Journal of Cardiac Failure Vol. 00 No. 00 2022

Perspectives

Challenges of the LGBT Community in Health Care: Focus on Heart Failure

AMIN YEHYA, MD, MS, FHFSA, FACC[1]

Norfolk, Virginia

Key Words: Heart failure, LGBTQ, health care, cardiovascular disease, mental health, clinical trials.

When one of our heart transplant patients began rescheduling her appointments, an atypical practice for her, it caused concern for the transplant coordinator who had followed the patient before and after the heart transplantation. Fortunately, because of the well-established relationship between the two, the experienced coordinator was able to convince the patient to return for her routine follow-up appointment. Upon entry into the examination room, the patient's anxiety was undeniable; she avoided eye contact, her voice was tremulous, and her hands were restless. She began crying when we inquired about any potential barriers precluding her from attending her follow-up appointments. She then shared that she had been going through a "big change" in her life. "After my heart transplant, I have been given a new chance to live the life that I want and to be happy and live my true self," she said. She also mentioned that she had begun estrogen therapy as part of her transitioning process. She disclosed that she had been avoiding her follow-up appointments in fear of judgment, or even worse, exclusion from the clinic. It was a very emotional day for not only the patient, but for all members of the care team in that room as well, who witnessed firsthand the potential downstream effects of bias and health inequities on patients. To her surprise, we shared both our support and joy of her decision to pursue her journey to transition. Our patient's vulnerability and resilience was inspiring and elucidates many of the challenges the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community faces in accessing health care.

Sexual and Gender Minority: An Overlooked Disparaged Group

According to population-based studies, LGBTQ individuals account for about 11 million of U.S. adults.[1] Homosexuality was both criminalized and pathologized. In 1973, the American Psychiatric Association removed homosexuality from its *Diagnostic and Statistical Manual of Mental Disorders*.[2] It was not until the last decade that we finally began to witness true action aimed at promoting diversity, equity, and inclusion among the LGBTQ groups. In 2016, the National Institutes of Health (NIH) identified the "sexual and gender minority" as a population for NIH-related research to help better understand the underlying causes of health disparities in this population. The LGBTQ community falls under the "sexual and gender minority" group, which includes populations whose gender identity, sexual orientation, or reproductive development varies from traditional, societal, or cultural norms.[1]

Specifically, among the LGBTQ members, the transgender cohort disproportionately faces challenges, with approximately 25% of patients avoiding medical care owing to the fear of mistreatment. It has been noted that about 27% of transgender patients report being denied health care and 21% have experienced abusive and/or inappropriate communication in health care settings compared with 8% and 10% among lesbian, gay and bisexual patients, respectively,[3] The implicit bias of health care providers toward LGBTQ individuals and the lack of cultural competence about LGBTQ patients

From the Sentara Heart Hospital, Norfolk, Virginia; and the Eastern Virginia Medical School, Norfolk, Virginia.

Manuscript received November 20, 2021; revised manuscript received December 1, 2021; revised manuscript accepted December 13, 2021.

Reprint requests: Amin Yehya, MD, MS, FACC, FHFSA, Medical Director, MCS Program, Sentara Heart Hospital, Assistant Professor of Medicine, Cardiology, Eastern Virginia Medical School, Norfolk, VA. E-mail: amin.yehya@yahoo.com
twitter: @AminYehyaMD

[1]Dr. Yehya received honoraria from Merck, Zoll, Akcea therapeutics, and CareDx.

1071-9164/$ - see front matter

https://doi.org/10.1016/j.cardfail.2021.12.021

care can lead clinicians to erroneously assume that all patients are cisgender (individuals whose gender identity is the same as the one assigned at birth) and heterosexual.[4] This practice can create an uncomfortable environment for patients seeking care. In fact, up to one-third of the LGBTQ community do not disclose their sexual orientation and gender identity (SOGI) at all owing to fear of rejection and to being stigmatized for such a disclosure.[3]

Mental Health in LGBTQ Individuals, Including Medical Students and Health Care Providers

LGBTQ individuals struggle with intrapersonal and interpersonal stressors that increase their risk of substance abuse, mental health illnesses including depression and anxiety, and unhealthy coping skills.[1] In 1 study, medical students identifying as LGB are 2.2 times more likely to be depressed and are at 1.6−3.1 times the odds of having substance abuse disorders compared with their heterosexual counterparts.[5,6] In this study, there were no transgender respondents highlighting either the lack of representation in the medical profession or discomfort with disclosure. The Association of American Medical College surveyed medical students between year 2016 and 2017; 5.4% of responders identified as LGB. A large proportion of LGB students had concealed their sexual identity in medical school fearing discrimination and mistreatment. Compared with their heterosexual counterparts, LGB students experienced mistreatment, including humiliation, which correlated with an 8 times increased risk of burnout. Among those who experienced burnout, there was an increased rate of medical school dropout, depression, and suicidal ideation.[7]

In a profession traditionally regarded as conservative, LGBTQ physicians continue to struggle with the stigma and fear of discrimination. Workplace environments often remain unwelcoming and unsupportive for LGBTQ physicians and other health care professionals. In 1 survey, 40% of general internists witnessed homophobic references directed toward the LGBTQ community. Another survey by the American Association of Physicians for Human Rights noted that 17% of LGBTQ physicians reported that they have been denied employment, medical privileges, and promotions based on their sexual orientation.[8] These disparities can often lead to the feeling of exclusion and helplessness among the LGBTQ providers, triggering anxiety and depression.

Cardiovascular Risk in Individuals in the LGBTQ Community

Most of the research in LGBTQ health has been focused historically on HIV/AIDS and other sexually transmitted infections among men who identified as gay.[4] Despite cardiovascular disease (CVD) being a leading cause of mortality and morbidity in the United States, few data are available on the impact of CVD in the LGBTQ population. Until 2011, only 4% of all the NIH-funded studies in LGBTQ health has been focused on cardiovascular health. The collected data on cardiovascular health in LGBTQ population is not derived from health records, but from population-based surveys. It has been shown that there is an increased prevalence of tobacco abuse in adults, a higher body mass index, and increased heavy alcohol consumption in sexual minority women, and overall poor mental health in LGBTQ teens and adults.[1]

Transgender individuals appear to be at an increased risk for CVD within the LGBTQ community.[9] Transgender females taking gender-affirming hormones are at a higher risk for CVD, ischemic stroke, and venous thromboembolism when compared with cis gender females, mostly attributed to long-term estrogen use. In transgender males, more than 2 years on hormonal therapy is associated with decreased high-density lipoprotein levels and increased triglyceride and low-density lipoprotein levels, whereas in transgender females, only an increase in triglyceride levels is observed. These findings are limited, recognizing that they were population-based studies, retrospective with short a follow-up, did not include older adults, and have no mention of the dose, formulation, and mode of administration of the hormonal therapy.[9]

Heart Failure in the LGBTQ Community

There is a knowledge gap on the prevalence, incidence, pathophysiology, as well as phenotyping (eg, dietary habits, physical activity, cardiorespiratory fitness, body composition) in LGBTQ individuals with concomitant heart failure (HF). Recently, a preliminary multicenter, retrospective study involving 104 LGBTQ patients, noted that 16 patients were diagnosed with HF (approximately 15%) (9 patients with a reduced ejection fraction and 7 with a preserved ejection fraction). The preliminary data also noted that these patients had multiple risk factors, including hypertension, diabetes, coronary artery disease, dyslipidemia, and tobacco abuse, yet the majority were not receiving optimal guideline-directed medical therapy.[10]

Data related to LGBTQ individuals who fail medical management and require evaluation for advanced HF surgical options, including left ventricular assist devices and heart transplantation, are lacking. In the United States, although HIV/AIDS is disproportionately more common among LGBTQ patients, few centers offer advanced HF surgical options for patients with end-stage HF and HIV

owing to the preconceived increased risk for worse outcomes in this patient population.

Call for Action

Our patient's experience was both inspirational and an enlightenment. It underscores the challenges faced and the greater propensity for health disparities among LGBTQ individuals when compared with their heterosexual counterparts. However, this situation can be an opportunity for health care professionals, educators, administrators, and researchers as well as medical societies and legislators to work on rebuilding the trust between the LGBTQ community and the health care system. Initial steps include promoting inclusion in shared decision-making and practicing allyship. Allyship, which occurs when the leadership works in partnership with previously marginalized groups such as the LGBTQ community, can promote and cultivate relationships based on trust and accountability. Other measures include adopting a common language that is culturally sensitive and is founded on respect and integrity. As health care professionals, we need to learn about the intricacy of this community and self-reflect and evaluate any inherent biases we have toward the LGBTQ community.

Knowing that not only patients experience challenges owing to their SOGI, efforts should be made to combat discrimination and nurture a safe milieu for the medical trainees and practicing physicians who identify as LGBTQ. This process starts with ensuring that our medical schools and training facilities provide a diverse and inclusive teaching environment for LGBTQ trainees. Equally important is the need to identify a select group of LGBTQ physicians to serve as mentors for LGBTQ medical students, residents in training, and early career physicians. In addition, the leadership of the health care organizations should be invested in adopting policies and practices in their institution to ensure an inclusive and a diverse workforce environment. It starts by promoting hiring, supporting, and retaining qualified LGBTQ physicians. In addition, health care institutions should implement a zero tolerance policy for homophobic remarks or slurs and empower physicians to voice their concerns in a safe space.

In conclusion, there is paucity of data in LGBTQ patients with HF, their response to therapies, referral patterns for advanced HF surgical options when their HF progresses, and their outcomes post left ventricular assist device and heart transplantation are limited. We need clinical trial investigators and other researchers to include collecting SOGI as part of patients' demographics, and to help answer these questions, among others (Fig. 1). We have much to learn in this field. As Socrates said: "The secret of change is to focus all of your energy, not on fighting

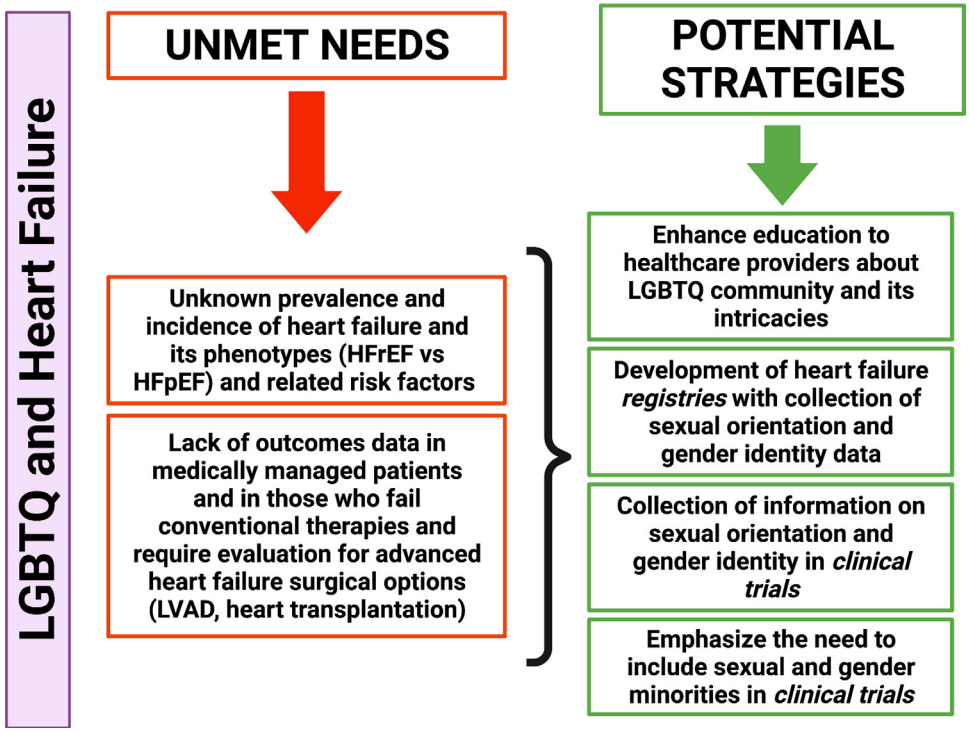

Fig. 1. The unmet needs and opportunities to address challenges in clinical research in HF and patients who identify as LGBTQ. HFrEF, HF with reduced ejection fraction; HFpEF, HF with preserved ejection fraction; LVAD, left ventricular assist device.

the old, but on building the new." We are very proud of our patient, remain steadfastly supportive of her personal journey, and, as with all of those for whom we care, are unwavering in our commitment to optimal health.

Acknowledgments

The author thanks Dr Salvatore Carbone and Dr Tracey Henry for critically reviewing the manuscript.

References

1. Caceres BA, Streed CG Jr, Corliss HL, Lloyd-Jones DM, Matthews PA, Mukherjee M, et al. American Heart Association Council on Cardiovascular and Stroke Nursing; Council on Hypertension; Council on Lifestyle and Cardiometabolic Health; Council on Peripheral Vascular Disease; and Stroke Council. Assessing and addressing cardiovascular health in LGBTQ adults: a scientific statement from the American Heart Association. Circulation 2020;142:e321–32.
2. Fredriksen-Goldsen KI, Simoni JM, Kim HJ, Lehavot K, Walters KL, Yang J, et al. The health equity promotion model: reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities. Am J Orthopsychiatry 2014;84:653–63.
3. Rossman K, Salamanca P, Macapagal K. A qualitative study examining young adults' experiences of disclosure and nondisclosure of LGBTQ identity to health care providers. J Homosex 2017;64:1390–410.
4. Coulter RW, Kenst KS, Bowe n DJ, Scout. Research funded by the National Institutes of Health on the health of lesbian, gay, bisexual, and transgender populations. Am J Public Health 2014;104:e105–12.
5. Lapinski J, Sexton P. Still in the closet: the invisible minority in medical education. BMC Med Educ 2014;14:171.
6. Williams ND, Fish JN. The availability of LGBT-specific mental health and substance abuse treatment in the United States. Health Serv Res 2020;55(6):932–43.
7. Samuels EA, Boatright DH, Wong AH, et al. Association between sexual orientation, mistreatment, and burnout among US medical students. JAMA Netw Open 2021;4:e2036136.
8. Risdon C, Cook D, Willms D. Gay and lesbian physicians in training: a qualitative study. CMAJ 2000;162:331–4.
9. Connelly PJ, Marie Freel E, Perry C, Ewan J, Touyz RM, Currie G, et al. Gender-affirming hormone therapy, vascular health and cardiovascular disease in transgender adults. Hypertension 2019;74:1266–74.
10. Radwan S, Ghazzal A, Ali L, Schwartz O. Demographics of heart failure in an LGBTQ community. J Am Coll Cardiol 2021;77(18 Suppl. 1):689.