



## Journal of Student Nursing Research

Volume 4  
Issue 1 2010-2011

Article 3

3-29-2014

# Examining Nursing Practice with Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Patients

Tiffany M. Holder  
*University of Pennsylvania*

---

# Examining Nursing Practice with Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Patients

## Examining Nursing Practice with Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Patients

Tiffany M. Holder

et al., 2006). Other relevant institutional policies, such as health insurance coverage, should also be changed or extended to be inclusive of same-sex relationships (Blackwell, 2008; Harrison, 2008). LGBT employees in workplaces with non-discrimination policies that include them have higher levels of job satisfaction, and are more likely to be open about their sexual orientation at work (Blackwell, 2008).

Educating nurses on LGBT issues, both in school and through continuing workplace education, demonstrates institutional support for LGBT students or staff and communicates information important to the care of LGBT patients (Bowers et al., 2006). Combined, these strategies have the power to improve the lives of all nurses and patients, regardless of sexual orientation.

### References

- Blackwell, C. W. (2008). Registered nurses' attitudes toward the protection of gays and lesbians in the workplace. *Journal of Transcultural Nursing, 19*(4), 347-353. doi:10.1177/1043659608322420
- Bowers R., Plummer D., McCann P., McConaghy C., Irwin L. (2006). *How we manage sexual and gender diversity in the public health system*. Armidale, NSW Australia: University of New England.
- Chinn, P. L. (2008). Lesbian nurses: What's the big deal? *Issues in Mental Health Nursing, 29*(6), 551-554. doi:10.1080/01612840802046604
- Harrison, S. (2006). Out in the open. *Nursing Standard, 20*(21), 20-22.
- Harrison, S. (2008). Equality for gay staff can only be good for the workforce as a whole. *Nursing Standard, 22*(22), 12-13.
- Hinz, C. A. (2009, Spring). Come on in, make yourself at home. *Minority Nurse, 2*, 42-47.
- Irwin, L. (2007). Homophobia and heterosexism: Implications for nursing and nursing practice. *Australian Journal of Advanced Nursing, 25*(1), 70-76.
- Miller, S. (2009, Summer). Standing up for the right to be ourselves. *Minority Nurse, 64*.
- Rondahl, G., Innala, S., & Carlsson, M. (2007). To hide or not to hide, that is the question! Lesbians and gay men describe experiences from nursing work environment. *Journal of Homosexuality, 52*(3-4), 211-233.

### Introduction

All patients entering a healthcare environment have the possibility of feeling apprehensive about how their medical concerns will be assessed, diagnosed, and, hopefully, treated. However, lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) patients have the added concern of whether healthcare providers will assume they are heterosexual, whether they will be judged or discriminated against by staff, and whether the provider will know the best health recommendations for members of their community (Kitts, 2010). This anxiety creates a barrier between the patient and the receipt of adequate care, which poses a major health risk to the patient (Kitts, 2010).

In nursing, this concern is especially significant, since a patient often relies on the nurse for daily care and coordination of the care team. If the nurse displays any level of discomfort during patient interactions, this could highly affect the level of care received by the patient. The nurse's personal presumptions and biases may lead to less-than-optimal care. Blatant discrimination is even more damaging to delivering care, and it is still common in the medical setting.

The purpose of this paper is to examine the biases and prejudices present in the nursing sector from a patient perspective and assess ways to improve access to and comfort during care for the LGBTQQ community.

### Heterosexism in Healthcare

Heterosexism or heteronormativity can be defined as the belief that everyone already is or should be heterosexual (Irwin, 2007; Corbett, 2007). Built into this belief is also a dismissal of other alternative sexualities, whether it be conscious or subconscious, in this case, on the part of the provider (Irwin, 2007). Irwin (2007) suggests that when heterosexism is part of a health care encounter, it can put pressure on patients who are not heterosexual and alienate them. Corbett (2007) interviewed 17 women and 10 men between the ages of 23 and 65 and asked about their experiences with nursing care. Corbett's (2007) and Irwin's (2007) findings are similar in asserting that LGBTQQ patients are often immediately alienated by the brochures in health care offices and the heteronorma-

tive forms that must be completed. In Irwin's (2007) article, she further discusses the relationship between heterosexism and health care of LGBTQQ patients by explaining the Australian Medical Association's view that homophobia itself is the health issue rather than homosexuality, thus refuting the idea that homosexuality creates the biological or health hazard for the patient. Additionally, a self-reported questionnaire from a study by Klitzman and Greenberg (2002) revealed that discrimination towards LGBTQQ patients causes them to underutilize services, since they view disclosure as a risk and fear receiving subpar care when they do seek it out. For many heterosexual couples, a husband/wife/partner would be a good support system during healthcare crises, but for homosexual couples, partners attempting to support their loved ones often receive negative non-verbal communication from nurses due to their sexuality (Corbett, 2007). These sorts of reactions cause unnecessary discomfort for patients and add undue stress during a difficult time (Neville and Henrickson, 2006).

### Discrimination in Nursing

The decision to disclose sexual orientation to healthcare providers is often a stressful situation for individuals in the LGBTQQ community. Patients can be anxious about facing discrimination, which then impacts their decisions to provide private information to members of the care team. Polek, Hardie, and Crowley (2008) conducted research based in Delaware, for which they recruited 96 lesbian and bisexual women from LGBTQQ. Each woman completed a questionnaire about a variety of experiences related their sexual orientation, including healthcare encounters. Many women in this study, especially bisexual women, reported discomfort with disclosing all aspects of their sexuality to healthcare providers (Polek et al., 2008). This is a clear barrier to receiving adequate care and to conversing openly with the nursing staff.

Rondahl's (2009) study of gay men and lesbians in Sweden found that lesbian and gay patients also feared discrimination or hostility if they were to disclose their sexual orientation. Many of the LGBTQQ patients Rondahl (2009) interviewed expressed

feelings that the nursing staff was avoiding them; however, they attributed it to the nurse's insecurity with dealing with an unfamiliar situation rather than a deliberate discriminatory attitude.

Rondahl's (2009) study also assesses the differences in perceived discriminatory behaviors among generations and cultures of nursing staff members. In some cases, her participants stated that they felt the younger generation was more accepting and open-minded, whereas they described the older staff members as quite "matronly" and firmly planted in their beliefs. She also received comments that many had negative experiences related to nurses exerting their religious beliefs on the patients in order to heal them of their "sinful ways" or grant forgiveness. Heterosexual patients rarely face this sort of judgment and treatment from nurses, yet LGBTQQ patients know that they could be forced to deal with this, and other complications, during any health care encounter. Due to this possibility, an uncomfortable situation could be created at the beginning of a nurse-patient interaction stemming from the patient's uncertainty and the nurse's lack of knowledge about the topic.

It has been stated that lesbian and gay patients have uncomfortable interactions in healthcare settings; but, and Polek et al. (2008) further found, during a survey of 96 women, that it is often even more difficult for a bisexual patient than for a lesbian or gay patient to disclose his/her sexual orientation to a nurse or healthcare provider. Meckler et al. (2006) also had similar findings in their research on LGB youth in Los Angeles, during which they found that bisexual adolescents disclosed their sexuality at a rate lower than their lesbian and gay counterparts. Bisexuals often face even more scrutiny and judgment based on society's assumption that they 'can not decide what they want,' or are people who are promiscuous individuals who want a man and a woman simultaneously. This mindset also affects questioning patients, those who are questioning their sexuality and may be having a variety of sexual experiences or identity confusion as they seek out their orientation, since they may be uneasy about disclosing their possible same-sex attractions or sexual encounters, adding another barrier to communication and care.

#### Relationship between LGBTQQ Health Issues and Disclosure

If patients are not comfortable enough to disclose their sexual identities, then a vital opportunity is

missed for education and risk assessment (Meckler et al., 2006). Concerning patient satisfaction, Meckler's (2006) community-based participatory research study involving 131 LGB youth between the ages of 14 and 18, showed that the ability to disclose sexuality is an important factor in maintaining health of patients, as it directly relates to the types of interventions a healthcare provider may recommend.

However, even if patients are willing to discuss their sexuality openly, some patients, nurses, and healthcare providers fail to realize that lesbians face many of the same health risks as heterosexual women, as Polek et al. (2008) discuss in their paper. Although research has shown that there are no specific illnesses that affect only lesbians, it is known that their health issues and concerns are often not adequately addressed (Polek et al. 2008). For example, lesbians should also consider annual pap smears, sexually transmitted infection testing, and mammograms. With direct knowledge of this particular disparity in the lesbian population, it would seem likely that other subsets of the LGBTQQ community would experience similar disparities in care. If open communication is present during a healthcare encounter, then some of these misunderstandings can be discussed and evaluated, thus elevating the level of care.

#### Solutions to Improve Care for LGBTQQ Patients

The aforementioned studies support the assertion that a problem does exist in access to care and treatment in healthcare facilities for LGBTQQ patients, and using this data will provide information and ideas for ways to improve future care. Meckler et al. (2006) discuss findings that LGB healthcare providers had witnessed others in their field treat LGBTQQ patients in a substandard way compared to their heterosexual counterparts. This particular finding suggests that LGBTQQ patients have legitimate fears of discrimination and substandard treatment that have been accurately measured in a clinical setting. Thus, these real concerns and situations must be confronted. Coker et al. (2009) suggest that a good starting place would be for nursing and medical education to include mechanisms for approaching sexual orientation and gender identity with their patients, including coursework and LGBTQQ patient interactions during their training. An increased knowledge of LGBTQQ lives and health concerns will result in more ease in communication and subsequent treatment. Related to this, there is an overall lack of research in this particular

Holder, T. M.  
area, especially transgender healthcare and management of care. Nurses are in a unique position to increase the amount of research done on interactions between healthcare providers and the LGBTQQ community, since they are the part of the team that works most directly with patients on a regular basis and could help identify gaps in knowledge.

Some possible solutions are more personal, such as encouraging nursing staff to reflect on their own biases and possible discrimination (Irwin, 2007; Rondahl, 2009). A deliberate attempt to respect a patient's personal life and different ways of living can change an interaction directly. Rondahl (2009) also suggests that it is a positive gesture to admit to patients when something goes wrong or when a misstep occurs concerning the approach to a patient's sexual orientation; this fosters openness and includes the patient in the discourse. This gesture also counteracts the patient's feelings of being out of control and can contribute to a better therapeutic relationship for the team as a whole.

Another step for nurses and other healthcare providers is to improve communication skills in several ways. First, providers should be more willing to discuss sex with all patients, allowing for LGBTQQ patients to openly discuss their sexuality and concerns. In a study conducted by Meckler et al. (2006), many of his patients answered survey questions stating that all a healthcare professional needed to do to improve their comfort levels was to ask the patient about their sexual experiences, rather than only about sexual identity (Meckler et al., 2006; Polek et al., 2008). This simple, open-ended question has the potential of increasing quality of care for people of all ages of the LGBTQQ community, since it would give members of the healthcare team a better opportunity to understand LGBTQQ health issues and to provide education on necessary topics. Similarly, a general discussion of sex increases the likelihood for disclosure of sexual orientation among adolescent patients, and consequently, that conversation alone would also positively impact care provided to LGBTQQ individuals. Additionally, the nurse or physician should aim to use gender-neutral words when discussing a patient's relationships in order to be inclusive of any sexual orientation or gender expression. This effort should be duplicated for all office forms and documents so that patients are able to complete the forms with as much ease as possible (Polek et al., 2008).

Increased training for healthcare providers

in clinical settings is also encouraged to improve the quality of care given to LGBTQQ patients (Polek et al., 2008). Training should include information about the LGBTQQ community, healthcare, and homophobia to prepare healthcare professionals for working with a diverse population and to dispel any myths they may have heard and believed (Irwin, 2007; Polek et al., 2008). This could be an ongoing effort so that staff are always updated and informed about patient care recommendations, and it could also be extended to student nurses and medical students so that they enter their field prepared to work with patients from diverse backgrounds and sexual orientations (Irwin, 2007). Corbett (2007) even suggests that staff have an opportunity to meet LGBTQQ individuals to help them understand various concerns they have and challenges that they face as a group and individually.

Another simple way to show LGBTQQ patients that they are in a safe and protective healthcare environment is to provide pamphlets in waiting rooms and exam rooms about LGBTQQ health and to even post a nondiscrimination policy in waiting areas (Meckler et al., 2006; Polek et al., 2008). This idea serves a dual purpose: (a) to create an open environment to LGBTQQ patients, and (b) to provide them with helpful materials that will enhance their overall health and level of care. Many of these materials may also benefit any staff who may not be fully aware of the health concerns for this particular population.

#### Conclusion

LGBTQQ patients seek care for many of the same reasons as heterosexual individuals. These patients expect the same level of care that others receive, and they deserve respect and considerate treatment by all staff members (Irwin, 2007). The changes that have been outlined would be small modifications in the way practice is currently done, but they would enhance care for a large segment of the population who now suffer from a considerable disparity in the amount of care sought and the quality of care offered. More research could be done in this area to better understand how patients feel about their interactions with nurses and other healthcare staff members, which could then ultimately lead to more welcoming and diverse approaches to providing care for every individual.

#### References

Coker, T. R., Austin, S. B., & Schuster, M. A. (2009). Health and healthcare for lesbian, gay,

- bisexual, and transgender youth: Reducing disparities through research, education, and practice. *Journal of Adolescent Health*, 45(3), 213-215. doi:10.1016/j.jadohealth.2009.06.020
- Corbett, K. (2007). Lesbian women and gay men found that nurses often assumed they were heterosexual, which led to feelings of discomfort and insecurity. *Evidence-Based Nursing*, 10(3), 94-94. doi:10.1136/ebn.10.3.94
- Irwin, L. (2007). Homophobia and heterosexism: Implications for nursing and nursing practice. *Australian Journal of Advanced Nursing*, 25(1), 70-76.
- Kitts, R. L. (2010). Barriers to optimal care between physicians and lesbian, gay, bisexual, transgender, and questioning adolescent patients. *Journal of Homosexuality*, 57(6), 730-747. doi:10.1080/00918369.2010.485872
- Klitzman, R. L., & Greenberg, J. D. (2002). Patterns of communication between gay and lesbian patients and their health care providers. *Journal of Homosexuality*, 42(4), 65-75. doi:10.1300/J082v42n04\_04
- Meckler, G. D., Elliott, M. N., Kanouse, D. E., Beals, K. P., & Schuster, M. A. (2006). Nondisclosure of sexual orientation to a physician among a sample of gay, lesbian, and bisexual youth. *Archives of Pediatrics & Adolescent Medicine*, 160(12), 1248-1254. doi:10.1001/archpedi.160.12.1248
- Neville, S., & Henrickson, M. (2006). Perceptions of lesbian, gay and bisexual people of primary healthcare services. *Journal of Advanced Nursing*, 55(4), 407-415. doi:10.1111/j.1365-2648.2006.03944.x
- Polek, C. A., Hardie, T. L., & Crowley, E. M. (2008). Lesbians' disclosure of sexual orientation and satisfaction with care. *Journal of Transcultural Nursing*, 19(3), 243-249. doi:10.1177/1043659608317446
- Röndahl, G. (2009). Lesbians' and gay men's narratives about attitudes in nursing. *Scandinavian Journal of Caring Sciences*, 23(1), 146-152. doi:10.1111/j.1471-6712.2008.00603.x

## Men Who Have Sex With Men: Innovations in HIV Prevention

Michael Kegerreis

---

### Abstract

---

HIV treatment can be very expensive and prevention is the best way to decrease this cost. The Human Immunodeficiency Virus has a history associated with a lot of stigma towards gay men in particular that has created barriers to spreading prevention education outside of the gay community. The available resources within Philadelphia, the state of Pennsylvania, and the United States were evaluated and found to be lacking in evidence-based interventions. More interventions are needed not only within the gay community but also in the heterosexual community, especially to reach men who do not identify as gay but still have sex with other men. After a review of the literature, several recommendations were made for new evidence-based interventions that can reach both of these populations.

### Introduction

Our understanding of the Human Immunodeficiency Virus (HIV) has increased greatly in the 30 years since the beginning of the HIV epidemic. Education about HIV and Acquired Immunodeficiency Syndrome (AIDS) is included in many school health curricula. An estimated one million people are living in the USA with an HIV infection and one in five have no knowledge of their status (Avert.org, 2010). In the 1980's, HIV was considered a much more fatal disease that usually resulted in death soon after the onset of AIDS. Current treatments can slow the progression of the disease, but HIV and AIDS diagnoses are often accompanied by increased hospitalizations resulting in increased health costs and loss of productivity. Additionally, the progression of the disease causes many patients to become unemployed and lose their health insurance. Patients without health insurance must then rely on the resources of the community and the government for their medical care. As a 2010 CBS article concluded, "the least expensive option would be to prevent the estimated 40,000 new HIV infections that occur each year in the U.S." Clearly, our current interventions are not doing enough to prevent these new infections. Nurses are at the forefront of HIV prevention because they have the knowledge of how to prevent and reduce transmission within the community and the skills to teach and communicate effectively with their patients. Many communities do not have resources regarding HIV at their disposal and they rely on community nurses and other health professionals that come into their community. Nurses that work at

local clinics or deliver home care are in excellent positions to teach the community about HIV prevention.

The populations at the highest risk for contracting HIV are men who have sex with men (MSM) and injecting drug users. Men who have sex with men represent over 47% of the cases of AIDS in America (Santis, 2006). With over one million individuals infected nationally, this means 500,000 of them are men who have sex with men. Additionally, a 2010 CBS article estimated the cost of living with HIV/AIDS to be around \$2100 per month. With current HIV therapy extending average life expectancy by about 24 years from the time of infection, this results in a lifetime cost of over \$600,000 per person (CBS Interactive Inc.). When applied to the half million men who contracted HIV from sex with other men, almost \$13 billion a year is spent on MSM for a preventable disease. As more people become infected, they miss more work, resulting in less income and less tax revenue for the government. Additionally as the epidemic grows, the government is forced to spend more money on research and health care for these people.

Historically, as more and more gay men started to die from this disease, HIV/AIDS became known as the "gay disease." HIV seemed to only be affecting gay men and became irrevocably linked to homosexual behavior. Many stereotypes and prejudices continued even after scientific research debunked most of them. Even though it is no longer considered a "gay disease", men who have sex with men still have the highest rates of infection for any group at risk for contracting HIV. The connection between homosexu-