

Title: EASD 23: Epidemiologic Trends & Disparities in Diabetes Risk Among LGBTQ+ Population

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*Please note that the text below has not been copyedited.*

Dr. Carl Streed:

I'm Dr Carl Streed. I'm the Research Lead in the Gender Care Centre at Boston Medical Centre and also a primary care clinician and funded researcher focused on cardiovascular health for LGBTQ populations.

The topic of our talk is going to be on the trends and understanding of diabetes risk factors and outcomes for broadly LGBTQ+ populations.

What is the existing evidence on the health of LGBTQ+ individuals?

For LGBTQ populations in general, we're really trying to play catch up in understanding their health and well-being across a number of conditions and issues. A lot of the work that we are doing essentially models after what has been done understanding diabetes and racial and ethnic marginalized populations, particularly in the US.

What we are finding is that when we do have the data to really compare LGBTQ folks to their straight and cisgender peers, we're seeing a number of disparities in issues in healthcare access, but also in actual healthcare outcomes. Including higher likelihood of diabetes, self-reported diabetes among gay and bisexual men, issues around risk factors for diabetes, such as lower physical activity, increased excess weight, or obesity among a number of subpopulations, including, for example, lesbian and bisexual women for some trans populations as well.

It's one of those situations where we're really characterizing something that we wish we could have characterized a few decades ago.

How do you explain the observed health disparities?

A lot of the disparities we feel are related to the experience of being marginalized in society. Again, similar to a lot of the research that has been done around racial and ethnic marginalized populations, there are effects for how society treats individuals and how people interact with society. What we see is through what we describe as the minority stress model, is that more experiences of stress or more experiences of discrimination lead to worse health outcomes. This can be through particularly mental health issues in terms of higher rates of depression and anxiety related to discrimination, but it can also be tied to issues around coping behaviour such as tobacco or alcohol use, or even essentially not feeling like they can engage in physical activity that would be helpful for their health.

And lastly, where we're seeing more research, thankfully is trying to understand how discrimination essentially gets under the skin. How does it get internalized in a way that affects people's physiology?

We have some experimental studies that show that the experience of either anticipated discrimination or what's called hypervigilance leads to higher and prolonged elevations in cortisol

and other stress markers that can lead to immune dysregulation and a number of issues that predispose people to diabetes as well as other cardiovascular outcomes.  
How can healthcare professional make a difference for LGBTQ+ patients?

Healthcare professionals have a lot of opportunities to help their patients. First, of course, in the one on one, in terms of assessing their risk factors, trying to understand them in a holistic manner, in terms of what may be motivating some of their coping behaviour, in terms of maybe alcohol use or inability to engage in recommended levels of physical activity.

All of those are things that we should be doing anyways. But I think it's worth us trying to peel back and understand what might be some of the motivations or barriers to them engaging in what we describe as healthier behaviour. But also, there is a notion of when somebody is diagnosed, how do we engage them in care?

In terms of certain programs that really have been proven to help, in terms of one on one, maybe nutrition counselling or ensuring that they're connected to a support group, I think we need to think about support groups that are specifically tailored around people's identities and the need for additional community support.

So as an example, for some individuals, for a trans individual, a trans woman going to a women's focused group may not actually be the most welcoming because their experience may be different compared to a lot of the cisgender individuals. Or again, trying to avoid making assumptions based on somebody's sex assigned to birth and which support group they should be in. But then, lastly, healthcare professionals still carry a significant amount of power within society. They should be advocating for, at minimum avoidance of any kind of discriminatory policies or laws, but then also really trying to advocate for additional community support resources for broadly LGBTQ populations.

My experience is very much in the US context, but we definitely see this with a lot of our international partners where there is no place that has got it all right in terms of ensuring people are not being discriminated against. So there's a lot of opportunities for healthcare professionals to weigh in and really advise folks on what is best for the population from their perspective.

What are the positive changes observed in the recent years?

In terms of the broader context, we definitely are seeing more larger healthcare organizations really speaking out against any kind of discriminatory policies, which is for me, as somebody who's part of the community and who does work with the community, really appreciative, really makes a difference in terms of trying to stall some negative legislation.

I think it's also important to recognize that as we have more evidence to really support these efforts, we need to really make sure that we are getting that in front of legislators and policymakers and people who are making the determinations that affect us. And I'm seeing again, more healthcare organizations really stepping up and doing that. I think it's just a reminder. We always have to have our individual members do that as well and really thinking about how that work can be done locally, not only just at a larger national perspective, but also locally.

What are the resources available?

There are a number of resources. Again, from my perspective in the US context, there is the American Heart Association scientific statements on cardiovascular health for LGBTQ populations as

well as specifically for trans and gender diverse populations. I help author those and provide an overview of the evidence. In terms of the clinical care issues, there are also opportunities to work more broadly around LGBTQ health within specific organizations within each nation, particularly a number of organizations, including the International Lesbian Gay Association, that covers most of Western Europe. That really provides a lot of insight and guidance for how to one, include better data collection, but also ensure that people are being protected.

There are plenty of opportunities to learn about the clinical effects and clinical ways we can do things, but also to get involved with a number of organizations that have been advocating for marginalized populations for decades.

How can we address the key data gaps?

There are a number of gaps in the data in terms of we just need people to actually be collecting sexual orientation, sexual identity, and gender identity information for us to begin to do better around population-level research. A lot of the research that I will present, it is really utilizing the most recent data just in the past 5-10 years around the experience of LGBTQ folks. What we need is just more data, and we need that data to exist in longitudinal studies. In the US context, for example, there's only one of a dozen cardiovascular longitudinal studies that include sexual orientation, gender identity, and those questions are only added in the past two, three years. We need so much more data to understand what's going on and we need to remind researchers that participants actually really want to answer these questions. T

here's been research specific to how comfortable people feel about answering questions around sex orientation, gender identity. Participants and patients are far more comfortable answering those questions than clinicians or researchers are asking them. I think we need to really get over our own discomfort and let our patients and research participants provide that information.

I think one last thing I would like to emphasize is that, as I mentioned earlier, we are really trying to fill in gaps in the data, really trying to catch up where we should be. That also requires us to train our clinicians and researchers now to be able to recognize that there are opportunities to do better for LGBTQ population health.