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Moving Beyond the LGBTQIA+ Acronym: Toward Patient-Centered Care

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Abstract

Purpose: The LGBTQIA+ communities experience distinct health disparities and inequities in health outcomes. Healthcare providers must be conscious of factors to facilitate optimal, person-centered care. This narrative briefly covers health disparities in the LGBTQIA+ community and posits strategies to promote inclusive care.

Methods: Current literature and clinical best practices from several authoritative sources on LGBTQIA+-specific issues and gender-affirming care were reviewed. Sources included several LGBTQIA+-specific healthcare organizations, national healthcare provider organizations, and federal agency policy statements. Inclusive terminology and healthcare practices were included.

Results: Healthcare providers must educate themselves on caring for gender- and sexual orientation-diverse populations to optimize the health status of these communities. It is essential that providers examine their own potential biases and maintain an openness to learning about LGBTQIA+ communities.

Conclusions: Healthcare providers have a responsibility to not only understand issues specific to LGBTQIA+ individuals but also advocate for these groups. As nurses, we must continue to support public health policies that seek to end disparities and ensure health equity for all.

Clinical Relevance to the Practice of Rehabilitation Nursing: Rehabilitation nurses are caring for more diverse populations than ever before and must understand how to provide compassionate, individualized care. Although this article focuses on the LGBTQIA+ community, the principles discussed are applicable across all populations.

Keywords: LGBT; lesbian; gay; bisexual; transgender; cultural competence; special populations.

Introduction

Today's healthcare providers are caring for more individuals from diverse backgrounds. This diversity may be in race, gender, religion, ethnicity, or sexual orientation. It is long known that health inequities have been associated with individuals from various races and diversities. Lesser known are the health inequities of individuals who identify as LGBTQIA+. According to the *Future of Nursing 2020–2030* report, health inequities disproportionately affect individuals who identify as LGBTQIA+ (National Academies of Sciences, Engineering, & Medicine, 2021).

The acronym LGBT denotes "lesbian, gay, bisexual, and transgender and is an umbrella term that generally refers to a group of people who are diverse with regard to their gender identity and sexual orientation" (The Joint Commission, 2011, p. 4). The "QIA" (questioning/queer, intersex, and asexual) and the "+" attempt to capture identities and orientations that do not fit the LGBT acronym. LGBTQIA+ individuals are from all races, ethnicities, religions, and socioeconomic classes.

The Williams Institute estimates 1.4 million U.S. adults and roughly 150,000 students under 13 years old identify as transgender or have experienced a social or medical gender transition (Williams Institute UCLA, n.d.). A 2015 transgender survey found that 35% of respondents categorized their experience as gender nonbinary (James et al., 2016). Gender nonbinary describes

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The Florida Board approved CE provider that provides training throughout the state and country for hospitals, healthcare agencies, and nurses on sexual and gender-diverse patient care and inclusion.

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individuals who do not identify as or relate to themselves as either female or male. Terms such as transgender and nonbinary represent individuals who *may,* in clinical terms, experience gender dysphoria according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychological Association [APA], 2013). *Gender dysphoria* is defined by the APA as "psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity" (APA, 2020, para. 1). However, not all transgender individuals experience gender dysphoria. Some transgender and nonbinary individuals may pursue social changes (name, pronoun, clothing, and personal appearance), medical treatment (hormone replacement therapy and gender-affirming surgeries), and/or legal identification changes to better navigate their authentic experience while having to exist and function in a binary, gender-rigid society.

Among transgender and gender nonbinary patient populations, authors of one study with 27,715 participants reported that 23% did not see a doctor for fear of being mistreated and 33% did not see a doctor because of cost. Of those who saw a healthcare provider, 33% reported at least one negative experience, including being refused treatment, being verbally harassed, physically or sexually assaulted, or having to teach the provider in order to receive appropriate care (James et al., 2016). An estimated 40% of transgender and nonbinary people have attempted suicide, and although transgender people comprise less than 1% of the U.S. population, HIV prevalence is estimated to be between 22% and 28% (Becasen et al., 2019; James et al., 2016; Toomey et al., 2018). The COVID-19 pandemic has highlighted existing gaps, specifically negative mental health outcomes experienced by LGBTQIA+ people compared to non-LGBTQIA+ peers (Dawson et al., 2021). For these reasons, it is essential that healthcare providers be educated to address the needs of these populations.

Social Justice

Having awareness and competency with gender- and orientation-diverse populations facilitates provision of compassionate care. The American Nurses Association (ANA, 2015) Scope and Standards of Nursing dedicates an entire chapter to social justice and outlines how nurses must uphold the principle of fair, just, and equitable care for all. In fact, the ANA "condemns" discrimination of an individual because of sexual orientation or gender identity (ANA Ethics Advisory Board, 2018). Nurses play a pivotal role in facilitating and fostering individualized, compassionate care so that all individuals have the opportunity to receive unbiased and nondiscriminatory care and treatment. As an example of how a specialty organization has incorporated those principles, the Association of Rehabilitation Nurses (ARN) has a diversity, equity, and inclusion statement, which speaks to caring for all with respect and humility in an effort to support diverse patient populations (ARN, 2021). Furthermore, the ARN role statement "Role of the Nurse on the Rehabilitation Team" stipulates that the nurse should provide holistic, compassionate care to each and every patient, regardless of race, ethnicity, or identity (ARN, n.d.). The tenet of patient-centered care, as defined by the Agency for Healthcare Research and Quality (AHRQ), is "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values" (AHRQ, 2018, para. 1). This response can be a guiding light for humane care, satisfactory provider goals and patient outcomes for both gender- and orientation-diverse populations described here, as well as many others.

Health Disparities in Sexual- and Gender-Diverse Populations

The Henry J. Kaiser Family Foundation defines healthcare disparities as "differences between groups in health coverage, access to care, and quality of care" (Ndugga & Artiga, 2021, para. 2). Equity is the nonexistence of avoidable and unfair distinctions among various groups, regardless of whether those groups are defined socially, economically, demographically, or geographically or by some other means (Larsen, 2021). Equity in health implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential (World Health Organization, 2020). However, a report from the World Health Organization, *U.S. Health in International Perspective: Shorter Lives, Poorer Health,* documents the alarming implications of poor health status among many individuals, families, and communities—many of which are results of inequities (Wolf & Laudan, 2013). Some of these inequities in health treatment and outcomes among gender- and orientation-diverse populations may begin in adolescence. Some of these discrepancies among the adolescent population include higher rates of antigay and gender-based bullying, increased incidence of suicidality and depression, substance abuse, and high-risk sexual behaviors (Hatzenbuehler et al., 2017; Institute of Medicine [IOM], 2011; McEwing et al., 2018). Transgender and nonbinary teenagers exhibit high rates of family rejection (Johnson et al., 2020) and homelessness, which can lead these young people to resort to survival sex (Fraser et al., 2019). These survival practices in turn may increase rates of sexually transmitted

infections (STIs) and HIV (Fraser et al., 2019; Hatzenbuehler et al., 2017; IOM, 2011). Health inequities also experienced by these populations include lower screening and preventative health initiatives, higher rates of STIs, higher rates of anxiety and depression, higher rates of alcohol and substance abuse, and lower overall health (Casey et al., 2019). This is both alarming and distressing.

Other studies show overrepresentation of LGBTQ youth in foster care (30.4%) and having unstable housing (25.3%) compared with the non-LGBTQ community (11.2%; Baams et al., 2019). Not surprisingly, disparities in younger life may extend into later life. For example, rates of heart disease and breast cancer are higher in lesbians and bisexual women because of increased alcohol use, obesity, and tobacco usage (American Cancer Society [ACS], 2021; IOM, 2011). Older gender- and orientation-diverse individuals experience serious illness and disability, which can be worsened by ageism, discrimination, and healthcare providers' implicit biases (ACS, 2021; IOM, 2011). More recently, during the COVID-19 pandemic, research has shown that LGBTQ People of Color have inequitable COVID-19-related health and economic outcomes compared to White non-LGBTQ individuals (Moreau, 2021).

Challenges for the LGBTQIA+ Population

Rather than expect the individual patient to change or adapt to social expectations, rehabilitation nurses must provide individualized, patient-centered care. As healthcare providers, rehabilitation nurses must acknowledge and strive to overcome the stigma surrounding sexual- and gender-diverse individuals.

Nursing's social structures and clinical training are still largely based upon the assumption and bias that everyone will fit within an either/or female/male binary gender and heterosexual orientation options. This paradigm creates immediate barriers for patient-centered care practices to be fully enacted. Even at the seemingly lowest level, medical intake forms that have only "mother" and "father" listed are not inclusive of two male or two female parents. Similarly, if patients are only presented with two options (e.g., male/female) on intake forms, significant information could be missed by clinicians. Furthermore, clinically relevant information concerning biological family history and gender status (e.g., if the patient is on hormone replacement therapy) may not be readily volunteered by the patient out of fear.

From the YES Institute (2017) "*Affirming Gender & Orientation Patient-Centered Care*" video created for South Florida healthcare organizations, one mother shares her experience taking her transgender son for care when their birth name in the medical record did not align to the name and ID on check in:

> *There would be times when I would be taking my child to a doctor or therapist, and you hear the assistants making remarks, or sounds, or smirks that were degrading, like, "Oh, he's gay, or he's transgender," and it really is hurtful, you know. This is a person […] you should treat them with respect.*

Another participant in the video, who was born natally male but identifies as female, recounts a demoralizing experience after having been in a motor vehicle accident:

> *I was in the X-ray room and the tech starts helping me take off my shorts…then he just takes his hands off, backs up, and goes behind the glass and starts pointing and laughing with the other two techs that are sitting there and he's like "you're on your own." Mind you, I'm bloody from head to toe, not sure if I broke a bone so it took me almost half an hour to get my shorts down to my knees for them to take pictures.*

Nursing Implications

The most prevalent nonheterosexual orientation terms often include lesbian, gay, and bisexual, although there are many other experiences such as asexual (those who are fulfilled and content to not seek out or need sexual or romantic relationships), pansexual (someone who may be attracted to both cisgender and transgender people), or demisexual (an individual who does not feel sexual attraction to someone until an emotional bond develops). To distinguish people in conversation or writing who do not identify as transgender, the term *cisgender* has entered the current lexicon. *Cisgender* refers to someone assigned a gender at birth and identifies as that gender. Heterosexual is the most common term for those who seek out male/female relationships. One note of caution is to avoid assumptions based on these social identities relating to sexual behavior—a patient may identify as gay or lesbian and have chosen celibacy. A bisexual person can identify as such and be happy and fulfilled in a monogamous long-term marriage. An asexual person could find themselves a target of sexual assault. In addition, someone can identify as heterosexual and engage in same-sex experiences, known in HIV/STI medical communities as MSM (men who have sex with men) and WSW (women who have sex with women). The identity of an individual cannot be assumed. Furthermore, terms and identities are not lifelong and static experiences.

Rather as any human being grows, learns, and develops, it is common for people to discover new insights and awareness into themselves, which may shift gender and orientation identities at different stages of life.

Key approaches to recognizing and supporting an LGBTQIA+ individual can be achieved by the following:

1. Inquire as to how an individual identifies.
2. Ask an individual what pronoun they like to be referred by.
3. Learn basic terminologies associated with these populations (gender identity, sexual orientation) but be flexible and use affirmative practice and patients' chosen pronouns.
4. Clarify the patient's community and support systems.
5. Be committed to providing compassionate care.
6. Be willing to examine your own unconscious bias.
7. Educate or serve as a resource to others about the unique needs of LGBTQIA+ patients.
8. Share available resources targeted for these populations.
9. Adhere to policies that prohibit discrimination and promote inclusion.
10. Be open to learning from the patient regarding their unique needs (Fenway Institute, 2021a; U.S. Department of Health and Human Services, 2021; World Professional Association for Transgender Health, 2012)

Tips for a physical examination of the nonbinary patient:

1. The patient's gender should be affirmed during the visit.
2. Provide care in a sensitive and respectful manner.
3. Provide care for the anatomy present, regardless of the patient's identification or presenting gender.
4. Always address the patient with correct pronouns and affirmed name.
5. An examination should be performed only on body parts relevant to the reason for the visit.

Including questions on intake forms about preferred names and pronouns can increase patient comfort and trust with providers and increase the odds of treatment compliance (Franklin, 2021). Training for allied health and office workers in a facility or practice can also reduce barriers from seeing medical providers. Language is powerful; acknowledging and reflecting back to the patient any preferences in terms of name, pronouns, and gender identity can facilitate and foster a thoughtful, trusting, and engaging relationship.

Rehabilitation Case Study

A 16-year-old Hispanic, natally born female has recently been admitted to your unit with an incomplete spinal cord injury (ASIA D, T10) sustained during a motor vehicle accident 1 week ago. After the admission evaluations and assessment have been completed, the patient is ready for intensive rehabilitation therapy. Today during your morning medication pass, the patient states they are awaiting the arrival of their parents. The patient discloses that he identifies as male and prefers "he" pronouns and a masculine chosen name. The patient is afraid to tell his parents because of rejection threat and expressed feelings of worthlessness. He shares he has a small group of friends at school who "accept me for who I am." You leave the room to chart, and when you return to check on the patient, the patient's parents are in the room saying, "We love you, daughter. We're here to support you and help you get better." In addition, a team member expresses concern during the morning huddle as to how to compassionately care for the patient as they have never cared for a patient who is transgender. The authors offer the following self-reflection and questions that the rehabilitation nurse may want to consider:

1. How can you affirm and support the patient?
2. How would you communicate the patient's pronouns to the team?
3. How might you best address the patient and parents when you approach the bedside?
4. How might your approach be different if the patient were not a minor?
5. How would you structure your discharge teaching instructions?
6. What resources or support might you suggest to the patient and family?
7. How might you create a healing space for the patient on the unit?
8. How might patient preferences be communicated to the entire team and from shift to shift to create a positive, healing environment?

Although this is a complex situation, some ideas might include (a) affirming the patient's gender and name, (b) ensuring that all care team members are aware of pronouns/name, (c) having a conversation with the patient and parents about pronouns, (d) involving your nurse manager and/or diversity officer, (e) providing family links/phone numbers for LGBTQIA+ organizations and churches, and (f) considering structured hand-off reports that routinely cover patient gender and any specifics to care related to gender.

Conclusion

With every patient, it is our duty to provide care to each individual in a respectful and compassionate manner.

Nurses have an ethical obligation to provide culturally competent care to all individuals (Lund & Burgess, 2021). Nurses must not only advance the science and research of caring for sexual- and gender-diverse populations but actively advocate for and implement tangible processes within practice to ensure that equitable health care is achieved by all (Caceres et al., 2020). Understanding that the language surrounding LGBTQIA+ topics is evolving, nurses should familiarize themselves with resources such as the LGBTQIA Resource Center Glossary (University of California Davis LGBTQIA Resource Center, 2020), which maintains an up-to-date listing of terminology. We must commit to achieving diversity and inclusion as an important step toward addressing healthcare disparities. Using inclusive, equity-focused, person first language is the first step in providing compassionate, individualized care (American Medical Association, 2021). Future research priorities must include sexual- and gender-diverse populations as the foci of research studies as well as examine the intersection of gender/orientation and race/ethnicity, among other issues (Fenway Institute, 2021b). As nurses, we must continue to advocate and support public health policies that seek to end disparities and ensure health equity for all.

Conflict of Interest

The authors declare no conflict of interest.

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