Exploring health care professionals' experiences of supporting LGBTQ+ patients: A Qualitative Study

Abstract

Background:

LGBTQ+ patients report negative healthcare experiences such as healthcare professionals (HCP) making assumptions about their identities. Research shows that HCPs report not having enough knowledge to facilitate an open conversation with LGBTQ+ patients, leading to patients feeling ignored.

Aims:

To explore HCPs experiences of supporting LGBTQ+ patients.

Method:

Semi-structured interviews were conducted with HCPs recruited from the research teams' professional network. Data were analysed using deductive thematic analysis.

Findings:

HCPs reported positive and negative experiences as well as a variety of barriers and facilitators to effective communication with LGBTQ+ patients. HCPs discussed how the clinical practice could improve, for example, by developing more inclusive training that is specific to the HCPs' clinical group.

Conclusion:

HCP trainings needs to be more inclusive of LGBTQ+ identities. It should be tailored to the HCPs' patient group as this better reflects the varied needs of different clinical groups

Introduction

LGBTQ+ is an umbrella term that stands for lesbian, gay, bisexual, transgender, and queer (Montz, 2021). It represents a variety of sexual orientations and gender identities that are not heterosexual or cisgender (a person whose gender identity matches with the gender they were assigned at birth) (Montz, 2021). Increased acceptance of LGBTQ+ people is visible in the development of more inclusive UK laws (Marriage (same-sex couples) Act 2013; the Gender Recognition Act 2004, and the Equality Act 2010). The public has also reported increased acceptance of LGBTQ+ people (Nolsoe, 2021). Despite these developments, LGBTQ+ individuals still face inequalities in the healthcare sector. A UK survey showed that 108,000 LGBTQ+ people felt that their health needs were not being met by the healthcare system (Government Equalities Office, 2018). Research has shown that LGBTQ+ people are more likely to have negative experiences when accessing healthcare than non-LGBTQ+ people (Elliot, et al., 2015). They often report that healthcare professionals (HCPs) do not have sufficient knowledge and experience to be able to meet their healthcare needs (McNeill, et al., 2021) and that they have to educate them on health issues related to gender-identity such as hormones (Willis, et al., 2020). LGBTQ+ patients also tend not to disclose their sexual orientation as HCPs, typically, do not ask (Ching, et al., 2021; McNeill, et al., 2021), and because they sometimes experience clear homophobia and microaggressions (Fish & Williamson, 2018). This is a problem, as LGBTQ+ people are more likely to experience physical and mental health conditions (Elliot, et al., 2015), such as later cancer diagnoses and higher rates of mental health issues (McDermott, et al., 2021).

Limited research has explored HCPs' experiences in providing care to LGBTQ+ patients (McDermott, et al., 2021). Existing data show that even though there are still instances of overt homophobia and transphobia, HCPs typically have positive attitudes toward LGBTQ+ patients (Arthur, et al., 2021). However, research suggests that they have limited knowledge about LGBTQ+ issues and distinct needs (Bailey, et al., 2022;

Berner, et al., 2020; Ussher, et al., 2021). A review of the UK evidence further supported this. It showed that HCPs are uninformed about LGBTQ+ identities and terminology, particularly when it comes to transgender and non-binary individuals (McDermott, et al., 2021). Medical students also report lacking confidence in LGBTQ+ language (Arthur, et al., 2021; Parameshwaran, et al., 2017).

Past research has typically explored the experience of HCPs using surveys, which do not facilitate the gathering of in-depth narratives of participant experiences. It is important to explore in depth the views of a variety of HCPs as LGBTQ+ people report issues in primary (Cant & Taket, 2006) and secondary care (Floyd, et al., 2020). Therefore, this study aims to explore HCPs' experiences of supporting LGBTQ+ patients.

The research objectives were to explore:

1. How confident Health Care Professionals (HCPs) feel in supporting LGBTQ+ patients;
2. The barriers and facilitators that HCPs experience when supporting LGBTQ+ patients;
3. If and how current clinical practice can be improved.

Method

Design and sample

This study adopted a qualitative case-study design, as this was ideal to facilitate the gathering of detailed and rich narratives. The inclusion criteria were:

1. Practitioners from the National Health Service or the private sector
2. Any profession, for example, GPs and allied health professionals, with direct contact with patients

3. Working in the United Kingdom
4. Having experience of supporting LGBTQ+ patients

Participants were recruited using the research team's professional network.

Procedure

Initial contact was made via email by the first author (CP). If participants were willing to take part, an invite to the interview was sent. Participants were then asked to complete a demographic and consent form and email it back to CP before the interview. CP developed a topic guide for the interviews based on the literature (Appendix 1). The topic guide was used flexibly to allow follow-up questions and the exploration of emerging relevant topics. Interviews were conducted remotely via Microsoft Teams and recorded.

Data analysis

Audio files were transcribed verbatim, anonymised, and analysed by CP using deductive Thematic Analysis (Braun & Clarke, 2012). The research questions were used as initial themes to guide analysis. Any new themes identified in the transcript were annotated and integrated into a tentative code book. The codebook was discussed with the second author (CDL) until a consensus was reached on a final version, which was used to code all transcripts (Table 1).

Table 1. Themes and sub-themes identified through thematic analysis

Theme	Sub-theme	Definition	Quotes
1. Experiences of Supporting LGBTQ+ Patients		HCPs experiences with LGBTQ+ patients.	
	Positive Experiences	Positive experiences with LGBTQ+ patients and examples.	*"I suppose we were very sensitive around something that was probably very um embarrassing for him"*
	Negative experiences	Negative experiences with LGBTQ+ patients and examples.	*"A transfeminine patient who was admitted with cellulitis… they cut their leg shaving and this person was placed in a male bay in a ward… they were the subject of quite a lot of behind the curtain sniggering and derision"*
2. Facilitators and Barriers		Facilitators and barriers to effective communication with LGBTQ+ patients identified by HCPs.	*"Just have to assume nothing and ask" and be "open about asking people how they want to be addressed"* *"I don't always have the language or the structures to get the most out of a relationship with a same sex partner".*
3. Confidence in Practice		HCPs' confidence in their ability to communicate with and treat LGBTQ+ patients.	*"There aren't many questions and queries that… would um worry me about asking, I feel like I would be quite open with people".*
4. Ideas for Future Practice		HCPs ideas about how the NHS and private sector could improve clinical practice in the future.	*"It's quite clear that unless its um unless it's done at a systematic level that it's impossible to embed"*

Results

Eight HCPs were included (Table 2). The majority of participants were men (n = 5; 62.5%). Most participants were consultant geriatricians (n = 2; 25%). Seven participants were White British. Interviews lasted 33-55 minutes (mean = 38 minutes).

Table 2. *Demographic information for participants*

Participant ID	Gender	Age Range	Ethnicity	Sexual Orientation	Profession	Number of Years Practicing
P1	Male	55-64	White British	Heterosexual	Consultant geriatrician	30+
P2	Male	25-34	White Irish	Gay	Hospital physician (geriatric)	6-10
P3	Male	65+	White British	Heterosexual	Psychiatrist	30+
P4	Female	55-64	White British	Heterosexual	General Practitioner	21-29
P5	Female	35-44	White British	Heterosexual	Occupational therapist	21-29
P6	Male	45-54	Mixed	Gay	Consultant geriatrician	21-29
P7	Female	35-44	White British	Heterosexual	Physiotherapist	16-20
P8	Male	55-64	White British	Heterosexual	Hospital consultant (medical)	30+

Theme 1: Experiences of Supporting LGBTQ+ Patients

The majority of participants recounted a positive experience they had with an LGBTQ+ patient. Patient disclosure about their sexual orientation was generally linked to enhanced rapport (and positive outcomes). P6 reported that when a patient had come out to him, he had been able to refer him to a local befriender scheme. This had enhanced patient's social inclusion and emotional wellbeing. Providing effective support/care as a result of disclosure, was also discussed by P4, who described an instance where a transgender male patient was offered individualised care by a GP whom they had come out to.

Participants also identified negative experiences with LGBTQ+ patients. P5 and P4 reported that HCPs often made assumptions about LGBTQ+ patients' sexuality, "particularly older people". This led to patients losing their confidence in their HCPs. Some participants had witnessed instance where the HCPs had been overtly homo or transphobic with patients. P6 reported:

> "a transgender patient was admitted with cellulitis… they cut their leg shaving and this person was placed in a male bay in a ward… they were the subject of quite a lot of behind the curtain sniggering and derision"

Similarly, P2 reported hearing about an older man coming out to a healthcare professional, and being met with the response "oh, we don't need to hear about that".

Theme 2: Facilitators and Barriers

HCPs generally reported that being open and not making assumptions, but rather asking patients about their background were key facilitators to effective communication. While

P1 felt that openness in communication was a facilitator, he felt that disclosure had to be initiated by the LGBTQ+ individual:

"Disclosure probably has to be offered by the LGBT person because I'm not going to tend to ask about it unless I think it is relevant in some way"

P6 observed that open discussion about orientation and relationships were more problematic with older patients. P2 explained how this created an intersection of different layers of stigma against older patients:

"They're marginalised twice. They're marginalised because they're older and they're marginalised because they're LGBT"

He continued that there was a need to be "extra mindful" with older LGBTQ+ patients, who might be mistrusting of the healthcare system. Some described the value of kitemarking inclusivity through, for example, displaying the rainbow flag, in opening up communication. P2 described using "rainbow tape" in the past on their "stethoscope as a visual cue that specifically [they were] LGBTQ+ friendly". HCPs also identified potential barriers to effective communication. Participants felt that HCPs had limited understanding of LGBTQ+ issues. P6 explained that "staff are well meaning, but not skilled, and tend to then just avoid it rather than trying to talk to people about gender identity, sexual orientation, all those kind of things". This suggests that HCPs typically wanted to communicate effectively but lacked knowledge of the appropriate language and terminology.

<u>Theme 3: Confidence in practice</u>

Overall, HCPs felt confident to interact with LGBTQ+ patients because they had a lot of experience talking to patients in general. P4 felt, as a result of their experience as an

HCP, that "there aren't many questions and queries that… would um worry me about asking, I feel like I would be quite open with people".

Dealing with transgender patients, P3 reported, presented added challenges:

"There may or may not be difficulties in deciding what kind of accommodation to offer… a transgender man or a transgender woman or you know…people's experience dealing with non-binary people calling them "they"

He continued that members of the workforce were not ready to support effectively transgender patients.

Theme 4: Ideas for Future Practice

Participants were asked about whether they thought the NHS and private sector needed to improve clinical practice with LGBTQ+ individuals and how this might be achieved. Many participants felt that equality, diversity and inclusion (EDI) training needed to be improved. P3 recognised that "[LGBTQ+] is a big part of the EDI agenda generally… but I suspect it requires more attention". P5 continued that EDI training should be patient-group-specific:

"I think it would be no good to send everybody to the same training because different people in different settings with different ages ranges of… patients or service users have different… needs".

Improving undergraduate medical training could also be beneficial. P6 felt that activities such as "role play scenarios" and "simulation work" could be helpful to "get people used to and comfortable with terminology". P2 also expressed that while improving medical school teaching would be helpful, there should also be an effort to change the system by having information on LGBTQ+ patients collected on forms. Collecting patient data systematically also ensured monitoring of improvements, because

in order to be able to measure change, P2 continued, "you need to know who the patients are"

Other participants expanded on issues around equality and inclusion by advocating for improved healthcare for all vulnerable groups. P1 recognised the issue of intersectionality, whereby one person might be part of many vulnerable groups. P4 agreed with this view, and advocated for strategies to help multiple vulnerable groups, using a "multi-pronged approach".

Discussion

The LGBTQ+ community still faces health inequalities, but little research has gathered in-depth narratives of HCPs in providing care to LGBTQ+ patients. This study aimed to explore the experiences of HCPs in communicating with and treating LGBTQ+ patients.

Participants reported several examples where LGBTQ+ patients were provided with effective, personalised care due to the HCPs being aware of the patient's identity. This fits with the findings that disclosure of identity to an HCP can lead to better health outcomes (Ruben & Fullerton, 2018). The positive experiences described by the participants involved acknowledging a patient's identity, taking special care of sensitive topics, and providing them with extra resources. LGBTQ+ patients have unique needs, such as reduced service access, which could lead to poorer health outcomes, so it is important to identify these patients and consider their distinct needs (Berner, et al., 2020)

The HCPs also described instances in which they had witnessed stigmatising behaviour that have also been reported in previous studies by LGBTQ+ patients (Fish & Williamson, 2018; Whyman & Di Lorito, 2022). Negative experiences have implications for LGBTQ+ patients as it leads them to delay or avoid access to healthcare services (Guest & Weinstein, 2020; Stonewall, 2018). Some participants reported that they would not directly ask a patient, especially an older patient, about their identity. This is consistent with research by Parameshwaran, et al. (2017) who found that only 50% of their student sample had witnessed a doctor "very frequently" ask about sexual

orientation and 2% had "very frequently" or "always" witnessed a doctor ask a patient about their gender identity. Research has shown that people will often not disclose or hide their identity if the HCP does not ask (Ching, et al., 2021; McNeill, et al., 2021). This could further lead to patient needs being unmet and poor health outcomes.

HCPs in this study reported feeling comfortable with LGBTQ+ patients. However, they also reported lacking knowledge about their issues and making assumptions about their identities. Improving medical student education would be essential to address this. Also, updating EDI training to include information about LGBTQ+ terminology and communication is vital. However, training cannot be generic as this ignores the needs of different patient groups. For example, older patients may be more hesitant to use services because of stigmatisation (McCann & Brown, 2019). Thus, training should be developed with consideration of the specific needs of different cohorts that the HCP works with.

However, there also needs to be institutional changes, such as systematically including sexual orientation and gender identity questions on intake forms, which should use inclusive language. The use of visual cues to show that services are accepting and welcoming of LGBTQ+ communities is also paramount. For example, the NHS rainbow flag badge was introduced to show patients that the individual they were speaking to is safe to open up to (Huckridge, et al., 2021). Working with LGBTQ+ third sector organisations would enhance service understanding of the needs of LGBTQ+ communities and the kind of changes that should be implemented to meet them.

This study is characterised by certain strengths and limitations. One strength is that it is exploring an under-researched topic area. Therefore, it is contributing novel insight. In addition, the data came from a diverse group of professionals including GPs, physiotherapists, and psychiatrists. Therefore, it contributes a variety of experiences from different professional backgrounds. The main limitation of this study is the small sample, which makes the findings not generalisable.

Conclusion

Future research should expand on this study by interviewing other non-clinical patient-facing staff such as receptionists. To further expand on study findings, further research should be conducted to understand more widely what kind of initiatives/strategies related to undergraduate teaching and EDI training should be implemented to better prepare the workforce of HCPs to effectively communicate and support LGBTQ+ patients.