Advancing Equity in Nephrology
Enhancing Care for LGBTQ+ Patients and Our Workforce

Dinushika Mohottige1 and Mitchell R. Lunn2,3

Introduction
Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals face social, economic, legal, health, and health care–related disparities amid evolving threats to sociopolitical advances made in the last decade (1,2). In response, organizations, including the National Institutes of Health, recommended multidisciplinary efforts to eliminate disparities affecting LGBTQ+ people (3). LGBTQ+ issues are nephrology issues, because they affect the health and well-being of our patients, their loved ones, and our colleagues and trainees in the nephrology workforce. Disproportionate substantial barriers to receiving timely, high-quality health care—including diabetes and hypertension screening—may increase kidney disease risk among LGBTQ+ individuals. Fear of discrimination may prevent LGBTQ+ patients from discussing their social supports and potential donors—including same-gender partners—in kidney transplantation evaluations. Achieving equity necessitates addressing inequalities and bias across all domains of human identity, including sexual orientation, gender identity, and gender expression. Through our collective efforts, the nephrology workforce can contribute to Healthy People 2020 goals of (1) eliminating health and health care disparities, (2) valuing all members of society with equity-driven ideals and opportunity, and (3) demonstrating unwavering efforts to undo historic and present-day injustices while improving the contexts in which disparities thrive (1).

Defining Sexual and Gender Minority Terms
The umbrella term LGBTQ+ is used to describe distinct and inherently diverse groups that share experiences of stigmatization and marginalization on the basis of sexual or gender minority status (3). The term sexual and/or gender minority (SGM) is a larger umbrella term that includes LGBTQ+ individuals as well as those who are not heterosexual or who are not cisgender (i.e., gender identity consistent with sex assigned at birth). We use SGM in this perspective.

To best understand the “sexual minority” and “gender minority” classifications, understanding relevant terminology—sexual orientation, gender identity, and gender expression—is required. Sexual orientation is a complex construct incorporating romantic/emotional attraction, sexual behavior, and identity (3). Sexual minority individuals are those who have a nonheterosexual sexual orientation. Although “lesbian,” “gay,” and “bisexual” may be the most described sexual orientations, other distinct sexual orientations (e.g., asexual, pansexual, queer, and same-gender loving) are now increasingly visible.

Gender identity and gender expression (3) are relevant terms for gender minority individuals—that is, people whose gender identity differs from their sex (female or male) assigned at birth. The term “transgender” can describe people who (1) have a gender identity (i.e., gender with which an individual identifies) different from their sex assigned at birth, (2) have a gender expression (i.e., method in which a gender identity is expressed in appearance, behavior, etc.) that varies from the expression typically associated with their sex assigned at birth, or (3) vary from or reject the social construct of a female-male gender binary. Those in this last group may also be described as “nonbinary” or “gender nonconforming” and may not necessarily identify as transgender.

Importantly, gender identity is distinct from sexual orientation; transgender and gender nonconforming individuals can have any sexual orientation just as sexual minority individuals can have any gender identity. Avoiding assumptions and acknowledging a person’s self-designated name, pronouns (e.g., she/her/hers, they/them/theirs), and partnership(s) are important elements of respectful communication.

Challenges Facing SGM People
Accurate estimates of the size, demographics, and health of SGM communities are unavailable, because there is no standardized collection of sexual orientation and gender identity in longitudinal, large-scale research (1) and federal studies (including the census). Medical mistrust is a well-described impediment to research participation, health service utilization, and health care satisfaction among racial and ethnic minority individuals (4). Operating through discriminatory experiences, mistrust also exacerbates SGM under-representation (especially of gender minorities) in research. Estimated to represent 4%-6% of the United States population (1), SGM individuals are at higher risk for bullying, isolation, violence, and resultant deleterious health behaviors and mental and physical health effects compared with their non-SGM counterparts.
peers (1,3). Violence against transgender and gender non-conforming individuals, especially transgender women of color, is alarming. Among transgender individuals, >33% had a negative experience in health care, including harassment or denial of care, and >75% took steps to avoid mistreatment at work, including hiding or delaying gender transition or quitting their jobs (5). SGM individuals are disproportionately burdened with anxiety, depression, suicide, substance abuse, homelessness, sexually transmitted infections, cardiovascular disease, and other negative physical and mental health outcomes (5,6). These disparities also affect our workforce and trainees. In a study of SGM physicians, 15% reported harassment from colleagues, 22% reported feeling ostracized by colleagues, and 65% heard derogatory comments about SGM individuals at work (7). In addition to implicit and explicit bias, SGM providers may struggle with disclosing their SGM identities for fear of negative consequences, including patient dismissal, delayed promotion/advancement, or isolation at work (8). SGM-identified medical students face similar challenges, with many reporting discriminatory experiences and nondisclosure of their identities, highlighting the need for targeted interventions to address discrimination and promote inclusive culture change within our profession (8).

Intersectionality is a critical framework for health equity work (9), and it is on the basis of the premise that “multiple social identities (e.g., race, socioeconomic status, gender)...intersect at the individual level...to reflect interlocking systems of privilege...at the socio-structural level” (e.g., homophobia, transphobia, and racism) to produce health inequalities (3,9). Intersectional approaches recognize that SGM people are simultaneously members of other groups, including those defined by race, ethnicity, culture, religion, ability, age, immigration status, socioeconomic status, and other identifying characteristics. Certain SGM communities experience compounded challenges because of additional experiences of discrimination and marginalization (e.g., racism and sexism) (9). We must address these unique experiences and all forms of bias and discrimination in our research, advocacy, and clinical efforts toward equity.

In spite of these formidable challenges, modifiable determinants of SGM health exist. Poor quality of care and negative SGM health outcomes are linked to (1) limited provider knowledge about SGM health needs and inclusive methods for person-centered communication, (2) historic and persistent individual- and system-level discrimination, and (3) mistrust-related health care avoidance (8). Each is exacerbated by limited education and bias-reducing interventions throughout medical training and variability in the quality and depth of the SGM-related medical curricula (10). Workforce and training issues are exacerbated by legal and structural inequities facing SGM people. The majority of states do not have laws protecting SGM people from discrimination in health insurance, employment, housing, and other social determinants.

At the institutional/clinical level, inclusive environments may include SGM-affirming and inclusive signage and educational materials in waiting rooms, dialysis units, and other clinical areas (e.g., visible nondiscrimination statements that expressly include SGM individuals; images of SGM people; SGM-associated symbols, such as the rainbow; and all-gender restrooms); institutional nondiscrimination policies that protect SGM patients and staff; health care providers competent in SGM-specific health care needs as well as culturally and structurally competent communication; and inclusive intake forms and electronic medical records. Many environments remain far from this ideal and negatively affect our patients and workforce: a patient on dialysis who never feels comfortable coming out after having witnessed discriminatory anti-SGM comments from other patients/staff or a colleague who struggles to disclose their decade-long relationship with a same-gender partner out of fear of being professionally isolated, harassed, fired, or dismissed by patients. There is a clear role for each of us in the path toward equity.

The Path Forward

We must move beyond conversations describing inequality. We must embrace our responsibility to undo inequality and enhance equity across all identity domains. We propose engaging the following evidence-based strategies to enhance equity for SGM individuals.

- Enhance inclusion by implementing antidiscrimination policies that codify protections and benefits for all individuals. These policies should (1) be upheld without retribution for reporting; (2) explicitly mention gender identity, gender expression, and sexual orientation; and (3) encompass multiple domains, including recruitment, hiring, retention, clinical care, and the physical and cultural workplace environment (e.g., access to health insurance, all-gender restrooms, SGM-inclusive intake forms, communication, and electronic health records that include diverse gender and sexual identities).

- Provide intersectionality training to teach how different forms of discrimination result in some individuals within SGM communities bearing a disproportionate burden of stress, violence, and inequality. SGM advocacy must simultaneously combat all other forms of discrimination and bias (e.g., racism, ableism, and xenophobia). Without this, inequality and divisiveness thrive.

- Enhance and expand bias-reduction interventions and training around SGM health to increase capacity in providing equitable and compassionate care to our patients and support for the SGM workforce. Our organizational efforts to support SGM individuals and other groups disproportionately burdened by inequalities should also promote structural competency (8) to advocate for and improve the multilevel social determinants that contribute to health disparities.

- Engage and welcome SGM-identified staff, trainees, and patients across educational and clinical efforts to increase and diversify SGM representation in our clinical, research, and advocacy workforce.

- Conduct research and clinical care that includes, assesses, and engages SGM people using standardized measures to better understand and combat health inequities.

- Commit to self-education and equity-enhancing culture change, including open and inclusive feedback mechanisms, to ensure that SGM voices and perspectives are valued. Being attuned and responsive to diverse voices enhances organizational culture and ensures that we are equipped to care for each other and all individuals who we serve across the continuum of kidney disease.
Acknowledgments

We thank Juno Obedin-Maliver for her review of this manuscript. We thank the American Society of Nephrology (ASN) and the ASN Diversity and Inclusion Committee for their commitment to promoting diversity and inclusiveness within the ASN to enhance the nephrology profession and the lives of people with kidney diseases through improved health care, research, and education.

Dr. Mohottige served as the 2018–2019 American Society of Nephrology Diversity and Inclusion Committee Intern, and was supported by a training grant (2T32-DK007731-22) from the National Institute of Diabetes and Digestive and Kidney Diseases. Dr. Lunn is a member of the American Society of Nephrology Diversity and Inclusion Committee.

The content of this article does not reflect the views or opinions of the ASN or the CJASN. Responsibility for the information and views expressed therein lies entirely with the author(s).

Disclosures

None.

References


Published online ahead of print. Publication date available at www.cjasn.org.