

Promoting cultural competency in the nursing care of LGBT patients

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The eight principles of nursing practice developed by the professional nursing union, the Royal College of Nursing (RCN) of the United Kingdom, in collaboration with the UK nursing regulatory body, the Nursing and Midwifery Council, and the UK government's Department of Health for England set out '*what patients, colleagues, families and carers can expect from nursing*'. Patients, members of the public and healthcare staff were involved in developing the principles. They describe what safe and effective nursing care looks like, and the behaviours, attitudes and approaches adopted by nursing staff applying the principles in their practice. They describe what it means to treat people with dignity and humanity; to take personal responsibility for care provided; to manage risk; to put people at the centre of decision-making about their health and well-being; to communicate effectively; to ensure professional knowledge and skills are up to date; that care and treatment is co-ordinated, of a high standard and assures the best possible outcome; and that nurses lead by example (RCN, n.d.). Together with initiatives such as the Chief Nursing Officer for England's rallying call for the evidence of the '6 Cs' of care, compassion, competence, communication, courage and commitment in nursing (NHS England, 2014), these principles offer a framework for patient and public feedback and professional reflection on the quality of nursing.

Arguably, when these principles underpin each individual's experience of prevention, treatment and care it will improve the health and experiences of healthcare for the whole community, including that of lesbian, gay, bisexual and trans (LGBT) people. However, evidence suggests that LGBT patients in England have poorer health and worse healthcare in comparison to the general population (Elliott et al., 2015). Moreover, a report conducted by the UK-based lobbying and campaigning group Stonewall found evidence of a lack of confidence among healthcare staff in their ability to understand and meet the needs of LGBT patients (Somerville, 2015), with the majority reporting that they did not consider sexual orientation relevant to people's health needs.

Experiences of illness are mediated by people's social positioning; the concept of holistic care affords understanding that sexual orientation and gender identity have relevance for the health and well-being of LGBT patients (Evans, 2013). But professionals sometimes believe that treating people equally means treating everyone in the same way. Such an approach, however, does not recognise the multiple impacts of stigma and discrimination, or address the heteronormativity which often underpins nursing practice. For example, while women aged 25–65 are invited for cervical screening, there remains an assumption that cervical cancer is associated with sex with men and consequently that lesbian and bisexual women do not require cervical cytology (Fish, 2009). A lesbian or bisexual woman may present for screening and be turned away by the practice nurse because she is not deemed to be eligible, or she may be told that she is wasting publicly-funded National Health Service (NHS) resources as she is not perceived to be at risk of the disease (Hunt and Fish, 2008). Similarly, young gay and bisexual men may be at increased risk of HIV infection because sex and relationship education in schools fails to address safer sex, and the development of the necessary self-esteem and personal skills to negotiate safer sex for 'queer' young people is rarely considered. (Many young non-heterosexual people have reclaimed the term 'queer' to describe their affectional and behavioural relationships.) Evidence suggests that mental health needs can include

depression, anxiety and self-harm (King et al., 2008), which may lead to an increased reliance on substances such as tobacco, alcohol and recreational drugs. Increased risk of mental health problems is not caused by sexual or gender identities, but can constitute the sequelae related to discrimination or perceived lack of acceptance (Clark, 2014).

UK-based research highlights that nurses and other health professionals may be embarrassed or uncomfortable in providing care for LGBT patients (Hinchliffe et al., 2005). Studies have shown that nurses are sometimes reluctant to ask about a patient's sexual orientation for fear of intruding into what is perceived to be a private matter (Lim et al., 2014). Some practitioners are concerned about appropriate terminology, or about the possibility of offending patients (Lim et al., 2013). Nurses sometimes say that there are no opportunities to enquire about sexual orientation and gender identity, yet there are numerous moments during the patient journey where disclosure may be facilitated. Not all patients wish to disclose their sexual orientation to nursing and other healthcare professionals, but nurses can actively take steps to facilitate coming out if this is the patient's wish. Being aware of those moments that matter can enable nurses to do this in a sensitive and culturally competent way. Some people are uncomfortable in identifying themselves along a queer–heterosexual continuum, particularly if they have been victims of discrimination or fear poor healthcare.

Cultural competence in nursing with non-heterosexual communities acknowledges that people's identity, desire and behaviour are complex domains: their attraction to and behaviour with others may not always correspond with the terminology they use to describe themselves. The impact of labelling may be affirmative for some people, but for others may contribute to prejudice, stigma and discrimination. In particular, nurses should be equipped to understand the role of significant others in informal caregiving and recovery and be enabled to respond sensitively to questions about the impact of treatment on well-being. For example, how will treatment for prostate cancer impact on a gay man's sexual relationships? How might nurses show compassion to a transman with breast cancer who feels his masculinity has been threatened by the disease and has become increasingly isolated from social networks during the course of his treatment (Fish and Harris, 2012)? In accessing healthcare, many LGBT people wish that their sexual orientation and gender identity were not merely tolerated, but actively promoted and valued.

The UK House of Commons Women and Equalities Committee report on Transgender Equality argued that trans patients in the English NHS are often nervous about accessing healthcare because they are not treated sympathetically, and found evidence of a lack of training and cultural competency about their distinctive health needs (House of Commons Women and Equality Committee, 2016). The Committee concluded that trans people are let down by the NHS, with evidence of practice that contravenes the UK Equality Act 2010. The disclosure of gender identity in UK healthcare is protected in legislation by section 22 of the Gender Recognition Act 2004, except in cases where nondisclosure may cause harm. In providing care for trans people, nurses must take their cue from the patients themselves, taking care to respect their right to privacy and using the pronouns and name that the patient uses to describe themselves. Research into the health and healthcare needs of trans patients in particular is urgently needed in the NHS.

Although a number of studies have investigated the inclusion of LGBT care needs in the nursing curriculum, for example in the US (Brennan et al., 2012; Carabez et al., 2015; Lim et al., 2014) and Sweden (Rondahl, 2009), to the best of our knowledge there have been no recent studies conducted in a UK context. It is therefore perhaps unsurprising that little

attention has been paid to LGBT patients' needs in many university nursing programmes in the UK, or that there is a lack of confidence in nursing care for this group of patients. Without appropriate self-reflection, underlying attitudes, feelings and beliefs can sometimes hinder a genuine therapeutic relationship. Clinical and nursing educational research suggests that too few nurses make a habit of routinely addressing sexual orientation and gender identity issues and how these may influence illness prevention or nursing care. Academic and clinical educators need to provide specific knowledge and support the development of appropriate attitudes, together with competent skills and regular habits on how to provide LGBT patients with compassionate care. Existing guidance provides a framework which can underpin good quality nursing care for LGBT patients where nurses are knowledgeable, able to communicate sensitively and show insight into individual needs (RCN, 2012). Putting patients at the centre of care and involving partners and carers in decision-making about treatment can ensure that care is tailored in ways which take account of patients' preferences and needs and obtain the best possible outcomes for the health and well-being of LGBT patients.

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