

“Baby, you were born this way”: LGBTQI+ discrimination in communication between healthcare provider and patient

EDUCATION

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ABSTRACT

Summary

In multiple healthcare situations, LGBTQI+ people still receive inadequate care due to their sexual orientation and/or gender identity. This is in part a result of a gap in knowledge and skills concerning inclusive communication with LGBTQI+ patients. Patients often feel discriminated against by their healthcare provider. Discrimination can occur both directly due to heterosexism or indirectly and unintended due to heteronormative microaggressions. These microaggressions mostly occur during communication between the LGBTQI+ patient and their healthcare provider.

Relevance

Most healthcare providers are not aware they display heteronormative microaggressions, making it hard to challenge this habit. This is problematic, because LGBTQI+ patients can be discouraged from disclosing their sexual orientation and/or gender identity, or choose to withhold information that might affect their health. Communication training and increasing awareness can reduce the withholding of important information, resulting in a more fulfilling provider-patient relationship and more adequate care overall. However, an individual approach will not suffice to tackle this problem once and for all, as most of these microaggressions are supported by a heteronormative society. The problem is rooted in our healthcare system as well as education and institutions, and as such a holistic and systems approach to a solution is needed.

Take Home Messages

To improve communication with LGBTQI+ patients, it is important that healthcare providers receive adequate communication training. This is crucial even in the early stages of medical education and the inclusion of this topic in the medical student curriculum would achieve particular impact. Nonetheless, changes at a wider level are required to solve the problem of microaggressions and heterosexism in healthcare communication.

INTRODUCTION

The challenges that members of the LGBTQI+ community face in their daily lives have a direct impact on their health. Due to their sexual orientation (SO) and/or gender identity (GI), they are confronted with adverse situations such as discrimination, stigmatisation, bullying and harassment. One example of systematic discrimination was the pathologizing of homosexuality within the DSM-I/DSMII, leading to a medicalisation of this SO. (1) Another example is the ICD-10, where transgender identity was labelled as a mental and behavioural disorder. The ICD-11 provides the definition of gender incongruence, taking a more nuanced individual stance on the matter. (2) Facing such discriminatory issues elicits negative emotions and leads to a higher prevalence of a number of mental issues in all ages compared to cisgender heterosexuals. (3) To illustrate, a nationwide study in the US evaluating the sexual behaviour in youth found the prevalence of suicide attempts at 20% in LGB youth compared to 6% in self-identified heterosexual peers. (3) Also, elderly LGBTQI+ people concealing their sexual identity are at increased risk of depression due to the heterosexual approach to care. (4) People belonging to the LGBTQI+ community experiencing indirect and/or direct discrimination are placed in a situation of distress. Identifying factors that are associated with mental burdens increases understanding of LGBTQI+ people and the assistance they may require.

As illustrated above, LGBTQI+ people have a higher prevalence of mental health issues compared to cisgender heterosexuals. As a consequence, substance abuse is seen in LGBTQI+ people to cope with stressors like discrimination, stigmatisation and prejudice. According to the National Survey on Drug Use and Health (2015), LGBTQI+ people are using more than twice the quantity of addictive substances such as tobacco, alcohol and other drugs compared to cisgender heterosexuals within the US. (5) Furthermore, within the LGBTQI+ community there are different health issues depending on SO/GI. For example, gay men are reported to have a higher risk of contracting HIV and other STIs than their cisgender heterosexual peers. (6) On the contrary, lesbian and bisexual women are wrongly believed to have lower risk of STIs than their cisgender heterosexual counterparts. This results in receiving fewer preventive interventions and tests for STIs. (7) Overall, LGBTQI+ people have a wide range of health disparities which are not reflected in cisgender heterosexual care, leading to neglect of their needs.

Identifying Mechanism of Systematic LGBTQI+ Discrimination

As a result of negative views towards their SO/GI, LGBTQI+ people can experience “minority stress”, referring to the tension and pressure felt by a marginalised group due to deviation from the accepted norm which can lead to conflict with a dominant group. (8) This is especially accentuated in immigrant populations, creating a “double stigma” which is reflected in poor mental health and a lack of family support. (9) Additionally, the expectation of stigma increases vigilance within the LGBTQI+ community and instigates a constant guard of the self-concept. (8) For example, institutional

discrimination based on policies unsupportive of same-sex marriage leads to mistrust of public figures and discomfort disclosing SO/GI.

A predominant source of minority stress is heteronormativity, which influences stereotypes of LGBTQI+ people. Heteronormativity signifies that the norm is the binary male/female perception where heterosexuality is deemed as the normal and sometimes only SO. (10, 11) Closely related to heteronormativity is heterosexism. Heterosexism can be defined as discrimination that ignores non-heterosexual behaviours and identities. (10, 11) For example, stating “lesbian surgeon” or “gay nurse” is a form of heterosexist communication because heterosexuality as a SO is never emphasised. Furthermore, heterosexism is translated into gender stereotypes, like “masculine lesbians” or “feminine gays”. (10) Such a view is deemed problematic as it poses LGBTQI+ people as “the other group” and not as equals of heterosexuals. (10) Stereotypical views are a particularly troubling source of bias during the sexual history of a LGBTQI+ patient where a healthcare provider (HCP) may assume that a GI is “male” when the patient is gender dysphoric, for instance. The influence of heteronormative expectations on stereotypes can create implicit bias by a healthcare professional and discrimination against a LGBTQI+ person.

Besides direct discriminations, indirect microaggressions are prevalent in healthcare. Sue D.W (2010) defines microaggressions as “brief and commonplace daily verbal, behavioural, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious slights and insults to the target person or group”. (12, 13) When these microaggressions occur towards LGBTQI+ members, they follow a heteronormative scheme. (11) The organisation of the consultation room, the decoration and folders could be examples of how microaggressions are expressed through the environment. (14) Systematic microaggressions are often perceived as institutional and are expressed mostly through regulations and policies as illustrated above. (14) Referring to the partner of a male patient as “wife” without knowing whether the patient is heterosexual is an example of a communication microaggression. Another is the presumption that certain STIs are linked to patients SO/GI. (14) These can generate the feeling in patients that their HCP could be biased, might give them improper care or mistreat them because of their SO/GI. (12) Therefore, the fear of heterosexist microaggressions is influential in the disclosure of the SO/GI by LGBTQI+ people within the healthcare setting and could lead to a poor patient-provider relationship.

Communication Affecting Disclosure

HCPs can be uncomfortable during sexual history taking. (25) When enquiring about SO/GI, this may be due to fear of insulting LGBTQI+ patients and (15) possibly resulting in the patient not wanting to disclose information. Only 30% of LGBTQI+ adults in the US avoid disclosing their SO/GI to their HCP, indicating that there are several factors influencing a patient’s decision. (16) For instance, in a study conducted by Rossman et al. (2017), young adults’ motives to disclose or withhold their SO/GI found that the

most common reason for non-disclosure is a lack of inquiry from the HCP. (17) 74% of LGBTQI+ patients say that asking about SO is pivotal and 82% of LGBTQI+ patients think it is important to ask about GI. (17) This explains why the other 70% of LGBTQI+ adults do disclose their SO/GI. Other factors that influence the willingness of patients to disclose are the relevance of the information to the medical care, the patient-provider relationship and the concerns of LGBTQI+ patients about a potential negative reaction from their HCP. (18)

Negative reactions by HCPs deter patients from disclosing their SO/GI again and may result in, for instance, anxiety. (19) These reactions include signs that show lack of knowledge about LGBTQI+ experiences, sexual practices, etc. Even graver, denying a patient's SO or addressing them by non-preferred pronouns have been reported. (20) It can even go as far as refusal of treatment. In the study by Rossman et al. (2017), it was clear that LGBTQI+ young adults anticipated these inadequate reactions and had low expectations of their HCP overall. (17)

On the other hand, there are various behavioural traits and actions that are considered positive and encouraging by LGBTQI+ patients. A few of these are:

- The use of general terms: The terms “partner” or “significant other” are preferred over “husband” and “wife”, because they are more inclusive and less stereotypic. (21)
- The use of open communication and direct questioning: Asking directly about SO/GI gives the patient a chance to talk about disclosure. Even questions about specific topics can create such an opportunity. For example, think of talking about birth control with lesbian patients. (22)
- Staying calm and positive: It is considered positive when HCPs keep calm when talking about disclosure as LGBTQI+ patients may already be stressed enough on their own. LGBTQI+ patients also prefer their HCP to stay positive but realistic. (23)
- Disclosure of the SO/GI of the HCP: if the HCPs themselves are a member of the LGBTQI+ community, talking about it can help to create a safe space for their patient. Interviews with LGBTQI+ patients demonstrate that hearing about their HCP being a member of their own community helps them to feel accepted and understood. (23)

Strategies to Move Forward

Multiple strategies can be implemented to facilitate inclusive communication between HCPs and LGBTQI+ patients. The first is the inclusion of communication training in healthcare students' curricula and further education programmes for HCPs.

Hayes et al. (2015) found that HCPs feel less comfortable discussing intimate practices and determining the sexual history of LGBTQI+ patients in comparison to other patients. In this study, inadequate training is reported as the main reason for this discomfort. (25) The authors calculated that 20% of HCPs have never received training in taking LGBTQI+ patients' sexual history. Of those that did receive training, 33% felt it was insufficient. (25)

Communication training for HCPs is thus essential to achieve a thorough, inclusive, and sensitive sexual history. The benefits of such training were demonstrated by a study conducted at the University of New Mexico School of Medicine, (26) in which the comfort of medical students in their clerkship year when discussing sexual health with LGBTQI+ members was assessed before and after taking a course. After the course, “students felt significantly more comfortable discussing sex overall and discussing sex with patients of a different SO/GI than their own.” (26) Notably, when asked about their knowledge involving men who have sex with men and women who have sex with women many students reported this as insufficient before the session when compared to the knowledge they had after the session. Moreover, the students gained insight into which vocabulary was most appropriate to use towards members of the LGBTQI+ community. (26)

Although training HCPs in good communication is crucial to root out discrimination, it does not suffice. Good communication may provide a buffer against limited amounts of discrimination in healthcare, but this effect disappears when the amount of discrimination increases. It is not only important that HCPs are trained and aware of their communication, but also that the healthcare environment is inclusive and accessible for LGBTQI+ patients. (19)

Diversity training aims to address people's biases and can educate HCPs about the varied resources available to them. Unfortunately, heteronormative microaggressions as mentioned above are frequently invisible to people who use them. When HCPs believe firmly that they give equal treatment to all their patients they are often unable to realise the microaggressions involved in their communication. (14) Boysen and Vogel (2008) found that diversity training does not help HCPs improve their implicit biases. (29) This is unfortunate, given that these particular biases are the ones that contribute to most microaggressions in the first place. Furthermore, diversity training focussing on interpersonal communication may not address environmental and systemic microaggressions embedded in our healthcare systems. (14) These can only be overcome by addressing the bigger problems of institutional discrimination. Hospitals can apply different interventions for this purpose, such as providing scripts for a structured approach to a patient, consisting of common questions and behavioural cues that demonstrate respect. Furthermore, by representing all SOs and GIs in their activities and media they can create a more inclusive healthcare environment.

(14) In conclusion, inclusive healthcare for LGBTQI+ patients can only be achieved by qualitative training to address conscious bias and communication errors in combination with institutional and environmental changes to prevent unconscious bias.

Another striking problem and therefore entry point for strategies is the lack of evidence-based guidelines. Interventions to improve the care of LGBTQI+ people, if any, are often based on findings of small observational studies that have not been reproduced in other settings. Research should focus on the value of different communication strategies and the effect of diversity training for HCPs on the experiences of LGBTQI+ patients. The role of heteronormative (micro)aggressions and the most effective ways to address them needs thorough investigation. (14) This information is of great importance in producing evidence-based guidelines for HCPs and changes to the healthcare environment at an institutional level.

The differences between the inclusion criteria of different LGBTQI+ studies is also remarkable as many studies do not include every SO/GI of the LGBTQI+ spectrum, which makes it difficult to compare one study with another. The transgender and non-binary population are often not included in study protocols, while simultaneously being affected by the highest amounts of discrimination and ignorance. Accurate multicentred studies focusing on this group of the LGBTQI+ community must be performed to expand current understanding. (28)

CONCLUSION

Unfortunately, there is still a major gap in knowledge and skills concerning inclusive communication with LGBTQI+ patients in healthcare situations. Often HCPs themselves are not aware of displaying heteronormative microaggressions. With all the different forms these can take, it is not surprising that they are frequently encountered in healthcare settings and, for most LGBTQI+ patients, are part of their average healthcare experience. This contributes to the fear of bias these patients might have as a result of disclosing their SO/GI to their HCP. Even though many microaggressions are unintentional and most HCPs do not intend to cause any harm, patients are afraid that biased HCPs might give improper care or mistreat them because of their SO/GI.

The challenge is to overcome different kinds of microaggressions that often have their roots in institutional discrimination. A brief training session will not suffice to fix heteronormative schemes that have been developing during the HCPs life through constant exposure to a discriminating society. As they have a complex social origin, they cannot be solved by intervention at an individual level. Therefore, there is great need for institutional changes around the culture of patient-provider communication. The incorporation of intensive communication training in every HCP's curriculum is a crucial first step towards achieving inclusive and holistic healthcare communication, but other strategies tackling environmental and institutional microaggressions are needed as well.

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