Health Care Discrimination and Care Avoidance Due to Patient-Clinician Identity Discordance Among Sexual and Gender Minority Adults

Michael Liu, MPhil[1]
Vishal R. Patel, MD, MPH[1,2]
Sahil Sandhu, MSc[1]
Sari Reisner, ScD[3,4,5]
Alex S. Keuroghlian, MD, MPH[1,4,6]

[1]Harvard Medical School, Boston, Massachusetts

[2]Department of Surgery, Brigham and Women's Hospital, Boston, Massachusetts

[3]Department of Epidemiology, Harvard T. H. Chan School of Public Health, Boston, Massachusetts

[4]The Fenway Institute, Fenway Health, Boston, Massachusetts

[5]Department of Epidemiology, University of Michigan School of Public Health, Ann Arbor, Michigan

[6]Department of Psychiatry, Massachusetts General Hospital, Boston, Massachusetts

MORE ONLINE
www.annfammed.org

Conflicts of interest: A.S.K and S.R. report receiving royalties as editors of a McGraw Hill textbook on transgender and gender diverse health care. A.S.K. also reports receiving royalties as editor of an American Psychiatric Association textbook on gender-affirming psychiatric care. No other disclosures were reported.

CORRESPONDING AUTHOR

Michael Liu
Harvard Medical School
25 Shattuck Street
Boston, MA, 02115
mliu02@hms.harvard.edu

ABSTRACT

Sexual and gender minority (SGM) adults experience poor health outcomes, in part due to frequent avoidance of necessary health care. Little is known, however, about factors contributing to patterns of health care utilization in this population. Using national data from the All of Us Research Program, this study evaluated the prevalence of care avoidance due to patient-clinician identity discordance (PCID) and its association with health care discrimination among SGM adults. Sexual minority (20.0% vs 9.4%; adjusted rate ratio [aRR] = 1.58; 95% CI, 1.49-1.67, $P < 0.001$) and gender minority adults (34.4% vs 10.3%; aRR = 2.00; 95% CI, 1.79-2.21, $P < 0.001$) were significantly more likely than their non-SGM counterparts to report care avoidance due to PCID. Exposure to health care discrimination was also more prevalent in this population and was dose-dependently associated with significantly higher rates of PCID-based care avoidance. Study findings highlight the importance of diversifying the health care workforce, expanding SGM-related clinical training, and preventing health care discrimination against SGM patients.

Ann Fam Med 2024;22:329-332. https://doi.org/10.1370/afm.3130

INTRODUCTION

Sexual and gender minority (SGM) adults experience worse health outcomes than their non-SGM counterparts, due in part to more frequent avoidance of necessary health care.[1,2] These health inequities are ascribed to a range of structural and interpersonal minority stressors associated with belonging to a marginalized group, including discrimination experienced by this population in health care settings.[3]

Previous studies have shown that identity discordance between patients and clinicians is associated with worse self-rated patient experience and less receipt of necessary care.[4,5] The mechanisms posited to explain better outcomes in racially concordant patient-clinician dyads include more patient-centered communication, greater levels of patient trust, and higher quality of care.[6-8] Some evidence also suggests that perceptions of discrimination compel racially minoritized patients to seek care from clinicians with concordant racial identities.[9]

It is not currently known, however, whether these phenomena surrounding identity discordance extend to SGM patients. Therefore, this study evaluated the prevalence of care avoidance due to patient-clinician identity discordance (PCID) and its potential association with health care discrimination among SGM adults.

METHODS

We conducted a cross-sectional analysis of the National Institutes of Health's All of Us Research Program, a national and community-engaged cohort that explicitly aims to recruit participants from communities historically underrepresented in biomedical research.[10] Data were collected from adults aged 18 years or older enrolled from May 2018 to July 2022 through a health care provider organization or enrollment website.

We identified sexual minority, heterosexual, gender minority, and cisgender adults based on responses to self-identified sexual orientation, gender identity, and sex assigned at birth questions. PCID-based care avoidance was defined as an affirmative response to delaying or forgoing care because a clinician was of a different

background. We measured exposure to health care discrimination using the validated Discrimination in Medical Settings Scale.[11]

Additional survey and measure details are available in Supplemental Table 1 and Supplemental Table 2. The Supplemental Figure shows the flowchart of eligible and included study participants.

We used multivariable robust Poisson regression to compare the prevalence of PCID-based care avoidance by sexual orientation and gender identity. Models were adjusted for age, sex, race and ethnicity, household income, educational attainment, insurance status, relationship status, birthplace, and survey year. We then added health care discrimination scores to models using natural cubic splines to evaluate the association between health care discrimination and PCID-based care avoidance in this population. Interaction terms between sexual orientation or gender identity and health care discrimination scores were also included to evaluate differential associations between SGM and non-SGM adults. Adjusted prevalence rates of PCID-based care avoidance at specific levels of health care discrimination were derived using marginal standardization.

A 2-sided P <0.05 defined statistical significance. Analyses were performed in the All of Us Researcher Workbench using R, version 4.2.2 (the R Foundation for Statistical Computing). The All of Us Institutional Review Board approved study procedures and all participants provided written informed consent.

RESULTS

Of 97,130 participants with sexual orientation data, 9,699 (10.0%) were identified as sexual minorities and 87,431 (90.0%) as heterosexual. Of 98,309 participants with gender

Table 1. Characteristics of All of Us Participants by Sexual Orientation and Gender Identity

	No. (%)					
	Heterosexual Adults	Sexual Minority Adults	*P* Value[a]	Cisgender Adults	Gender Minority Adults	*P* Value[a]
Sample size, No.	87,431	9,699		97,032	1,277	
Health care discrimination score, median (IQR)	1.29 (0.86)	1.57 (1.00)	<0.001	1.43 (0.86)	2.00 (1.14)	<0.001
Age, median (IQR)	61 (23)	44 (29)	<0.001	60 (24)	33 (19)	<0.001
Female sex	57,131 (65.3)	6,005 (61.9)	<0.001	63,039 (65.0)	915 (71.6)	<0.001
Race and ethnicity						
Asian	2,317 (2.7)	256 (2.7)	<0.001	2,589 (2.7)	44 (3.5)	
Black	6,188 (7.2)	510 (5.3)		6,808 (7.1)	47 (3.7)	
Hispanic	6,808 (7.9)	888 (9.2)		7,853 (8.2)	109 (8.6)	
Other[b]	2,339 (2.7)	435 (4.5)		2,775 (2.9)	71 (5.6)	
White	68,505 (79.5)	7,527 (78.3)		75,613 (79.1)	992 (78.5)	
Annual household income, $						
<25,000	9,459 (12.0)	1,826 (19.9)	<0.001	11,282 (12.8)	321 (27.2)	<0.001
25,000-50,000	12,915 (16.3)	1,873 (20.4)		14,680 (16.7)	282 (23.9)	
50,00-100,000	24,146 (30.5)	2,594 (28.3)		26,682 (30.3)	301 (25.5)	
100,000-150,000	15,154 (19.2)	1,378 (15.0)		16,475 (18.7)	155 (13.1)	
≥150,000	17,407 (22.0)	1,489 (16.3)		18,827 (21.4)	123 (10.4)	
Educational attainment						
High school or lower	8,839 (10.2)	879 (9.1)	<0.001	9,873 (10.3)	155 (12.2)	<0.001
Some college	20,110 (23.2)	2,374 (24.6)		22,422 (23.3)	352 (27.8)	
Bachelor's degree or higher	57,721 (66.6)	6,384 (66.2)		63,882 (66.4)	758 (59.9)	
Uninsured	1,930 (2.2)	256 (2.7)	0.007	2,213 (2.3)	46 (3.7)	0.002
Relationship status						
Married or living with partner	56,621 (65.3)	4,692 (48.8)	<0.001	61,178 (63.6)	550 (43.6)	<0.001
Never married	12,077 (13.9)	3,600 (37.5)		15,556 (16.2)	552 (43.8)	
Widowed, separated, or divorced	18,026 (20.8)	1,313 (13.7)		19,453 (20.2)	159 (12.6)	
Non-US–born	8,326 (9.6)	706 (7.3)	<0.001	9,222 (9.6)	74 (5.8)	<0.001

IQR = interquartile range.

[a] Characteristics were compared across sexual orientation and gender identity groups using χ^2 tests and Mann-Whitney U tests.

[b] Individuals who identified as "Middle Eastern or North African," "Native Hawaiian or Other Pacific Islander," "More Than One Population," or "None of These."

Table 2. Care Avoidance Due to Patient-Clinician Identity Discordance Among Sexual and Gender Minority Adults

Group	Care Avoidance Due to Patient-Clinician Identity Discordance		
	No. (%)	Adjusted Rate Ratio (95% CI)	*P* Value
Sexual orientation			
Heterosexual adults (n = 87,431)	8,192 (9.4)	[Ref]	[Ref]
Sexual minority adults (n = 9,699)	1,944 (20.0)	1.58 (1.49-1.67)	<0.001
Gay adults (n = 2,673)	394 (14.7)	1.79 (1.60-2.01)	<0.001
Lesbian adults (n = 1,497)	248 (16.6)	1.47 (1.28-1.68)	<0.001
Bisexual adults (n = 3,973)	865 (21.8)	1.43 (1.32-1.55)	<0.001
Gender identity			
Cisgender adults (n = 97,032)	9,968 (10.3)	[Ref]	[Ref]
Gender minority adults (n = 1,277)	438 (34.3)	2.00 (1.79-2.21)	<0.001
Transgender adults (n = 417)	131 (31.4)	2.03 (1.67-2.43)	<0.001
Non-binary adults (n = 626)	206 (32.9)	1.79 (1.54-2.07)	<0.001

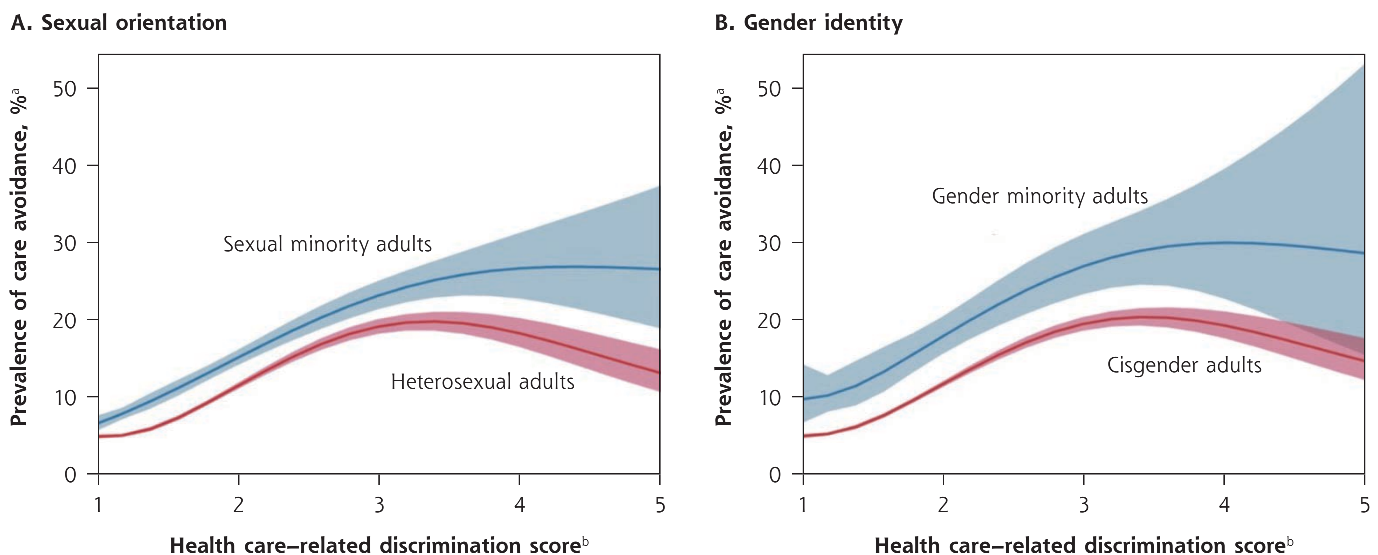
Note: Adjusted rate ratios are from robust Poisson regression models adjusting for age, sex assigned at birth, race and ethnicity, annual household income, educational attainment, insurance status, relationship status, birthplace, and survey year.

identity data, 1,277 (1.3%) were identified as gender minorities and 97,032 (98.7%) as cisgender. Sexual and gender minority adults were more likely to have lower income, be younger, uninsured, and not married or living with a partner compared with heterosexual and cisgender adults (Table 1).

After adjusting for sociodemographic characteristics, sexual minority adults were significantly more likely than heterosexual adults to report PCID-based care avoidance (20.0% vs 9.4%; adjusted rate ratio [aRR] = 1.58; 95% CI, 1.49-1.67; *P* <0.001) (Table 2). Gender minority adults were also more likely to report PCID-based care avoidance than cisgender adults (34.3% vs 10.3%; aRR = 2.00; 95% CI, 1.79-2.21; *P* <0.001). Similar patterns were observed among gay (aRR = 1.79; 95% CI, 1.60-2.01; *P* <0.001), lesbian (aRR = 1.47; 95% CI, 1.28-1.68; *P* <0.001), bisexual (aRR = 1.43; 95% CI, 1.32-1.55; *P* <0.001), transgender (aRR = 2.03; 95% CI, 1.67-2.43; *P* <0.001), and non-binary adults (aRR = 1.79; 95% CI, 1.54-2.07; *P* <0.001).

Median health care discrimination scores were higher among sexual minority (1.57 [interquartile range (IQR) = 1.00] vs 1.29 [IQR = 0.86]; *P* <0.001) and gender minority adults (2.00 [IQR = 1.14] vs 1.43 [IQR = 0.86], *P* <0.001) relative to their non-SGM counterparts. Among SGM adults, health care discrimination scores were associated with a higher prevalence of PCID-based care avoidance in a dose-dependent manner (Figure 1). Sexual minority adults with health care discrimination scores of 1 had an adjusted prevalence of 6.1% (95% CI, 5.2-7.2) vs

Figure 1. Health care discrimination and care avoidance due to patient-clinician identity discordance by sexual orientation and gender identity.



Note: Adjusted prevalence rates were derived from multivariable robust Poisson regression models that included sexual orientation (Panel A) or gender identity (Panel B), health care discrimination score, an interaction term between sexual orientation × health care discrimination score or an interaction term between gender identity × health care discrimination score, age, sex assigned at birth, race and ethnicity, annual household income, educational attainment, insurance status, relationship status, birthplace, and survey year. Health care discrimination scores were modeled using natural cubic splines with 3 degrees of freedom. Shaded regions represent 95% CIs.

[a] Participants delaying or forgoing health care because clinician was of a different background.

[b] Health care discrimination was assessed using the 7-item Discrimination in Medical Settings scale, which measures exposure to discrimination while receiving health care (eg, provided poorer service or treated with less courtesy and respect). All items were scored on a 5-point Likert scale (from 1 = never to 5 = always). The final score was calculated by summing responses across all items (resulting in total scores between 7 and 35) and calculating a mean score by dividing this sum by the number of answered questions (resulting in mean scores between 1 and 5).

26.1% (95% CI, 18.5-36.9) among those with scores of 5. The corresponding prevalence rates of PCID-based care avoidance were 4.7% (95% CI, 4.4-5.0) and 28.3% (95% CI, 15.2-53.0) for gender minority adults, respectively.

DISCUSSION

This study found that SGM adults in the United States disproportionately reported avoiding care because of perceived patient-clinician identity differences. One in 5 sexual minority adults and more than one-third of gender minority adults shared this experience. These rates were 58% and 100% higher relative to those of their non-SGM counterparts, respectively. Notably, exposure to discrimination in health care settings was more prevalent among SGM adults and was dose-dependently associated with significantly higher rates of PCID-based care avoidance.

To our knowledge, this study is among the first to quantitatively demonstrate that identity concordance between SGM patients and their clinicians plays an important role in seeking necessary health care. These findings are consistent with emerging qualitative research showing that SGM patients prefer clinicians who share similar sexual orientations and/or gender identities.[12] Participants attributed this preference to the need for affirming care, desire for SGM-specific expertise, and perceptions of safety, comfort, and solidarity.[13] Preferences for identity-concordant clinicians are particularly salient among SGM patients who have previously experienced stigma and discrimination in health care settings.[14] Future studies should investigate whether identity concordance between SGM patients and clinicians improves patient experience, quality of care, and health outcomes.

Our study has some limitations. First, the questionnaire used to ascertain care avoidance due to PCID referred to identity broadly and did not explicitly reference sexual orientation or gender identity. Second, the All of Us cohort is not a probability sample of the US population, although it is one of the largest and most diverse samples of SGM adults. Third, an intersectional analysis across sexual orientation, gender identity, race, and ethnicity could not be pursued given limited subgroup sample sizes and should be a priority for future research, especially as the All of Us cohort continues to recruit more participants.[15]

The findings of this study suggest that reducing SGM health inequities will require concerted efforts from health systems and policymakers. For example, health care and educational institutions should prioritize recruitment and retainment of workforces with diverse sexual orientations and gender identities. The provision of affirming and inclusive care for SGM patients, however, is not solely the responsibility of SGM clinicians. National policy strategies to universally mandate adequate SGM-related clinical training and explicitly prohibit anti-SGM health care discrimination are needed to improve the care experience and health of SGM patients.[16]

Key words: primary care; health care workforce; health care utilization; LGBTQ; vulnerable populations; health equity

Submitted October 22, 2023; submitted, revised, March 18, 2024; accepted April 12, 2024.

References

1. Liu M, Sandhu S, Reisner SL, Gonzales G, Keuroghlian AS. Health status and health care access among lesbian, gay, and bisexual adults in the US, 2013 to 2018. *JAMA Intern Med*. 2023;183(4):380-383. 10.1001/jamainternmed.2022.6523
2. Thomas SD, Dempsey M, King RJ, Murphy M. Health care avoidance and delay in the transgender population: a systematic review exploring associations with minority stress. *Transgend Health*. Published February 12, 2024. 10.1089/trgh.2022.0202
3. Casey LS, Reisner SL, Findling MG, et al. Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans. *Health Serv Res*. 2019;54(Suppl 2)(Suppl 2):1454-1466. 10.1111/1475-6773.13229
4. Takeshita J, Wang S, Loren AW, et al. Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. *JAMA Netw Open*. 2020;3(11):e2024583. 10.1001/jamanetworkopen.2020.24583
5. Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med*. 1999;159(9):997-1004. 10.1001/archinte.159.9.997
6. Street RL Jr, O'Malley KJ, Cooper LA, Haidet P. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. *Ann Fam Med*. 2008;6(3):198-205. 10.1370/afm.821
7. Shen MJ, Peterson EB, Costas-Muñiz R, et al. The effects of race and racial concordance on patient-physician communication: a systematic review of the literature. *J Racial Ethn Health Disparities*. 2018;5(1):117-140. 10.1007/s40615-017-0350-4
8. Frakes MD, Gruber J. Racial concordance and the quality of medical care: evidence from the military. *Natl Bur Econ Res*. Published Dec 2022. 10.3386/w30767
9. Chen FM, Fryer GE Jr, Phillips RL Jr, Wilson E, Pathman DE. Patients' beliefs about racism, preferences for physician race, and satisfaction with care. *Ann Fam Med*. 2005;3(2):138-143. 10.1370/afm.282
10. Denny JC, Rutter JL, Goldstein DB, et al; All of Us Research Program investigators. The "All of Us" research program. *N Engl J Med*. 2019;381(7):668-676. 10.1056/NEJMsr1809937
11. Peek ME, Nunez-Smith M, Drum M, Lewis TT. Adapting the everyday discrimination scale to medical settings: reliability and validity testing in a sample of African American patients. *Ethn Dis*. 2011;21(4):502-509.
12. Harner V, Moore M, Casillas B, Chrivoli J, Lopez Olivares A, Harrop E. Transgender patient preferences when discussing gender in health care settings. *JAMA Netw Open*. 2024;7(2):e2356604. 10.1001/jamanetworkopen.2023.56604
13. Matsuzaka S, Romanelli M, Hudson KD. "Render a service worthy of me": a qualitative study of factors influencing access to LGBTQ-specific health services. *SSM Qual Res Health*. 2021;1:100019. 10.1016/j.ssmqr.2021.100019
14. Martos AJ, Wilson PA, Gordon AR, Lightfoot M, Meyer IH. "Like finding a unicorn": healthcare preferences among lesbian, gay, and bisexual people in the United States. *Soc Sci Med*. 2018;208:126-133. 10.1016/j.socscimed.2018.05.020
15. Bauer GR. Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity. *Soc Sci Med*. 2014;110(110):10-17. 10.1016/j.socscimed.2014.03.022
16. Liu M, Sandhu S, Keuroghlian AS. Achieving the triple aim for sexual and gender minorities. *N Engl J Med*. 2022;387(4):294-297. 10.1056/NEJMp2204569