Academic Emergency Medicine
Editor-in-Chief Pick of the Month

Competency

This month's EIC POTM focuses on a dimension of competency required of a wholly developed emergency physician. Some refer to this domain as cultural competency. Some call it humanism. My daughter, being taught this domain in her first year of medical school, calls this "learning to not be a jerk."

This topic starts with the basic premise of respect for persons. The specific topic addressed by the mixed-methods paper by Maragh-Bass, et al, is how to address our patients' sexual orientation and gender identity to optimize dignity and respect, and provide data needed for high value medical care and processes. Anyone who practices emergency medicine long enough will have heard the apocryphal ER tale of the biological male patient who happens to dress as a woman (a person who used to be called a "transvestite"), and who was in the ED with abdominal pain, and who ended up in stirrups for a pelvic examination.

The work by Maragh-Bass conveys the striking imperative for emergency physicians to have open hearts and open minds; the mandate to advocate for all patients. Consider this statement by a transgender male participant, on the need for provider education in LGBT health:

"If I know that my provider is competent in transgender care. I don't like having to explain my situation for them to understand. I am here for a medical concern, not to teach them about what being transgender is…"

In the negative perspective, a block-headed doc who has transgender agnosia can fail to access medically important information as underscored by the statements of another transgender male study participant:

"Asking not just orientation but behaviors, having knowledge about how I have sex and risk factors, understanding the uncomfortableness of discussion."

The medical effect of transgender cluelessness can be illustrated by way of analogy using this never-to-happen contrived scenario: You see a patient with chest pain, and are handed the just-printed ECG. You stare at it quizzically, furrow your brow, and hand it to the patient and ask "…can you help me read this damn thing? Just looks like a bunch of squiggly lines to me."

This paper is about having a clue, or in corollary, not being perceived as clueless by 4% of your patients. I submit this paper to you as the EIC POTM because it will achieve the rare act of effecting positive change to the way some of us think and act.

Best Wishes,
Jeffrey A. Kline
Editor-in-Chief, Academic Emergency Medicine

Narrative Summary

Zachary F. Meisel, MD, Associate Professor of Emergency Medicine at the Perelman School of Medicine at the University of Pennsylvania, places the EIC Pick into perspective in the emergency setting:

A few years back, I worked at a hospital that launched a campaign to attract more LGBT patients by increasing and advertising for health care services for this population. Located in a neighborhood known for its strong and dynamic LGBT community, it was a natural and laudable goal to expand and improve care in this realm. Yet clearly there were gaps in this effort. Notably, we, the providers and staff who worked in the emergency department and elsewhere, were not given additional training about how, when, and why to ask and collect sexual orientation (SO) and gender identity (GI) information. I wish we had. Because as Drs. Maragh-Bass and colleagues illuminate, there is nuance to this process. For example, asking about SO has different meaning for many of our patients than asking about GI, and asking these questions in order to collect and track accurate data – while important – can, for some patients, be different than asking for therapeutic purposes. In sum, it's complicated. Doubtless, we needed (and

still need) better training and education in this realm in order to improve care and reduce disparities for LGBT patients.