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Culturally Competent Care for LGBT Patients in Dermatology Clinics

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Lesbian, gay, bisexual, and transgender (LGBT) patients face unique health disparities.[1] Routine collection of sexual orientation and gender identity (SOGI) data can optimize patient-provider interactions.[2] Gender-neutral bathrooms promote inclusivity for LGBT patients.[3] There is limited data on the extent to which dermatology practices make use of such features to deliver culturally competent care to LGBT patients.

We developed an anonymous, online survey to investigate dermatology practice characteristics relevant to LGBT patients. IRB approval was obtained prior to distributing the survey via a listserv of board-certified dermatologists available on the American Academy of Dermatology's website. Bivariate associations were explored using Monte Carlo estimation for the Fisher's exact test and chi-square. Multivariable logistic regression was performed to evaluate the associations between provider demographic, practice variables, and likelihood of routine patient intake form use.

891 board-certified dermatologists received the survey link. 81 dermatologists completed the survey. Of providers surveyed, most were female (63%), heterosexual (80%), practiced in urban environments (53%), and in private practice settings (64%) (Table 1). Most practices reported seeing less than 5 transgender patients annually (54%), though 21% of practices reported seeing more than 10 transgender patients annually. 79% of practices surveyed reported making using of gender-neutral bathrooms. Of 71 respondents with knowledge of their intake forms, 15 (21%) reported routine collection of patient sexual orientation and 14 (20%) reported their forms asked about patients' preferred gender pronouns, in addition to gender identity. Intake form administration did not vary significantly by provider sexual orientation (P=0.43) or practice setting (P=0.10). Of 13 dermatologists not using intake forms, 7/13 (54%) cited administrative burden, 2/13 (15%) reported intake forms were not in the scope of their practice, and 1/13 (7%) cited a lack of data for patient benefit.

TABLE 1.

Survey Respondent Demographics and Practice Characteristics

Variable		Count	Percentage
Gender	Male	30	37.5%
	Female	50	62.5%
Age	Mean ± SD (years)	45 ± 11	
Sexual Orientation	Bisexual	3	3.7%
	Lesbian or gay	13	16.1%
	Straight or heterosexual	65	80.2%
Practice Area	Rural	7	8.6%
	Suburban	31	38.2%
	Urban	43	53.1%
Practice Setting	Academic	23	28.4%
	Both	6	7.4%
	Private	52	64.2%

Based on our survey results, we hypothesize that the frequency of gender-neutral bathrooms in dermatology practices is increasing in comparison to past decades. However, our results suggest that routine SOGI data collection using intake forms is less common. In oncology, it has been shown that patients have favorable perceptions regarding gender, sex-at-birth, pronoun, and sexual orientation questions regardless of demographic characteristics.[4] Routine SOGI data collection is important to provide medically appropriate and culturally sensitive care, especially as the volume of transgender patients seen by dermatologists increases. Interestingly, our results suggest that neither provider demographic variables nor practice variables such as location or practice setting affect likelihood of routine SOGI data collection. Our study highlights the need for further research to investigate additional barriers to the implementation of routine SOGI data collection in dermatology clinics.

Limitations of our study include the small sample size, low response rate, and risk of response bias. Private practice dermatologists were also overrepresented in our sample. Nonetheless, we believe our data suggest the need for greater investigation of this issue and validation of our results with larger, more highly controlled studies.

DISCLOSURES

The authors have no conflicts of interest to declare.

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