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Contact Hours: **2**

Cultural Competency, including Caring for LGBTQ+ Patients

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LEARNING OUTCOME AND OBJECTIVES: Upon successful completion of this continuing education course, you will be prepared to provide effective and respectful care for patients belonging to different populations, including those identifying as LGBTQ+. Specific learning objectives to address potential learning gaps include:

- Discuss elements of culturally competent care among different populations.
- Describe terminology that is inclusive and respectful of the LGBTQ+ community.
- Summarize health disparities, health risk factors, and clinical implications specific to members of the LGBTQ+ community.
- Identify best practices regarding collecting and protecting patient information for LGBTQ+ patients.
- Discuss elements of culturally competent care for LGBTQ+ patients, including physical space, informational materials, patient communication, and staff training.
- Examine the intersection of oppression, discrimination, and implicit biases in order to provide nondiscriminatory care.

CULTURAL COMPETENCY AMONG DIFFERENT POPULATIONS

According to the National Institutes of Health (2021), culture involves a combination of elements that are often specific to ethnic, racial, religious, geographic, or social groups. Some of these elements include personal identification, language, thoughts, communications, actions, customs,

beliefs, values, and institutions. These elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services.

In order to provide culturally competent care, nurses and other healthcare providers must be understanding and sensitive to the cultural characteristics common to certain populations, such as:

- Persons from various gender, racial, and ethnic backgrounds
- Persons from various religious backgrounds
- Lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) persons
- Children and senior citizens (older adults)
- Veterans
- Persons with a mental illness
- Persons with an intellectual, developmental, or physical disability

Healthcare professionals can provide improved care to diverse patients through education and training, increased knowledge and skills, and changes in attitudes and behaviors. Systems and organizations must also change their structures and culture in order to bring about better patient outcomes and reductions in disparities (Butler et al., 2016).

IMPLICIT BIAS

The term *implicit bias* (also referred to as *unconscious bias*) refers to the idea that human beings are not neutral in their judgment and behavior and that unconscious experience-based associations and preferences/aversions occur outside our control. Such biases may lead to unequal treatment of others based on race, ethnicity, nationality, gender, gender identity, sexual orientation, religion, socioeconomic status, age, disability, or other characteristics (LERU, 2018).

Researchers have designed tests that make implicit biases visible. For instance, Harvard University's Project Implicit has developed implicit association tests (IATs) that can identify preconceived in-group preferences and implicit biases in individuals. (See "Resources" at the end of this course.)

Race and Ethnicity

A patient's race or ethnicity may contribute to various healthcare-related considerations:

- Physiologic variations make some groups more prone to certain diseases and conditions, such as sickle cell anemia among African Americans or Tay-Sachs disease among Eastern European Jews.

- A patient's reaction to pain may be culturally prescribed; for example, some cultures encourage the open expression of emotions related to pain while others encourage suppression.
- Different ethnic groups have different norms of psychological well-being and acceptance of mental illness.
- Perceptions of appropriate personal space and physical contact, including between the sexes, vary among cultures.
- Different food preferences among cultural groups can be a factor in whether a patient is receiving adequate nutrition while in a hospital or other healthcare setting.
- Cultural views on sex roles, families, and relationships may impact areas such as decision making, privacy, and information sharing among patients, loved ones, and healthcare providers.
  (Taylor et al., 2019)

Religion

A patient's religion and spirituality is often an important consideration in regard to medical decisions and culturally competent care. Therefore, healthcare providers should be aware of and respectful of a patient's religious beliefs as they relate to issues such as diet, medicines that may include animal products, modesty, the preferred gender of their health providers, prayer times that may interfere with treatment regimens, and more.

Similarly, many patients may turn to their religious faith in order to reduce their anxieties, respond to healthcare challenges, and make difficult healthcare decisions, including end-of-life care and preparations. Health professionals should therefore provide an opportunity for patients to discuss their religious and spiritual beliefs and tailor their evaluation and treatment to meet patients' specific needs.

Children

Culturally competent care for children requires an awareness of cultural differences that may have an impact on growth/development as well as other healthcare-related concerns. For instance:

- Common diets and feeding practices differ among groups and may contribute to nutritional or weight status in children.
- Parenting styles and health promotion behaviors can vary significantly, such as encouraging or discouraging independence in infants and toddlers.
- Practices such as infants and small children sharing a bed with parents may be of significance for the comfort of pediatric inpatients.
- Emotional development, such as acceptance around crying, can be affected by cultural views.

- For adolescents, cultural values and attitudes toward sexuality vary.

Nurses must consider these and other cultural habits, beliefs, language, and ethnicity in order to provide appropriate care for all children and families (Ricci et al., 2021).

Older Adults

Older adults are generally considered to be those ages 65 years and older. Health disparities become magnified in this population, and issues around race, ethnicity, sex, gender identification, sexual orientation, and disability continue to impact these patients' access to healthcare and outcomes (Taylor et al., 2019).

Older adults have different healthcare needs due to normal physiologic changes of aging, the increasing prevalence of age-related disease, and other psychosocial factors. Despite these differences, culturally competent care for older patients requires nurses to avoid bias and discrimination based on age (referred to as ***ageism***).

Stereotypes about aging, particularly in North America, are primarily negative—a time of ill health, loneliness, dependency, and poor physical and mental functioning (Donizzetti, 2019). Such negative attitudes toward and discriminatory treatment of older adults are present throughout the healthcare community and affect the quantity and quality of care provided to older patients, putting them at increased risk for undertreatment or overtreatment. For example, if a nurse has the belief that older adults are less healthy, less alert, and more dependent, then their initial assessment of the patient will reflect this belief (Swan & Evans, 2021).

A few common myths and realities about older adults include:

- Myth: Old age means mental deterioration. In reality, neither intelligence nor personality normally decrease because of aging.
- Myth: Older adults are not sexually active. In reality, although less frequent, sexual activity lasts well into the 90s in healthy older adults.
- Myth: Bladder problems are a problem of aging. In reality, incontinence is not a part of aging; it generally has a root cause and requires medical attention.
  (Taylor et al., 2019)

Veterans

Military service members, their families, and veterans have unique needs that require a culturally competent approach to healthcare services. Combat and military experiences directly and indirectly impact veterans' health and well-being. It is important to recognize how military experiences may be associated with different adverse outcomes in order to provide quality interventions and support services.

The key elements of **military culture** include:

- Chain of command
- Strict routine and structure
- Respect for authority and oneself
- Strength (not asking for help)
- Honor (used to being trusted)
- Aggression (faster, harder, louder, meaner)

There is no conventional identity for a veteran. Not all veterans are older, served during wartime, were injured or have a disability, or are male. Likewise, not all those who served in the military self-identify as "veterans"; thus, healthcare professionals may ask, "Were you in the military?" instead of "Are you a veteran?"

Culturally competent care also includes an awareness of **common stereotypes** about the veteran population, which include:

- All veterans are in crisis.
- All veterans have posttraumatic stress disorder and/or substance use issues.
- All veterans have served in combat.
- All veterans have access to Department of Veterans Affairs (VA) healthcare.
- All veterans are homeless.
- All veterans want to be thanked for their service.
  (CalVet, n.d.)

Mental Illness

Despite all that has been learned and the urgency surrounding the need for evidence-based treatment, mental illness continues to be highly stigmatized (see table below). Mental illness–related stigma, including that which occurs in the healthcare system and among healthcare providers, creates serious barriers to access to healthcare and the quality of care a patient receives. The impact of provider stigma has been identified as the strongest barrier toward help-seeking behavior of individuals with mental illness.

MENTAL HEALTH MYTHS VS. FACTS	
Myth	**Fact**
Children do not experience mental health problems.	Even very young children may show early warning signs of mental health concerns. Half of those with mental health disorders show

	first signs before the person turns 14 years old.
People with mental health issues are violent, unpredictable, and dangerous.	The vast majority of those with mental health problems are no more likely to be violent than anyone else. Only 3% to 5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population.
People with mental health issues, even those who are managing their illness, cannot tolerate the stress of holding down a job.	People with mental health problems are just as productive as other employees. Employers who hire people with mental health problems report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees.
Mental health problems are caused by a personality weakness or character flaws, and the individual can snap out of it if they try hard enough.	Mental health problems have nothing to do with being lazy or weak, and many people need help to get better. Many factors contribute to mental health problems, such as genes, physical illness, injury, brain chemistry, life experiences such as trauma or a history of abuse, or family history of mental health problems.
There is no hope for people with mental illness.	Studies show that people with mental health problems get better and many recover completely.
Therapy and self-help are a waste of time.	Treatment for mental health problems varies depending on the individual and could include medication, therapy, or both.
(Mental Health.gov., 2022)	

Lack of cultural understanding by healthcare providers may also contribute to underdiagnosis and/or misdiagnosis of mental illness in people from racially/ethnically diverse populations. Factors that contribute to these kinds of misdiagnoses include language differences between patient and provider, stigma of mental illness among minority groups, and cultural presentation of symptoms. While racial/ethnic minority groups overall have similar (or, in some cases, fewer) mental disorders than Whites, they often bear a disproportionately high burden of disability resulting from mental disorders. People from racial/ethnic minority groups are also less likely to receive mental health care (APA, 2017).

Disability

The Americans with Disabilities Act (ADA) defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activities. Examples of elements of culturally competent care for patients with disabilities include:

- Ensuring all facilities are accessible in compliance with ADA requirements
- Providing individuals with access to communication aids and services, such as medical interpreters, signers, audio recordings, etc.
- Using "people first" language (see table below)
- Practicing disability etiquette when interacting, such as:
    - Mobility impairments: Don't push or touch someone's wheelchair; bring yourself down to the person's eye level to speak to them.
    - Visual impairments: Identify yourself; don't speak to or touch a working service animal.
    - Hearing impairments: Speak directly to the person, not the interpreter; don't assume they can read lips; don't chew gum, wear sunglasses, or obscure your face.
    - Speech disorders: Don't finish the person's sentences; ask the person to repeat or repeat yourself to confirm you understood.
    - Developmental disabilities: Speak clearly using simple words; do not use "baby talk" or talk down to the person; do not assume they cannot make their own decisions unless you've been told otherwise.

  (SHP, 2018)

EXAMPLES OF PEOPLE FIRST LANGUAGE	
Instead of saying:	**Say this:**
Handicapped	Person with disability
Handicapped parking/seating	Accessible parking/seating
Patient	Use only when under a healthcare professional's care
Victim/suffering from	Had or has a disability
Retarded	Person with developmental disability or intellectual impairment
Wheelchair-bound	Uses a wheelchair
The Deaf/The Blind	A person who is deaf/blind
(SHP, 2018)	

CULTURALLY COMPETENT CARE FOR LGBTQ+ PATIENTS

Even though social acceptance of LGBTQ+ individuals has been increasing, LGBTQ+ patients continue to face barriers to culturally competent care, including stigma and discrimination. For these patients, access to healthcare that is unbiased and culturally affirming remains a challenge in most parts of the United States (Butler et al., 2016).

LGBTQ+ ACRONYM

The acronym *LGBTQ+* is an umbrella term used in this course to refer to the lesbian, gay, bisexual, transgender, and queer/questioning populations. The "+" designation is included to encompass additional populations (e.g., intersex [I], asexual [A], genderfluid, and others) that are not explicitly referred to by the acronym *LGBTQ* alone.

It is not uncommon for a person who identifies as lesbian, gay, bisexual, transgender, or questioning/queer (LGBTQ) to have had negative experiences in the healthcare environment due to discrimination and/or stigmatization based on their sexual orientation and/or gender identity. Such encounters may occur due to cultural bias or a lack of awareness and understanding by the provider of the healthcare needs and goals of such individuals.

For example:

- A gay man might be screened for HIV before being assessed for actual risk.
- A transgender man may be denied a mammogram because they transitioned from female to male.
- A lesbian visiting a new primary care provider might be asked if they would like a mental health referral to explore "abnormal" sexual feelings.
- A gender fluid person may not know how to respond to a healthcare form that only provides the options of male or female gender identity.

These sorts of negative encounters immediately affect the patient's trust of the healthcare system and marginalize their needs. Continuing stigma makes many patients reluctant to reveal their sexual orientation or gender identity to healthcare providers even though this information can be important to receiving individualized care.

From a historical perspective, it was not until 1973 that the American Psychological Association declared that homosexuality (now considered a marginalizing term) was not a mental illness (McHenry, 2022). This was a major milestone in the movement toward cultural awareness and in the fight for equal rights for people who identify as lesbian, gay, or bisexual. Similarly, being transgender was listed as "gender identity disorder" until 2013, when the DSM-5 changed it to "gender dysphoria," a more patient-centric term (Byne et al., 2020).

Over the past 20 years, the healthcare community has started to recognize and research the unique needs of these groups. One of the most significant reports includes the 2011 Institute of Medicine report titled "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding." This document outlined a research agenda for the future. The report also placed a focus on the needs of LGBT patients and described the uniqueness for each of the LGBT groups (IOM, 2011). Similarly, Healthy People 2030 includes a goal to improve the well-being, safety, and health of the LGBT patient population (ODPHP, n.d.).

Even though social acceptance has been increasing since that time and laws and policies are changing, LGBTQ+ individuals continue to face barriers, stigma, bias, and discrimination. Access to healthcare that is unbiased and culturally affirming remains a challenge in most parts of the United States.

People within the LGBTQ+ population are extraordinarily diverse, representing every social class and ethnicity in every geographical area and every profession (HRC, 2020). Healthcare professionals who practice cultural sensitivity in working with LGBTQ+ patients can have a positive impact and increase trust as they continue to understand the individual needs of their patients.

Terms and Definitions

To better understand the LGBTQ+ population and their unique health concerns, it is important to define and clarify some basic concepts of gender identity and sexual orientation. Terms and definitions are ever-evolving, and clinicians must update their knowledge regularly to provide effective and respectful care for all patients. It is also important that clinicians have the comfort and sensitivity to ask their patients how they would like to be addressed in terms of identifiers of gender identity and sexual orientation in a respectful, honest, and open-minded manner.

Terminology described in this course is taken from recognized sources at the time the course was written. These terms may not reflect every individual's personal preference, may become outdated (even as they are mentioned in current clinical references), and may not reflect all local and regional variations.

- **Anatomical sex:** The presence of certain female or male biologic anatomy (including genitals, chromosomes, hormones, etc.); also referred to as ***assigned sex at birth (ASAB)***
- **Asexual (A):** People with no or little sexual attraction to other people
- **Bisexual (B):** Men or women who are sexually attracted to people who are the same as and different than their own gender
- **Cisgender:** People whose gender identity aligns with the sex they were assigned at birth, i.e., the opposite of *transgender* or *gender diverse*

- **Gay (G):** A person who is attracted to someone of the same gender; historically, the term referred to men who are attracted to men, but it may also be used by women to refer to themselves
- **Gender expression:** The way a person presents their gender in society, through social roles, clothing, make-up, mannerisms, etc.
- **Gender identity:** A person's internal sense of being a male/man, female/woman, both, neither, or another gender
- **Genderfluid or genderqueer (also called *nonbinary*):** People who do not strictly identify as male or female; a mix of male and female (genderqueer/genderfluid); neither male nor female (nonbinary); or no gender at all
- **Intersex (I):** People with an indeterminate mix of primary and secondary sex characteristics, such as a person born appearing to be female "outside" who has mostly male anatomy "inside," a person born with genitals that are a mix of male and female types (a female born with a large clitoris or without a vaginal opening, or a male born with a small penis or a divided scrotum that has formed like labia); may identify as either cisgender or gender diverse
- **Lesbian (L):** Women who are attracted to women
- **MSM:** Men who have sex with men
- **Queer:** An umbrella term for all who are not heterosexual or who are not 100% clear of their sexual orientation and/or gender identity
- **Questioning (Q):** A person who is in the process of discovery and exploration of their sexual orientation, gender identity, or gender expression
- **Sexual orientation:** How a person identifies their sexuality, including who they are physically and emotionally attracted to and with whom they choose to have sex; a person may not have a sexual attraction to others (asexual)
- **Transgender (T):** People with gender identities that do not align with their assigned sex at birth; some transgender individuals may alter their physical appearance and often undergo hormonal therapy or surgeries to affirm their gender identity. However, medical intervention is not required for a person to identify as transgender. Some transgender people do not undergo the medical transition process for a variety of reasons, including cost or other health concerns. Gender identity terms that may be used by transgender people to describe themselves include:
    - Demiboy: A person who feels their gender identity is partially male, regardless of assigned sex at birth
    - Demigirl: A person who feels their gender identity is partially female, regardless of assigned sex at birth
    - Transgender female/woman, trans woman: A transgender person who was assigned male at birth (AMAB) but who identifies as female; formerly referred to as *male-to-female (MTF)*

    - Transgender male/man, trans man: A transgender person who was assigned female at birth (AFAB) but who identifies as male; formerly referred to as *female-to-male (FTM)*

- **WSW:** Women who have sex with women
(AECF, 2021; APA, 2022; PFLAG, 2022)

CULTURE AND TERMINOLOGY

Terms for sexual orientation and gender identity vary according to culture. For example, *two spirit* is a non-Western term used by some Indigenous populations to describe gender identity, sexual identity, and/or spiritual identity. Some Indigenous languages do not have terms such as gay, lesbian, or bisexual and instead describe what people do rather than how they identify (Researching for LGBTQ2S+ Health, n.d.).

Terms and Concepts That May Be Marginalizing

Terms that marginalize and stigmatize people who are LGBTQ+ are still common. Also, some words previously used and accepted in the medical community may no longer be in common usage or considered acceptable/respectful today. Examples include:

- Homosexual
- Sexual preference
- Transvestite
- Male-to-female (MTF) transgender
- Female-to-male (FTM) transgender
(PFLAG, 2022; GLAAD, n.d.)

Examples of concepts that may contribute to societal stigmas for LGBTQ+ patients include:

- Heterosexism: The general presumption that everyone is straight or the belief that heterosexuality is a superior expression of sexuality
- Homophobia: Negative attitudes and feelings toward people with nonheterosexual sexualities; may include discomfort with expressions of sexuality that do not conform to heterosexual norms
- Internalized oppression: The belief that straight and cisgender people are "normal" or better than LGBTQ+ people, as well as the often-unconscious belief that negative stereotypes about LGBTQ+ people are true
- Transphobia: Negative attitudes and feelings toward transgender people or discomfort with people whose gender identity and/or gender expression do not align with traditionally accepted gender roles
(PFLAG, 2022; Ni, 2020)

Sexual Orientation, Gender Identity, and Gender Expression

Sexual orientation, gender identity, and gender expression are separate parts of a person's identity. *Sexual orientation* refers to a person's sexual attraction and sexuality. *Gender identity* refers to a person's innate sense of their own gender. *Gender expression* refers to the outward expression of one's gender. All of these terms fall along a spectrum, and a person can identify with more than one sexual or gender identity.

The terms *lesbian*, *gay*, and *bisexual* describe an individual's sexual orientation, attraction, or behavior and reflect the fact that sexuality is not exclusively heterosexual. In contrast, transgender people are defined according to their gender identity and presentation. This group is composed of individuals whose gender identity differs from the sex originally assigned to them at birth or whose gender expression varies significantly from what is traditional for that sex (i.e., people identified as male at birth who subsequently identify as female and people identified as female at birth who later identify as male).

Transgender individuals (and many others) may also reject traditional concepts of gender as being strictly binary in terms of the male-female dichotomy. The population is diverse in gender identity, expression, and sexual orientation. Transgender people can be any sexual orientation. Some lesbians, gay men, and bisexuals may be transgender (APA, 2022).

The gender-binary system is also important to understand in the context of the LGBTQ+ population. This system is based on the idea that society categorizes people as falling into one of two categories (man/woman, male/female, masculine/feminine), not recognizing gender is a spectrum. Individuals who identify as nonbinary or genderfluid often identify as being somewhere in the middle of this spectrum and may use gender-neutral pronouns such as "they/them/theirs." Therefore, it is important to address the question of pronouns with patients in each healthcare encounter.

LGBTQ+ POPULATION

It is difficult to accurately describe the demographics and statistics of the LGBTQ+ population. This may be due to the lack of appropriate survey questions on demographic questionnaires as well as a reluctance of individuals to respond for fear of stigma or discrimination. However, researchers have estimated that approximately 8% of adults in the United States identify as lesbian, gay, bisexual, and transgender and that more than 1% identify as transgender. An estimated 1 in 100 Americans is intersex. Among adults under 30 years of age, 2% identify as transgender, and 3% identify as nonbinary (Powell, 2021; Cleveland Clinic, 2022; Brown, 2022).

HEALTH DISPARITIES AND HEALTH RISK FACTORS

Ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location are all factors that contribute to an individual's ability to achieve good health. *Disparity* refers to a health outcome that is seen to a greater or lesser extent in one population relative to another population. *Risk factor* refers to a behavior or condition that increases a person's chance of developing a disease or health condition. This may include social and environmental factors (Medina-Martinez et al., 2021). The LGBTQ+ population is diverse in terms of race, ethnicity, disability, and socioeconomic status. Therefore, risk factors and disparities in each patient will vary depending on these individual factors. (See discussion below on specific population groups.)

Research has uncovered that LGBTQ+ individuals often face health disparities related to societal stigma, discrimination, and denial of civil and human rights in some manner. Discrimination has been linked to higher rates of psychiatric disorders, substance abuse disorders, and suicide. Violence and victimization are also more common and have life-long consequences to the individual and the community as a whole. Personal, family, and social acceptance of an individual's sexual orientation and gender identity often affects these individuals' mental health and personal safety (Medina-Martinez et al., 2021).

Individuals who identify as LGBTQ+ may also experience minority stress. Minority stress theory connects health disparities among individuals to stressors induced by a hostile, homophobic culture in society as a whole. This often results in experiences of prejudice, internal expectations of rejection, and internalized homophobia. Aspects of minority stress, including the perception of prejudice, stigma, or rejection, are associated with higher rates of depression and dysfunctional coping strategies (Hoy-Ellis, 2021).

LGBTQ+ populations experience a greater prevalence of mental health distress and diagnosis, such as:

- Anxiety and depression
- Suicidal ideation and attempts
- Other forms of emotional, physical, and sexual trauma (such as intimate partner violence) (Hoy-Ellis, 2021; Coleman et al., 2022)

Gay, lesbian, and bisexual adolescents and young adults have higher rates of tobacco and alcohol use, substance abuse, eating disorders, and risky sexual behaviors. This may be due to a higher level of psychological distress (CDC, 2022d; The Trevor Project, 2020, 2022).

Men Who Have Sex with Men (MSM)

The most researched health disparity among MSM is HIV/AIDS incidence and prevalence. In 2018, 81% of new HIV cases among men occurred in men who had sex with men (CDC, 2020). Gay, bisexual, and men who have sex with men have also been found to be at increased risk of other sexually transmitted infections (STIs) (CDC, 2022a), including:

- Syphilis
- Gonorrhea
- Chlamydia
- Human papillomavirus (HPV)
- Hepatitis A and B

Gay men are also at an increased risk of cancers, including prostate, testicular, anal, and colon, which may be related to limited cancer screening and prevention services for this population (Domogauer et al., 2022). Moreover, men who have sex with men are also at higher risk for tobacco and drug use and depression (CDC, 2022b).

CLINICAL IMPLICATIONS

When providing care for men who have sex with men, clinicians and case managers should not assume that the individual is engaged in actions that increase the risk for certain disorders; a history should first be performed to understand the individual's risk (HEC, 2021). Understanding the risk factors and health disparities for MSM, it is important to address the unique clinical concerns for this population through:

- Regular assessment and screening for STIs and HIV
- Routine vaccination for hepatitis A, hepatitis B, and HPV
- Prevention and screening for prostate, testicular, anal, oral (head and neck), and colon cancers
  (CDC, 2022a)

Women Who Have Sex with Women (WSW)

Lesbian and bisexual women are more likely to be obese and to use tobacco and alcohol than heterosexual women. Stress may be a contributing factor to the increased substance use or abuse in this population. WSW are also at increased risk for depression and anxiety disorders and are less likely to receive routine reproductive care. Lesbian women are also less likely to access cancer screening and prevention services (Office on Women's Health, 2020; Open Access Government, 2020; ACS, 2021).

Lesbian women may be at a higher risk for uterine, breast, cervical, endometrial, and ovarian cancers for some of the factors listed above (ACS, 2021). Also, lesbians have traditionally been less likely to bear children, and hormones released during pregnancy and breastfeeding are believed to protect women against breast, endometrial, and ovarian cancers (WebMD, 2020).

CLINICAL IMPLICATIONS

Clinicians and case managers working with women who have sex with women should carefully assess and address the multiple risks that this population faces by providing:

- Preventive and wellness care to prevent or treat tobacco use/abuse and alcohol use/abuse
- Screening and early identification of behavioral health concerns such as depression or anxiety
- Regular preventive care and screening for uterine, breast, cervical, endometrial, and ovarian cancers
- Programs for healthy weight and exercise
  (WebMD, 2020)

Transgender and Gender Diverse

Transgender individuals often face victimization, violence, and minority stress, and they are less likely to have access to health insurance for a variety of reasons. Transgender individuals have a higher prevalence of:

- HIV
- Sexually transmitted infections (STIs)
- Behavioral health disorders
- Suicide
  (CDC, 2022c; CDC, 2021; NAMI, 2022)

CLINICAL IMPLICATIONS

Caring for transgender patients therefore includes screening for the following risks, as appropriate:

- Access to appropriate health insurance
- Violence
- Minority stress
- HIV
- STIs
- Suicide
- Behavioral health disorders
  (Caughey et al., 2021; Eder et al., 2021; Goldsmith & Bell, 2022)

GENDER-AFFIRMING MEDICAL INTERVENTIONS

Some transgender individuals desire to undergo medical interventions to alter their outward appearance and secondary sex characteristics in order to feel aligned in their body with their gender, while others do not desire this intervention. It is important to recognize the unique needs of these patients as they make decisions about transition-related care and treatment.

Some surgical treatments can take years, with multiple procedures needed to complete a gender-affirming transition. Education on preparation, treatment, supportive care, and follow-up care are essential to support transgender patients in this process. In many cases, gender-affirming surgeries are done at specialty centers, so it is important to understand where this care can be obtained and how to refer patients to these services, while also tending to their healthcare needs before, during, and after treatment for transition (Coleman et al., 2022).

Adolescents and Young Adults

Many concerns may impact the health and well-being of an LGBTQ+ individual. This is especially true for adolescents, who are in the process of navigating developmental milestones along with sexual orientation and gender identity.

Young adults who "come out" may be faced with bullying from their peers or family rejection. LGBTQ+ youth have a high rate of substance abuse, STIs, and homelessness (Hao et al., 2021). They are more prone to have an increased risk of depression, suicidal ideation, and substance use, including tobacco, alcohol, cannabis, cocaine, ecstasy, and heroin (The Trevor Project, 2020, 2021).

Research has shown that LGBTQ+ adolescents and young adults with family acceptance have greater self-esteem, more social support, and better health outcomes. This acceptance also reduces the risk of substance abuse, depression, and suicide (Delphin-Rittmon, 2022).

CLINICAL IMPLICATIONS

Clinicians and case managers working with this population should pay careful attention to subtle clues and risk factors of each individual, as adolescents and young adults may be especially reticent to discuss their concerns. Careful assessment focuses on:

- Evidence or risk of bullying
- Dysfunctional family dynamics
- Substance abuse risks
- Depression screening
- Suicide risks
- STIs screening

- HPV vaccination
- Home living conditions
  (Hao et al., 2021; Eder et al., 2021)

CASE

Mark is a 38-year-old presenting to the urgent care clinic with UTI symptoms. The nurse practitioner, Jocelyn (she/her), asks Mark about pronouns, and Mark responds with "they/them." Mark describes to Jocelyn their concern about having three UTIs in the past three months.

According to the medical record, Mark is male and currently taking testosterone and bupropion. The nurse practitioner confirms this information, stating "I see on your intake form that you marked your gender identity as trans man. Is that correct?" Mark nods and replies, "Thank you for acknowledging this. Most providers ignore my gender identity." Jocelyn then asks about sexual orientation, and Mark responds, "I am gay and have a male partner." She documents Mark's responses so that the medical record accurately reflects sexual orientation and gender identity.

It could be easy to assume that Mark's genitals and organs match their outward male appearance and gender identity. But due to Mark's medication history and in order to clarify, Jocelyn asks which organs Mark has. She explains that asking Mark about their organs is important to determine whether there may be another medical reason Mark is having repeated UTIs. Mark reports having ovaries, a uterus, and a vagina. Jocelyn then explains to Mark that UTIs are common in people with frontal genital openings or vaginas.

Aware that using public restrooms can be uncomfortable or unsafe for some transgender people, Jocelyn asks if Mark is always able to empty their bladder when it is full or if there are times or situations where they are not able to do this. Mark responds that they are able to empty their bladder now but that prior to top surgery (6 months ago), they did not feel comfortable or safe using either female or male public restrooms due to a large chest.

Ruling this out as an issue that might be contributing to Mark's UTIs, Jocelyn explains how testosterone can lead to vaginal atrophy and that the urethra is estrogen responsive. Since Mark is having repeated UTIs, it may be helpful to treat them with a course of vaginal estrogen.

Since Jocelyn has normalized the discussion of Mark's UTIs and gender identity, Mark leaves the office not only feeling very affirmed in their gender, but also relieved to understand that there is a medical reason for their continued infections.

BEST PRACTICES REGARDING PATIENT INFORMATION

The process of collecting, storing, using, and keeping confidential information regarding sexual orientation and gender identity is evolving at most healthcare institutions. In 2011, the Institute of Medicine recommended that all healthcare institutions integrate data related to sexual orientation and gender identity into medical records. Appropriate data collection and privacy policies can lead to improved access, quality of care, and outcomes (Medina & Mahowald, 2022; GLMA, n.d.).

Inclusive Data Collection

Data collection on intake and other forms should allow for appropriate responses that are inclusive of LGBTQ+ patients. Best practices when collecting data include asking questions about gender first, then sexual orientation, followed by relationship status. Examples of inclusive data collection are indicated below.

Name

- Legal name:_____
- Name you use:_____

Gender Identity

- What was your assigned sex at birth (ASAB)?
  [ ] Male
  [ ] Female
  [ ] Other ASAB not listed here
  [ ] Do not wish to disclose

- What is your gender identity? (check all that apply)
  [ ] Male
  [ ] Female
  [ ] Transgender Male
  [ ] Transgender Female
  [ ] Queer
  [ ] Nonbinary
  [ ] Cis-male
  [ ] Cis-female
  [ ] Gender identity not listed above_____
  [ ] Do not wish to disclose

- What are your pronouns (check all that apply)?
  [ ] He/him
  [ ] She/her
  [ ] They/them

[ ] Your name
[ ] Pronouns not listed above_____

Sexual Identity

[ ] Straight
[ ] Gay
[ ] Lesbian
[ ] Bisexual
[ ] Queer
[ ] Questioning
[ ] Don't know
[ ] Sexual identity not listed above_____
[ ] Do not wish to disclose

Relationship Status

[ ] Single
[ ] Married
[ ] Partnered/long-term or domestic partnership
[ ] Divorced/separated
[ ] Widowed
[ ] Do not wish to disclose

(Grasso et al., 2021; National LGBT HEC, 2022)

Privacy Policies

It is important to assure all patients that any information collected is considered confidential. Confidential information may include patient-provider conversations and any data collected and stored in the medical record. Assurance of patient privacy may help LGBTQ+ patients feel more comfortable disclosing information within a healthcare setting knowing that it is protected. A confidentiality and privacy policy should be available in written format and readily available for patients to read and understand.

Elements to include in a privacy policy include:

- What information is covered by the policy
- Who has access to the medical record
- How test results remain confidential
- How information is shared with their insurance provider
- Any instances when maintaining confidentially is not possible
(GLMA, n.d.)

BEST PRACTICES FOR CULTURALLY COMPETENT CARE

LGBTQ+ patients, particularly those who identify as transgender or nonbinary, often face barriers to accessing healthcare services due to the lack of provider understanding of their gender identities. Providing high-quality, culturally competent, patient-centered care is a complex process that requires ongoing learning and awareness of the various factors that affect the LGBTQ+ population.

Even healthcare organizations that have taken positive steps toward improving cultural competency for LGBTQ+ patients will find new ways to address barriers to care and engage staff in improvement initiatives. Improving skills and knowledge among healthcare leaders, providers, and staff should be looked at as opportunities rather than as organizational or individual weaknesses.

Physical Space

Best practices start at the front door and extend into the provider's office and treatment areas. Everything from the hospital website to the front desk and waiting areas should reflect a healthcare setting that is welcoming, open, and inclusive.

- Include gender-neutral restrooms and signage.
- Post signage to affirm nondiscrimination policies that include sexual orientation, gender identity, and gender expression.
- Evaluate environmental factors of potential concerns for LGBTQ+ patients and families, such as bathroom designations, artwork, posters, educational brochures, etc.
  (Reynolds, 2020; GLMA, n.d.)

Internet and Website

Informational, educational, and support materials should be designed to help LGBTQ+ patients feel comfortable and supported in the healthcare setting.

- Include inclusive language on any websites and marketing materials that describes a commitment to high-quality, culturally competent, patient-centered care.
- Ensure that marketing, advertising, and informational materials reflect diverse populations, including same-sex couples and families.
- Create a separate webpage or portal for information and resources related to LGBTQ+ care.
  (National LGBTQIA+ HEC, 2021; GLMA, n.d.)

Supportive Communication

An individual may delay or avoid accessing care due to the fear that their provider may not take their gender identity and pronouns seriously or be entirely dismissive of them, causing them to feel "invisible." There are many ways that a healthcare provider and support staff can communicate with patients to help them feel respected and comfortable.

- Avoid the use of gendered titles such as "Sir" or "Ma'am." Instead of Mr. or Ms., patients may also wish to be addressed as Mx. (pronounced with a "ks" or "x" sound at the end).
- Introduce yourself with your pronouns. Ask patients for information such as their pronouns, preferred name, and gender identity. Pronouns may include: he/his/him, she/hers/her, or a range of options for nonbinary transgender patients, such as they/their/them, ze, sie, hir, co, and ey. Always respect the patient's pronouns and apologize if the wrong pronouns are used by mistake.
- Always ask for clarification when not clear what a patient would like to be called or how the patient would like to be addressed. Apologize if you refer to a patient in a way that seemed offensive.
- Ask patients what terms they use to refer to their anatomy, and mirror those terms during the patient interaction. Transgender patients may experience gender dysphoria and/or may not be comfortable with traditional terms for body parts.
- Ask the patient to clarify any terms or behaviors that are unfamiliar, or repeat a patient's term with your own understanding of its meaning to make sure you have a good understanding of what it means to them.
- Do not make assumptions about patients' sexual orientations, gender identities, beliefs, or concerns based on physical characteristics such as clothing, tone of voice, perceived femininity/masculinity, etc.
- Do not be afraid to tell a patient about one's own inexperience working with LGBTQ+ patients. Honesty and openness will often stand out to a patient from their previous healthcare experiences.
- Do not ask patients questions about sexual orientation or gender identity that are not material to their care or treatment.
- Do not disclose patients' sexual orientations or gender identities to individuals who do not explicitly need the information as part of the patients' care.
- Keep in mind that sexual orientation and gender identity are only two factors that contribute to a patient's overall identity and experience. Other factors—including race, ethnicity, religion, socioeconomic status, education level, and income—also contribute to the patient's experiences, perceptions, and potential barriers to healthcare.
(TJC, 2011; Reynolds, 2020; GLMA, n.d.; LGBTQ+ Resource Center, n.d.; Garrett, 2022.)

CASE

James is a 23-year-old patient brought to the emergency department by a close friend who is concerned about James's symptoms of depression and a statement James made about "wishing I were dead." James has no significant medical or mental health history according to the medical record.

The clinician enters the room and greets the patient, saying, "Hello, I am Tonya. My pronouns are she/her. I am a nurse and will be taking care of you today. May I ask what name and pronouns you use?" James doesn't respond right away, and Tonya notices James looking at her name badge, indicating her own pronouns, and also staring at the rainbow flag hanging on the wall of the exam room.

After a moment of silence, James quietly tells Tonya her name is Jenna and her pronouns are "she/her." Jenna then breaks down in tears and says she has never shared her preferred name with a "stranger" before. She says that she sometimes just wants to die because she feels like she is supposed to be a woman but is afraid this will never be a reality or possibility. Jenna worries about how her family will react and about losing her job and healthcare coverage if she comes out to others with her true gender identity.

Tonya responds with understanding and stresses that the most important thing now is to make sure that Jenna is safe and has the support she needs. Tonya brings in the social worker to complete a behavioral health assessment and to address the possible risk of imminent self-harm. The social worker also documents Jenna's preferred name and pronouns in the medical record and then provides Jenna with a national suicide hotline number for transgender people, a list of local support groups, the name of a psychologist who specializes in gender issues, and an insurance contact to review her benefits related to gender care.

Jenna states that she was previously unaware of all these support resources. She adds that she feels more hopeful than she has in a long time and that she had never been able to express her feelings so freely before.

Institutional Policies and Practices

In order to provide culturally competent care, institutions must assess current organizational practices and identify gaps in policies and services related to care and services for LGBTQ+ patients. This also includes ensuring that policies comply with all federal and state regulations (see "The Joint Commission Field Guide" earlier in this course).

Recommendations to build awareness within an organization about the LGBTQ+ community include:

- Hold an open discussion with healthcare professionals and staff about the difference between sexual orientation (lesbian, gay, bisexual, etc.) and gender identity (transgender,

nonbinary, intersex, etc.), since this can be confusing to those who are not familiar with such concepts

- If not already in place, establish a point person, office, or advisory group to oversee LGBTQ-related policies and concerns, ideally including members representing the LGBTQ+ community
- For inpatient facilities, review visitation policies to empower patients to decide who can visit them and act on their behalf (see also "Legal Issues" earlier in this course)
- Review codes of conduct and ethics to ensure they include expectations for respectful communication with all patients, visitors, and staff members and that they specify consequences for code violations
- Provide training and orientation on a regular basis to professionals and staff on culturally competent care and organizational policies related to conduct, ethics, privacy, nondiscrimination, and antiharassment policies
(GLMA, n.d.; National LGBTQIA+ HEC, 2021)

OPPRESSION, DISCRIMINATION, AND CULTURAL BIAS IN HEALTHCARE

While a person may define themselves largely by their sexual orientation and/or gender identity, one's experience is also influenced by the intersection of sex, race, ethnicity, socioeconomic status, ability, and other social determinants. All these factors have an impact on a patient's access to healthcare, health risks, and health outcomes. Any past and present discrimination, oppression, or fear related to these factors can greatly influence an individual's actions to actively seek care when needed or, conversely, to defer their healthcare needs until a crisis occurs (Medina-Martinez et al., 2021).

An Intersectionality Perspective

Providing whole-person, patient-centered care requires proactively considering how the intersection of each person's diverse identities and broader cultural factors can affect their health risks, healthcare experiences, and health outcomes. Such an "intersectionality" perspective should not lead to assumptions about an individual based on the minority groups with which they identify but should inform the clinical experience in a positive manner in order to respect and address each person's unique needs (Medina-Martinez et al., 2021).

Cultural Bias and the Provision of Care

When working with LGBTQ+ patients, it is especially important for clinicians and case managers to build a positive rapport as a way to counteract the exclusion, discrimination, and stigma their patients may have experienced previously in the healthcare environment. However, despite their best intentions, healthcare professionals may hold internalized cultural

biases that affect their interaction with patients. For example, a clinician, case manager, or other staff member may say something or use body language that communicates a stereotype or negative message about LGBTQ+ people.

These biases can lead to unequal care and affect a patient's decision to follow medical advice or return for follow-up care. Negative messages can also become internalized in the patient, adding to an LGBTQ+ person's stress and contributing to negative mental and physical health outcomes (Medina-Martinez et al., 2021).

Studies have shown that no matter how individuals may feel about prejudiced behavior, everyone is susceptible to biases based on cultural values and stereotypes that were embedded in their belief systems from a young age. To increase one's own awareness of internal bias, it is helpful to notice times when biased attitudes and beliefs may arise. Such internal awareness is the first step in making changes. Internal questions to ask may include:

- How do my current beliefs help me?
- What might I lose if I change my beliefs?
- How might my current beliefs harm others?
- How might it benefit me and others to change my beliefs?
  (NCCC, n.d.)

It is important for clinicians and case managers to focus on remaining open and compassionate by consciously intending to set aside assumptions and get to know a patient as an individual. For example, when first meeting a new patient who is a transgender man, the clinician can imagine what it might be like for this person to see a new provider for the first time. Instead of focusing on the patient's gender identity and when or if he has transitioned, the clinician or case manager can focus on getting to know him as a person, such as understanding where he lives and works and more about his family support.

CONCLUSION

Providing high-quality, culturally competent care to all patients involves understanding the cultural contexts of each individual. In the case of LGBTQ+ patients, it is important to educate oneself on issues related to sexual orientation and gender identity in order to address and understand the spectrum of these patients' health concerns. This may include addressing any health risks or disparities, with careful attention to any behavioral health needs and transgender care.

When considering best practices for providing culturally competent care, healthcare professionals should carefully evaluate their practice environment; examine, advocate for, and modify practice policies when needed; take detailed and nonjudgmental histories; educate themselves and/or update their knowledge on the health issues of LGBTQ patients; and reflect on any personal attitudes or bias that may prevent them from providing the highest level of

care to their patients. By taking these positive steps, healthcare providers can ensure that all patients they care for achieve the best possible health outcomes.

RESOURCES

GLMA: Health Professionals Advancing LGBTQ Equality
https://www.glma.org/

Human Rights Campaign
https://www.hrc.org/

Lesbian, gay, bisexual, and transgender health (Centers for Disease Control and Prevention)
https://www.cdc.gov/lgbthealth/index.htm

National Center for Transgender Equality
https://transequality.org/know-your-rights/health-care

National Coalition for LGBTQ Health
https://healthlgbtq.org/

National LGBT Health Education Center (Fenway Institute)
https://www.lgbthealtheducation.org/

National LGBTQ Task Force
https://www.thetaskforce.org/

PFLAG
https://pflag.org/

Project Implicit
https://www.projectimplicit.net/

WPATH (World Professional Association for Transgender Health)
https://wpath.org/

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TEST

[Take the test online at wildirismedicaleducation.com]

1. Which statement is **accurate** regarding culturally competent care among different populations?

a. Take additional safety precautions with patients with mental illness, since they are more prone to unpredictable and violent behaviors.
b. Counsel older adult patients that incontinence is a normal part of aging and generally cannot be treated medically.
c. Understand that a patient's reaction to pain may be culturally prescribed and therefore expressed differently than expected.
d. When caring for developmentally disabled patients, turn to their caregivers to make treatment-related decisions.

2. Which statement defines a transgender person?

a. A man who is primarily attracted to men
b. A person who has a gender identity that does not match their assigned sex at birth
c. A woman who is primarily attracted to women
d. A person who is attracted to someone on the basis of their characteristics rather than their gender

3. Which term is no longer considered acceptable usage today?

a. Transgender
b. Queer
c. Homosexual
d. Gay

4. Which condition is an individual who identifies as a lesbian at increased risk for acquiring?

a. Gonorrhea infection
b. Hepatitis infection
c. Depression
d. Colon cancer

5. For which condition should an adolescent who is teased by peers for being transgender be assessed?

a. Obsessive compulsive disorder
b. Attention deficit disorder
c. Bipolar disorder
d. Suicide ideation

6. Which action should the clinician take when conducting an intake interview with a patient being admitted to the hospital?

a. Document the gender identity that matches the patient's outward appearance
b. Enter sexual orientation into the medical record
c. Omit relationship status because it is not part of an admission interview
d. Enter only the patient's legal name into the medical record

7. Which action should be taken when a newly admitted patient has the legal first name "Karl"?

a. Show the patient the men's restroom when orienting them to the clinic facilities
b. Refer to the patient as "sir" until a more relaxed relationship has been established
c. Ask the patient the name they use and their pronouns
d. Inquire if the patient is married in the event they will need help at home during recovery

8. Which action would a healthcare professional take to reduce their personal cultural bias?

a. Answer the question, "Is my current belief wrong or right?"
b. Take a test on knowledge of LGBTQ+ terminology
c. Answer the question, "How might my current beliefs harm others?"
d. Debate personal beliefs on LGBTQ+ issues with other clinicians