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Review article

Improving the health care experiences of lesbian, gay, bisexual and transgender patients

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ABSTRACT

Systematic discrimination against lesbian, gay, bisexual and transgender people (LGBT) persists across most contemporary societies and institutions such as health care despite increasing social tolerance and legislative progress. This article explores discrimination against LGBT people, and examines LGBT health and social issues. The implications this has for health care access and quality of care delivered by patient-facing health care professionals such as radiographers are explored. Finally, three categories of suggestions to improve the care of LGBT patients are suggested; changes to the physical environment, improvement in health forms and awareness training. Some of these suggestions can be taken up directly by radiographers, particular accessing training. Others (such as positive changes in the physical space) could be championed by department managers. There is a need to promote better culturally competent training for radiographers to be able to sensitively respond to their LGBT patients' specific health and social needs.

Introduction

Attitudes towards lesbian, gay, bisexual and transgender (LGBT) people have shifted significantly in the last few decades. Advancements in human rights (such as access to legal marriage and anti-discrimination legislation), and the decrease in criminalisation and medicalisation of homosexuality have resulted in LGBT people becoming more visible, including in our health care environments. However, despite these social and legislative changes, discrimination against LGBT people still persists across most contemporary societies.[1]

This exploratory review paper examines some of the issues facing LGBT people, and how these may impact on how they experience and access health care. The paper can serve as an introduction to the topic, and suggestions are made for patient-facing health care professionals (HCPs) such as radiographers to improve the experience of care for LGBT patients.

Review methodology

A search was made of the CINAHL/CINAHL PLUS, PubMed, Academic Search Complete, and Proquest Nursing and Allied Sources databases for articles that dealt with LGBT patients, health care staff and their use of the health care system. To ensure the reviewed literature is relatively recent, the search was limited to English journal articles published after 2000. There was no restriction on the origin of the publication. Additionally, an internet search for health care organisation and association guidelines, policies and background papers was conducted. Finally, the authors carried out a targeted search of the three main international medical radiation science journals for papers on LGBT patients, staff or related issues.

Terminology and definitions

The terminology used in LGBT literature and by LGBT people can be varied and confusing, thus the following section contains a brief explanation of some of the more commonly used words. The term sexual orientation defines who the person is sexually attracted to whereas gender identity relates to an individual's sense of being female, male or other gender.[2] People who are cis-gender, for example, have a gender identity that corresponds to the sex they were assigned at birth and those who are transgender generally don't identify with their birth-assigned sex. The word “homosexuality” is seen by many in the LGBT community as a medicalised or pathologised term and is not generally used. Apart from the commonly used gay, lesbian, bisexual and transgender there are a number of other terms such as “pansexual, omnisexual, trisexual,

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agender, bi-gender, third gender … transvestite, intersexual, two-spirit, hijra, polyamorous" that express various non-binary (male or female) or fluid sexual orientations and/or gender identities.[3] Some people use the self-affirming "queer" as an umbrella term for sexual and gender minorities. The word transgendered[4] (trans, trans people or trans people) describes a wide variety of cross-gender behaviours and identities (not necessarily someone who is "transitioning" to the opposite of their birth-assigned sex).

Labels should be used with caution – some people in the LGBT community may find them inappropriate, externally imposed or uncomfortable. It is important to always respectfully ask about and use people's preferred self-definitions and pronouns.

Societally, heterosexuality is seen as the normative state and there is often a sense of silence and exclusion surrounding LGBT experiences.[5] The term homophobia describes an individual's dislike, fear or hatred of LGBT people, while heterosexism refers to the associated belief that everyone is (or should be) heterosexual. Heterosexism can involve conscious or unconscious exclusion, bias or discrimination. The term heteronormativity similarly describes a heterosexually dominant culture and ideology where LGBT perspectives, cultures and discourses are absent or silenced.

Background

LGBT individuals are present in all social-economic groups, cultures, abilities, ages and ethnicities. All or any of these factors can have an additional effect on how they are viewed by society, how they view themselves and also on their health status[6] This intersectionality can work to create new inequities or increase existing ones:

> I am a black lesbian mother and I suffer from clinical depression. I am isolated because of the different levels of discrimination due to my race, sexuality, mental health problems and single mother status. Health workers tend to take the culturally sensitive approach and will expect me to fit in the black community who are often homophobic as most family help is centred around religious organisations. If they know my sexuality they may feel LGBT organisations are appropriate but none deal with the combination of mental health, families and race. My own family believe homosexuality is a result of mental illness[7]

LGBT people have historically faced discrimination, harassment and violence and homosexuality was regarded as a mental illness by the American Psychiatric Association until 1973. Despite increasing awareness and improvement in human rights legislation there are still 76 counties in the world where homosexuality is illegal. In eight of these countries the death penalty can be imposed for same-sex intimacy.[8]

An Institute of Medicine report stated that LGBT people face barriers to equitable health care that can significantly affect their overall well-being.[10] These barriers are being increasingly linked to the concept of stigma, which can occur in populations that are discriminated against or marginalised by social determinants of health such as income level, education, employment status, housing, early childhood development, aboriginal status or sexual orientation.[9,10] Stigma, for LGBT people, can occur at different levels:

1. Individual: Personal beliefs, e.g. internalised homophobia and shame.
2. Social: From social interaction, e.g. hate crimes, homophobic remarks and micro aggressions.
3. Structural: At the institutional, provincial, federal or international level, e.g. anti-discrimination legislation that does not include sexual orientation and/or gender identity.

Awareness of bias at individual, social and structural levels can be described as "felt stigma" which can have a negative impact, even with people who have encountered relatively little discrimination.[11,14]

LGBT health and social issues

Particular health and social issues that disproportionally affect the LGBT population (compared to heterosexuals) include[12–16]:

- Higher rates of various chronic health conditions such as asthma, diabetes, heart disease, or other disabilities
- Greater proportional poor health behaviours such as tobacco use, heavy drinking and recreational drug use
- Higher rates of mental health conditions including an increased risk for eating disorders, mental illness, depression and suicidal ideation/attempts
- HIV/AIDS rates are high in gay, bisexual and transgendered women (especially in the black and Latino population)
- LGBT youth may experience higher levels of violence, victimisation, harassment and homelessness
- Greater risk of obesity and higher rates of breast cancer in bisexual women and lesbians due to a clustering of breast cancer risk factors
- Lower rates of health care access and service utilisation
- Greater risk of anal cancer in anoreceptive gay and bisexual men

Socially, the lifestyles and support systems of LGBT people are often different to that of heterosexual people. They may be estranged from their birth family and instead have a network of loved-ones that they rely on for emotional and practical support.[17] Older LGBT individuals are more likely to live alone and less likely to have children thus they may face a high degree of social isolation as they age.[18] They may also have lived through a time when homosexuality was classed as a mental disorder and it was illegal to be gay. Long standing internalised shame and stigma can affect how willing they are to be open about their sexual orientation or gender identity to HCPs.

In addition to health and social issues that may differ from the heterosexual population, LGBT people often have difficulties accessing care. Spaces and systems can be oriented towards certain people or groups, and conversely away from others.[19] Many health care spaces, for example, are oriented towards straight people, allowing them to feel at ease and comfortable in the environment but may exclude LGBT people. This includes the physical environment as well as interactions with organisational systems and patient-facing HCPs. Examples include a lack of acknowledgement of non-heterosexual orientation or gender identity other than cisgender on forms, during medical assessments and in health promotional material and other locally available printed material.

Experiences of past discrimination or the expectation of negative encounters with HCPs can serve to marginalise the health of LGBT people. Many LGBT patients don't disclose their sexual orientation ("come out"), even though this might help HCPs to identify specific health risks.[12] Previous negative experiences with care can also affect health seeking behaviours such as accessing screening for cancer. Before coming out to HCPs LGBT patients routinely ask themselves "'what kind of reaction will I get?' and 'will this impact my care?'".[17] Thus the anticipation of potentially negative responses from HCPs can add to the stress of LGBT patients' interactions within the health care system at a time when their emotional resilience may already be low due to the state of their health.[20] One participant in the lesbian and bisexual women's health report "Prescription for Change[7]" commented on how she felt she had unequal access to care as a lesbian:

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> "I don't believe I have equal access to appropriate healthcare services as my heterosexual counterparts – partly due to the continued lack of understanding of specific lesbian health needs and at times of illness not always feeling emotionally confident or sufficiently resilient to frequently have to cope with outing myself each visit, facing a barrage of heterosexist and inappropriate questioning from GPs and other health workers. Most of which results in me not bothering to seek medical intervention or preventive healthcare advice until it's virtually not a choice. I will self-help and self-treat as far as possible. The healthcare sector is alienating, unsafe and does not meet my needs[7] (p. 11)."

In studies of LGBT attitudes to their health providers, the ability to be open and not having to counter constant heteronormative assumptions (the automatic expectation that someone is straight) is seen as extremely important.[2] To further complicate matters, generally LGBT people think that it is important for HCPs to know about their sexual orientation and gender identity, but many HCPs don't think that this information is relevant to health.[20,21]

Many organisations, jurisdictions and associations have anti-discrimination legislation, polices or guidelines. The code of ethics for the Canadian Association of Medical Radiation Technologists, for example, states that radiographers "shall provide care to all regardless of race, national or ethnic origin, colour, gender, sexual orientation, religious or political affiliation, age, type of illness, mental or physical ability".[22] However, there is ample evidence that when sexual orientation is disclosed some LGBT people do receive biased treatment.[21] In a recent UK study respondents reported less positive experiences compared to heterosexuals in the areas of (among other things) psychosocial support and the provision of dignity and respect.[23] In a number of quantitative studies, discriminatory attitudes have been recorded from physicians and other HCPs.[24] Studies with LGBT HCPs likewise indicate that they have observed homophobic treatment of LGBT patients that included denial of care, substandard care and disrespectful or disparaging remarks made about the patients and/or their partners.[2,25,26] There is sometimes a lack of acknowledgement when patients do disclose, or HCPs continue to treat the patient as though they are heterosexual. LGBT patients often encounter these heteronormative blind spots, where partners (for example) are excluded or referred to as "friends" even after being introduced as partners.[17] Thus the feeling of inclusion or recognition when patients are "seen" as LGBT can be very positive. One patient undergoing cancer treatment discusses the time that a nurse acknowledged and welcomed her wife:

> "It is the first time in my 42 years of life that I felt completely normal and absolutely accepted unconditionally[17]" (p. 6).

Improving care

In the medical and allied health literature, there are three clear categories of suggestions to improve the care of LGBT patients; changes to the environment, health forms and awareness training. Some of these suggestions can be taken up directly by radiographers in either imaging or radiation therapy departments, for example accessing training on the health needs of LGBT people and using inclusive language and practices. Others (such as positive changes to the physical environment) could be championed by department managers. The three main suggestions for change are as follows:

1. Make positive changes to the health care environment

Countering a heteronormative environment can include signalling that the organisation is LGBT friendly. Similarly to many oppressed groups, LGBT people may scan a new environment for clues that they are safe. Posters featuring same sex couples, brochures for LGBT support groups or specific LGBT health concerns or copies of gay friendly magazines can reassure patients that they will be welcome.[27] Hospital or organisational posters that demonstrate non-discrimination policies could also be on display. If the department is involved in any health promotion/awareness campaigns then these should contain inclusive imagery and language. Some LGBT organisations provide LGBT friendliness benchmarking services; this certification could also be on view.[21] Heyes, Dean, and Goldberg[29] suggest that environmental changes can be important first steps, but care must be taken to ensure the people who work within the space aren't "disconnected from these superficial signifiers and remain hostile to queer patients" (p. 9).

Hospital waiting rooms can also be difficult for LGBT patients who might want to express support and comfort to partners. Normal caring behaviour such as handholding and hugging can be made to feel transgressive. In highly emotional situations (such as a health care emergency or oncology consultations) this felt stigma can be an extra source of stress. For transgender patients, being called by their legal name (as opposed to their chosen name) can also be a source of concern and this forced public outing can place them at risk of transphobic reactions in a public place.[28] Finally, non-gendered or gender-neutral toilets can create a more inclusive and less challenging environment for trans people.[21]

Where possible, organisations could engage with local and national LGBT organisations to access resources and find support. Examples of possible collaborations include HCPs hosting information/cancer awareness sessions for LGBT people at their places of work; taking part in Pride events (for example, displaying posters for Pride week or hosting a booth to promote screening or wellness services) or developing joint research projects. Some organisations have recruited equality and diversity champions throughout the department/centre or have even appointed an Equality and Diversity Manager to coordinate efforts to improve care.

2. Improve organisational intake and health history forms

In most initial health care encounters there is an information-gathering phase that includes form-filling often accompanied by an intake interview. Including questions about sexual orientation and trans status on intake forms is important to help HCPs better identify the patient's health needs and social situation and provide better care.[29] However, there may be a substantial disconnect between the life and experience of the LGBT patients, and the categories and spaces on the paperwork they need to complete. Having alternative options for gender is more inclusive. Adding sexual orientation to the form (and having alternatives such as an open ended section for self-identifying) normalises sexual orientations other than heterosexual and can open up important conversations between patients and HCPs. In addition, having a "preferred name" option can help staff use the correct name/gender for trans patients.

Sexual orientation and trans status monitoring on intake forms can also be used to assess LGBT experiences of services and identify inequalities and disease trends as well as target particular services (such as emotional support) to this population.[17] Ensuring that information technology systems are set up to intake data on sexual orientation and/or trans status (particularly if new systems are being installed)is an important component of gathering data on LGBT patients.

Finally, it is important to use the information gathered to improve care for individual services or to guide HCP's interactions with LGBT patients. If a patient has self-identified it can be doubly frustrating for them to then be treated as heterosexual.[17]

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3. Improve provider knowledge about and sensitivity to LGBT patients.

Eliminating barriers to care requires "a skilled, culturally competent, sensitive and welcoming provider community[31]" However, HCPs may lack training to respectfully care for LGBT patients.[10] In a recent UK study, 72% of patient-facing staff had never received training on the health needs and inclusive language and practices for the LGBT community.[21] Being culturally competent can allow HCPs to effectively work in cross-cultural situations. Culture is defined as the thoughts, communications, actions, customs, beliefs, values and institutions of a particular social group. Thus cultural competency in health care is the application of cultural knowledge and skills to meet the patients' health and social needs.[14,30] A simple example would be in patient communication, using gender neutral language (e.g. partner instead of wife or husband) and then using the patient's preferred terminology. It is important to note that an openness to discuss gender identity and sexual orientation, and a willingness to learn, is the most important element of good communication with LGBT patients. Most LGBT patients don't expect their HCPs to be experts on sexual orientation and gender identity, but they do expect to be treated with dignity, sensitivity and respect.[2]

Awareness training should start at the undergraduate level where LGBT health issues and culture should be included in HCP curricula.[29] Currently there is very little LGBT content in HCP undergraduate education. Assessment of medical schools revealed a median of only about 5 h over the course of the curriculum.[31] A 2014 report from the Association of American Medical Colleges recommended strategies for change in medical institutions to improve care for LGBT patients that included a full curriculum revision, the addition of an elective LGBT health study or the addition of a required class.[32] Threading LGBT education and increasing visibility throughout the curriculum could also involve (for example) using case studies of LGBT people where the sexual orientation or gender identity of the patient is linked to the case study itself, or just incidental. LGBT standardised patients could also feature in communications skills training e.g. in objective structured clinical examinations. Training and education should also continue during clinical practice with continuing professional development.

If the health care needs of lesbian, gay and bisexual patients are often poorly addressed; those of trans patients can be seriously mismanaged. As well as normal health care needs, trans patients may access the health care system to align their physical appearance with their internal gender identity using hormones and/or surgeries.[33] Providing culturally competent care to these patients often presents challenges to HCPs who aren't familiar with transgender health issues. Trans patients gender identity must be respected but they may need screening related to their natal gender (e.g. pap screening for cervical cancer for trans men or prostate screening for trans women).

It is important where possible that HCPs reflect the diversity of the population they care for to promote a sense of comfort; inclusion and familiarity. Indeed LGBT patients often express a preference for LGBT staff who they feel may understand their perspectives.[34] In addition, knowing an LGBT person (such as a co-worker) is an important factor in increasing HCP's comfort level in working with LGBT patients. Organisational efforts that promote non-heteronormative health care environments can provide benefits for both patients and staff members. For staff, having LGBT role models who are visibly out and comfortable in the workplace is of particular importance. Role models can signal to existing and new staff and students that the organisation is a safe place to be out, and that the workplace values diversity. A UK report concluded that for LGBT employees, being open and comfortable at work "has a significant impact on their efficiency and productivity".[35]

Conclusions

HCPs such as radiographers enter their profession because they want to care for people. Patients want to be treated by HCPs who see them as an individual, and who they can trust to treat them with dignity and respect. To improve the care of LGBT patients we need to ensure both staff and our health care environments are welcoming. LGBT HCPs also deserve a safe and supportive work environment free from harassment and discrimination. Local health care changes such as LGBT-friendly spaces, forms and staff can make a big difference. Health care providers, including radiographers, need better education to improve the quality of care for LGBT people in diagnostic imaging and radiation therapy departments and to be able to knowledgeably and sensitively respond to their specific health needs.

Conflict of interest statement

None.

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