us to better understand LGBT health disparities, as well as to prevent, screen and early detect conditions that disproportionately affect LGBT people. Gathering such data in clinical settings will allow providers to better understand and treat their patients, and to compare their patients' health outcomes with national samples of LGB or LGBT people from national health surveys.⁷

Lesbians are more likely than heterosexual and bisexual women to be overweight and obese.

Optimal and effective provision of health care and prevention services to LGBT people requires that providers be informed of the health disparities affecting this population, including specific risk factors and health conditions. For example, lesbians are more likely than heterosexual and bisexual women to be overweight and obese, increasing their risk for cardiovascular disease, lipid abnormalities, glucose intolerance, and morbidity

related to inactivity.⁸ Bisexuals may have poorer health than homosexuals and heterosexuals, as well as higher rates of mental health issues and smoking.⁹ Transgender patients may be at greater risk of cardiovascular disease due to exogenous hormone use.¹⁰

Gathering data on sexual and gender identity is consistent with key recommendations in Healthy People 2020 and the 2011 Institute of Medicine's report on LGBT health issues and research gaps.¹¹ Healthy People 2020 calls on health care providers to "appropriately inquir[e] about and be...supportive of a patient's sexual orientation to enhance the patient-provider interaction and regular use of care."¹² The

IOM report recommends the gathering of such data on federally funded surveys, as well as its collection in electronic health records as part of the meaningful-use objectives for the Office of the National Coordinator for Health Information Technology. The report recommends that questions be standardized to allow for the comparison and pooling of data to analyze the unique needs of LGBT people. Gathering LGBT data in clinical settings is also consistent with efforts of the U.S. Department of Health and Human Services to gather health data on LGBT populations as authorized under Section 4302 of the Affordable Care Act.¹³

A provider’s knowledge of a patient’s sexual orientation and gender identity is essential to providing appropriate prevention screening and care.¹⁴ Patients who disclose their sexual orientation identity to health care providers may feel safer discussing their health and risk behaviors as well.¹⁵ A sample of New York City men who have sex with men (MSM) from the 2004–2005 National HIV Behavioral Surveillance system found that 61% had not disclosed their same-sex orientation or behavior to their medical providers. White MSM and native born MSM were more likely to have disclosed than black, Latino, Asian and immigrant MSM. Disclosure correlated with having tested for HIV.¹⁶ One study found that lesbians were less likely than gay men to disclose their sexuality to their health care provider.¹⁷

By asking about sexual orientation as a standard demographic variable, providers make it more likely that patients will come out and share personal information that could inform health discussions.



9.4% of men in a 2006 New York City study who identified themselves as “straight” reported same-sex activity within the past year.

DEFINING TERMS

Sexual orientation refers to an enduring emotional, romantic, sexual or affectional attraction to another person.¹⁸ Gay men are men attracted to other men; lesbians are women attracted to other women. Individuals attracted to both men and women are bisexual.¹⁹ Half a dozen national and state surveys that measure sexual identity indicate that there are as many self-identified bisexuals as gay men and lesbians, and that women are more likely than men to self-identify as bisexual. Technically men and women attracted to the same sex are homosexuals. However, many prefer other labels, such as gay or lesbian, because of the clinical nature of the word homosexual and its association with outdated science and cultural norms. For example, until 1973 the U.S. psychiatric profession considered homosexuality a mental illness, and at least through the 1950s families could commit a homosexual family member to a mental institution.

Same-sex behavior does not always match an individual's sexual orientation identity. For example, 9.4% of men in a 2006 New York City study who identified themselves as "straight" reported same-sex activity within the past year.²⁰

Gender identity refers to a person's self-perception as male or female, and may not be congruent with one's birth sex. Transgender people have gender identities, expressions, or behaviors not traditionally associated with their birth sex. Many transgender people identify as heterosexual, and some don't identify as transgender, but simply as male or female. Both gender identity and sexual orientation can change over the life course.

CONCLUSION

Gathering sexual orientation and gender identity data will increase our understanding of LGBT health disparities and how to prevent, screen and early detect conditions that disproportionately affect LGBT people. Gathering such data in clinical settings will allow providers to better understand and treat their patients, and to compare their patients' health outcomes with national samples of LGB or LGBT people from health surveys.²¹

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