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Contact Hours: **2**

LGBTQ Cultural Competence Training approved for Washington, DC (as per a public health priorities education for nurses)

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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. Specific learning objectives to address potential knowledge gaps include:

- 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.
- Discuss legal issues associated with quality care for LGBTQ+ patients.
- 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 cultural biases in order to provide nondiscriminatory care.

INTRODUCTION

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 (Franklin, 2023).

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.

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.

Even though social acceptance has been increasing 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, n.d.). 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.

LGBTQ+ ACRONYM

The acronym *LGBTQ+* is an umbrella term used 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.

(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 and women who are sexually attracted to people who are both 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, refers to men who are attracted to men, but may also be used by women to refer to themselves
- **Gender diverse (also *gender nonconforming, gender variant,* and *gender creative*):** a person who embodies gender roles and/or gender expression that do not match social and cultural expectations
- **Gender expression:** the way a person presents their gender in society, through social roles, clothing, makeup, mannerisms, etc.
- **Gender identity:** a person's internal sense of being male/a man, female/a 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 about 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.

- **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, 2023; APA, 2022; PFLAG, 2025)

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 2SLGBTQA+ 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, 2025; GLAAD, 2025)

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; prejudice against nonheterosexual behaviors, relationships, or communities
- 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, 2025; APA, 2023; Westfield, 2025)

HEALTH DISPARITIES AND HEALTH RISK FACTORS

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 lifelong 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 (Franklin, 2023).

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, concealment, and internalized stigma. Aspects of minority stress, including the perception of prejudice, stigma, or rejection, are associated with higher rates of depression and dysfunctional coping strategies (Fehling, 2024).

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)
(The Trevor Project, 2024; 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 (The Trevor Project, 2022).

Men Who Have Sex with Men (MSM)

The most researched health disparity among MSM is HIV/AIDS incidence and prevalence. Worldwide, the risk for MSM to acquire HIV is 26 times higher than that for the general population (WHO, 2025). In the United States, the lifetime risk for HIV for MSM is approximately 1 in 6 (CDC, 2022). Gay, bisexual, and other MSM have also been found to be at increased risk of other sexually transmitted infections (STIs), including:

- Syphilis
- Gonorrhea
- Chlamydia
- Human papillomavirus (HPV)
- Hepatitis A, B, and C
- Mpox
  (WHO, 2025)

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, MSM are also at higher risk for tobacco and drug use and depression (Lagojda et al., 2025).

CLINICAL IMPLICATIONS

When providing care for MSM, 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. 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
- Postexposure prophylaxis and preexposure prophylaxis (PrEP) for HIV prevention, as appropriate
- Routine vaccination for hepatitis A, hepatitis B, and HPV
- Prevention and screening for prostate, testicular, anal, oral (head and neck), and colon cancers
  (CDC, 2022)

Women Who Have Sex with Women (WSW)

Studies show that lesbian and bisexual women have a higher risk for cervical cancer, substance use, STIs, and mental illness. WSW are 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 (Arantes & Da Costa, 2024; ACS, 2025).

CLINICAL IMPLICATIONS

Clinicians and case managers working with WSW 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
- Resources for programs that promote healthy weight and exercise
  (ACS, 2025)

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)
- Substance use
- Homelessness
- Behavioral health disorders
- Suicide (approximately 40% of transgender individuals have attempted suicide, as opposed to less than 5% of the general U.S. population)
  (Centre for Suicide Prevention, 2025; NAMI, 2025; Goldsmith & Bell, 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
  (NAMI, 2025; Centre for Suicide Prevention, 2025; 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 is 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).

(See also “Health Insurance Laws” later in this course.)

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 high rates of substance abuse, STIs, and homelessness. They have an increased risk of depression, suicidal ideation, and substance use, including tobacco, alcohol, cannabis, cocaine, ecstasy, and heroin (The Trevor Project, 2024).

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
- STI screening
- Violence screening
- HPV vaccination
- Home living conditions
  (Bass & Nagy, 2023)

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 (six 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 feeling not only very affirmed in their gender, but also relieved to understand that there is a medical reason for their continued infections.

LAWS AND POLICIES RELATED TO LGBTQ+ HEALTHCARE

LGBTQ+ individuals continue to face unique legal challenges due to their frequent inability to be recognized as their identified gender and/or to formalize their relationships. This can leave many individuals and families feeling invisible in healthcare settings. In order to provide effective care and to keep up to date with changing laws and policies, healthcare professionals should educate themselves about such laws, policies, and requirements needed to protect and ensure quality, best-practice healthcare for LGBTQ+ patients.

Health Insurance Laws

The federal Affordable Care Act (ACA), passed in 2015, contained certain provisions important for LGBTQ+ patients and their families, such as:

- Coverage may not be denied based on preexisting conditions (important, for instance, for patients with a preexisting HIV/AIDS diagnosis).
- Insurance coverage must be made available regardless of employment status (important since protection from employment discrimination is not guaranteed for LGBTQ+ individuals).
- Expanded coverage is available (in most states) for LGBTQ+ partners and children (depending on the state's definition of "family members").
- Certain coverages are mandated for preventive services and screening, mental health, and substance abuse treatment.

Section 1557 of the Affordable Care Act (ACA) includes provisions regarding nondiscrimination in healthcare and health coverage on the basis of race, color, national origin, age, disability, or sex. Specific details of the nondiscrimination rules are determined by the Department of Health and Human Services (HHS), and these rules continue to change based on each presidential administration's views.

For instance, rules regarding discrimination based on gender identity, sex stereotyping, or sexual orientation continue to be reinterpreted and reversed by courts and federal administrations. As a result, transgender patients may encounter health insurance plans that exclude transition-related care (Healthinsurance.org, 2025).

Therefore, healthcare providers must stay current on changes to the ACA and other healthcare laws and policies affecting the healthcare rights of their LGBTQ+ patients. Clinicians and

providers can also assist patients who have questions about care or health insurance coverage by referring them to a social worker or case manager. Healthcare professionals can also advocate for and support policies that protect the provision of evidence-based care for LGBTQ+ patients. (See "Resources" at the end of this course for more on state laws and policies.)

Institutional Nondiscrimination Statements

AMERICAN NURSES ASSOCIATION (ANA)

The ANA (2018) advocates for continued efforts to eliminate discrimination in healthcare, as described in the following statement:

> The American Nurses Association (ANA) recognizes progress in most national efforts to eliminate discrimination associated with race, gender, and socioeconomic status through improving access to and attainment of health care, and quality of health care. However, concerted efforts must continue for discrimination to be eliminated in all of its forms. ANA recognizes impartiality begins at the level of the individual nurse and should occur within every health care organization. All nurses must recognize the potential impact of unconscious bias and practices contributing to discrimination, and actively seek opportunities to promote inclusion of all people in the provision of quality health care while eradicating disparities. ANA supports policy initiatives directed toward abolishing all forms of discrimination.

AMERICAN PHYSICAL THERAPY ASSOCIATION (APTA)

The APTA (2019) published the following nondiscrimination statement:

> The American Physical Therapy Association opposes discrimination on the basis of race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA)

The AOTA's "Vision 2030" affirms its commitment to diversity, equity, and inclusion, as follows:

> Vision Statement: Enriching life for ALL individuals and society through meaningful engagement in everyday activities.
>
> Foundational Pillar of Inclusive and Equitable Professional Community: Creates a supportive environment fostering belonging, collaboration, networking, and continuous learning for all professionals to enhance growth and development.

> Foundational Pillar of Occupational Justice and Advocacy: Promotes education, advocacy, accessibility, and the right for ALL to engage in meaningful occupations through collaboration with consumers, other professionals, and policymakers. (AOTA, 2025)

THE JOINT COMMISSION (TJC)

Joint Commission ambulatory care standards address discrimination and a patient's right to have an advocate: "As a patient, you have the right to be informed about and make decisions regarding your care. You also have the right to care that is free from discrimination as well as the right to have a patient advocate" (TJC, 2025).

Other Legal Concerns of LGBTQ+ Patients

While not all jurisdictions provide specific legal protections for LGBTQ+ individuals, healthcare professionals and institutions can discuss and address various legal issues with patients.

LIVING WILL AND MEDICAL DIRECTIVES

LGBTQ+ individuals, as with all patients, should file documents outlining their wishes concerning life-sustaining medical care, funeral arrangements, and organ donation. This is especially important as they grow older. Each state may have different document names or requirements. Documents may be called:

- Living will
- Medical directive
- Healthcare directive
- Directive to physicians
- Declaration regarding healthcare

The **District of Columbia Declaration** is the District of Columbia's living will. It allows individuals to state their wishes about medical care in the event that they develop a terminal condition and can no longer make their own medical decisions. The declaration goes into effect when a patient's physician and one other physician certify that the patient has an incurable condition that will lead to their death, with or without the use of life-sustaining medical care, and that life-sustaining procedures would serve only to postpone their death.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

A durable power of attorney for healthcare (or healthcare proxy) is a legal document that allows a designated person to make medical decisions for another person in the event they are unable to do so themselves. For an LGBTQ+ patient, this is a very important document that can protect their wishes at a time when they may not be able to speak for themselves. Same-sex partners

should file these documents and make their wishes known to their family members as well. This is a legal document that should be kept on file with the healthcare facility and with the person who is named as the healthcare proxy. The District of Columbia provides the **District of Columbia Durable Power of Attorney for Health Care.**

HOSPITAL VISITATION AUTHORIZATION

A hospital visitation authorization allows a patient to name specific individuals they wish to visit them in the event that they are no longer able to communicate their wishes.

For hospitals, critical access hospitals, and long-term care facilities participating in Medicare and Medicaid, regulations bar discrimination in visitation policies on the basis of race, color, national origin, religion, sex, sexual orientation, or disability. Patients and residents have the right to receive the visitors whom the patient or resident designates. These visitors can include, but are not limited to, a spouse or a domestic partner (including a same-sex spouse or domestic partner), another family member, or a friend (U.S. DHHS, 2025).

DURABLE POWER OF ATTORNEY FOR FINANCES

A durable power of attorney for finances designates another person (agent) to take care of finances when a person is not able to do so for themself. This may include paying medical bills, cashing checks, and receiving benefits.

WILL

A will is a legal document that allows a person to designate who will receive any property when they die. If a person dies without a will, their property is automatically distributed to their legal heirs. A will is important for anyone to have, but especially important for same-sex partners, since they may not be recognized as legal heirs in all states.

BEST PRACTICES REGARDING PATIENT INFORMATION

Appropriate data collection and privacy policies can lead to improved access, quality of care, and outcomes (Medina & Mahowald, 2022).

Inclusive Data Collection

All healthcare institutions are encouraged to integrate data related to sexual orientation and gender identity into medical records. 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 (National LGBTQIA+ HEC, 2022; Yu et al., 2024). Examples of inclusive data collection are indicated below.

Name

- First and last name on medical insurance:_____
- Name you would like our staff to use:_____

What are your pronouns?
- □ She/Her/Hers
- □ He/Him/His
- □ They/Them/Theirs
- □ Please specify: _____

Gender Identity

Sex/gender marker on medical insurance:
- □ Female
- □ Male

What is your current gender identity? (Check all that apply)
- □ Female/woman/girl
- □ Male/man/boy
- □ Nonbinary, genderqueer, or not exclusively female or male
- □ Transgender female/woman/girl
- □ Transgender male/man/boy
- □ Another gender: _____
- □ Don't know
- □ Prefer not to answer

What sex were you assigned at birth, on your original birth certificate? (Check one)
- □ Female
- □ Male
- □ X/Another sex: _____
- □ Don't know
- □ Prefer not to answer

Sexual Orientation

Do you think of yourself as: (check all that apply)
- □ Lesbian or gay
- □ Straight or heterosexual (that is, not gay or lesbian)
- □ Bisexual
- □ Queer
- □ Pansexual
- □ Something else: _____
- □ Don't know
- □ Prefer not to answer

(National LGBTQIA+ 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 concern for LGBTQ+ patients and families, such as bathroom designations, artwork, posters, educational brochures, magazines in the waiting room, etc.
  (Bass & Nagy, 2023)

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 with clear explanations that describe 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.
  (Bass & Nagy, 2023; Yu et al., 2024)

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, ve, xe, ze, per, 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.
  (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.

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 dedicated team leader, point person, office, or advisory group to oversee LGBTQ-related policies and concerns, ideally including members representing the LGBTQ+ community.
- 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.
- Collect and share data from LGBTQ+ patients and employees to promote empathy and understanding of the LGBTQ+ population among healthcare staff.
- Provide ongoing training and orientation to professionals and staff on culturally competent care and organizational policies related to conduct, ethics, privacy, nondiscrimination, and antiharassment policies.
  (Bass & Nagy, 2023; Yu et al., 2024)

OPPRESSION, DISCRIMINATION, AND CULTURAL BIAS IN HEALTHCARE

A person's healthcare experience is influenced by the intersection of their sex, gender identity, race, ethnicity, sexual orientation, 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.

Providing whole-person, patient-centered care requires a healthcare professional to proactively consider the intersection between each person's diverse identities and broader cultural factors. 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 (Vela et al., 2022).

When working with LGBTQ+ patients, it is especially important for clinicians 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 a person's stress and contributing to negative mental and physical health outcomes (Vela et al., 2022).

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 (Shah & Bohlen, 2023).

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

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 to LGBTQ+ patients, 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

Equality Maps: Healthcare Laws and Policies
https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies

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

National Center for Transgender Equality
https://transequality.org/issues/health-healthcare

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

National LGBTQIA+ Health Education Center (Fenway Institute)
https://www.lgbtqiahealtheducation.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 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

2. 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. Suicidal ideation

3. Which document should a patient with a same-sex partner be encouraged to obtain in order to protect their wishes for care?

a. Durable power of attorney for healthcare
b. Marriage certificate
c. Health insurance policy
d. Life insurance policy

4. 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

5. 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

6. 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 inclusive terminology
c. Answer the question, “How might my current beliefs harm others?”
d. Debate personal beliefs on discrimination with other clinicians