Saint Taylor

Kathleen Furin: Telling Stories, Sellin Stories

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The LGBTQ+ community are no strangers to discrimination. When it comes to healthcare, however, the consequences of discrimination are heightened. More than being refused custom wedding invitations (Daugherty, thehill.com), the repercussions of incomprehensive healthcare access prove dire. When seeking medical attention as a queer person, these repercussions must be taken into consideration. Vital to the wellbeing of 4.5% of the adult population in the U.S. alone (Fitzsimons, nbcnews.com), it is crucial that physicians receive the proper education surrounding how to care for non-heterosexual identifying individuals. The current approach to queer healthcare practices affect, not only the way that LGBTQ+ individuals pursue and receive care, but also the way(s) in which they communicate with healthcare professionals and understand the services entitled to them. These issues can begin to seek resolve with comprehensive education for physicians and other healthcare-adjacent professionals, queer representation within the professional level of healthcare, and the normalization of differing sexual orientations and gender identities throughout all levels of society.

At the most basic level, how might identifying as LGBTQ+ affect the experience of finding a general practitioner (GP)? More than finding a physician who accepts one’s health insurance policy, someone who identifies as queer has to keep in mind whether or not doctors will accept them. This acceptance is not the typical, personal-level acceptance that is usually associated with the “coming out” of LGBTQ+ identifying individuals. Rather, this acceptance refers to the affordance of basic respect and a lack of discriminatory action shown towards patients, in a healthcare setting. In a survey, referenced by Shabab Ahmed Mirza and Caitlin Rooney of AmericanProgress.org, the abuses toward individuals who identify as lesbian, gay, bisexual, and/or queer are both prevalent and varying. 6% of people surveyed reported having been refused healthcare altogether (due to actual or perceived sexual orientation), 9% of participants reported having been the victims of verbal abuses at the hands of their healthcare provider (Mirza & Rooney, AmericanProgress.org). Where have these ideas, which lead to discrimination (and abuse, in the most extreme cases) come from?

Another survey found that medical students who identify as LGBTQ+ themselves, have experienced anti-LGBT+ discrimination from their colleagues (Nassr, et al., pg. 3). If this attitude, towards individuals who identify with a minority sexual orientation, can be seen at the interpersonal level in medical students, it is a lesser shock, then, that these same students have the potential to become healthcare professionals whom discriminate against differently-identifying patients. According to the Journal of Homosexuality, a lack of proper education can be another factor. In an ethical surveillance of 166 UK medical students, it was shown that 84.9% self-reported a lack of education on LGBTQ+ specific healthcare terms, protocols, and even resources (Parameshwaran, et al., pg. 371).

 Due to this lack of proper education, once an LGBTQ+ individual is able to find a healthcare provider, free from prejudiced discrimination, what might the quality of care look like? One issue lies in perception. Though a medical practice or practitioner may claim that they are accepting of all patients, and their varying gender and/or sexual identities, their actions may not say the same. The “Patient Safety Monitor Journal” published an article that found that suggesting to medical professionals that their ideas of inclusive treatment may not necessarily be as inclusive as they thought, creates defensive feelings and, potentially, a hostile environment (PSQH.com). So, on top of understanding the differing gender and sexual orientation identities that a patient may hold, it is also important to then know how to best address and properly care for patients’ needs. Once a cumulative understanding of LGBTQ+ identities are obtained by one’s healthcare provider, specific disparities facing the community can begin to be acknowledged.

Being properly informed on preventative care such as safe-sex practices and disease prevention is crucial within this community. Hepatitis (A, B, and C) is prevalent among men who identify as gay and bisexual due to sexual contact with other men, who most often have not received any form of Hepatitis vaccination (CDC.gov). Contrarily, women who have sexual relationships with other women are at risk of contracting HPV, bacterial vaginosis, and trichomoniasis (mayoclinic.org). These facts support the previous mention that the ill-informed nature of physician education, when it comes to LGBTQ+ related health issues, is a major concern. The lack of educational content creates experiences where patients are turned away from doctor’s offices or told that their sexual practices are “safe”, despite the evidence that LGBTQ+ individuals are susceptible to contracting STDs and other diseases, just like heterosexual partners (Taylor&FrancisOnline).

With the expansion of healthcare services outside of traditional settings, such as hospitals, comes the need for a wider variety of awareness at all levels of society, which would ensure the safety and comfort of each and every patient, regardless of identity. More than concerns that revolve around “typical” healthcare services, namely wellness check-ups within hospitals, patients who identify outside of the heterosexual normative also differ in their accessing of other health-related/adjacent services. For example, social workers hone skills that are often needed within healthcare settings. Due to the heteronormativity of their professional training, such as being trained to ask questions that assume gender and/or relationship dynamics, as well as the language that we (specifically in the U.S.) use to collect patient data, healthcare inequities occur (Wheeler, Dodd, pg. 308). These differences range from a lack of consideration for and representation of LGBTQ+ patients within scholarly medical research, to the avoidance of care by queer-identifying individuals who feel stigmatized (Wheeler, Dodd, pgs. 307 & 308).

Though most people throughout their lifetimes will need a service provided by a healthcare professional, the need within the LGBTQ+ community proves disproportionate. In an article posted by the Human Rights Campaign Foundation (HRC), it was stated that 1/3 of LGBQ adults will at some point qualify for a mental health diagnosis while only one in five heterosexual adults will (suicidepreventionlifeline.org). Regarding transgender individuals, surgical procedures may be required in order to alleviate symptoms of gender dysphoria and confirm their gender identity (Grieser, 2018). These specific medical practices, and costs associated with them, are not typical for cis-gendered heterosexual patients. These statistics create concern, considering that LGBTQ+ patients are more likely to not seek treatment at all, due to fear of discrimination, when they are also more likely to need specialized services that only a healthcare professional can provide.

Another reason that LGBTQ+ individuals may find themselves in need of specialized care is the prevalence of certain cancer types among the queer community. Numerous factors feed into the higher rate of cancer among queer people, including (but not limited to) sexual practices and the miseducation of physicians as to when queer patients should receive health screenings (Quinn, et al., 2014). In this situation, however, the blame is not always totally on the doctor. One unique experience associated with LGBTQ+ identifying individuals is having to disclose potentially non-heteronormative sexual practices to a doctor. These differences could put queer individuals at different or heightened risk for disease. Despite this information, LGB patients are not likely to disclose their sexual orientation to their physician(s) (HRC.org). What factors are at play in patients’ feeling comfortable enough to come out to healthcare professionals?

It is first crucial to consider that some patients have not yet come out to themselves, nor those closest to them, when seeking healthcare services. Kriess and Patterson found that less than half of people who will (eventually) identify as LGBTQ+ have “come out” by the age of 22 (Kriess & Patterson, 1997). Of the same adolescent demographic, however, 3.5% of sexually active boys and 6.4% of sexually active girls have reported having sex with someone of the same gender (Tulloch & Kaufman, 2013). Though not necessarily identifying with a non-heterosexual sexual orientation, these behaviors might require the disclosure of some deeper level of personal information to one’s healthcare provider, in order to receive proper treatment. One study has shown that LGBTQ+ patients are more likely to disclose specific information, regarding their sexual orientation, to their healthcare provider if the provider themselves identifies as LGBTQ+ (Brooks, et al., 2018). This raises another question, then: What does the representation of LGBTQ+ healthcare professionals look like?

LGBTQ+ identifying doctors can be hard to identify, when searching for healthcare professionals. Gauging whether or not sharing details about oneself is appropriate in a particular care setting is not always so clear-cut for physicians. Physician self-disclosure (PSD), or the sharing of personal information with one’s patients, can become a tricky situation. One study found that when doctors disclosed any information about themselves to the patient, during a primary care appointment, that patient felt less comfortable in their presence (Sabin, journalofethics.org). The same study also reported that PSD before a surgical procedure led to positive reactions from patients (Sabin, journalofethics.org). Deciding when it is both appropriate and beneficial to come out to patients can be a difficult task for physicians to navigate. However, without visibility of LGBTQ+ people at the professional healthcare level, patients can find it increasingly difficult to trust providers. When deciding to come out to a patient, how might a doctor proceed, and what other factors could be at play?

Being an LGBTQ+ individual, regardless of profession or socio-economic status, comes with many parallels in relation to the experiences of other, similarly-identifying individuals. Most relevant to the argument which will proceed is the commonality of “coming out”. It was previously discussed that patients may have a difficult time expressing their sexual orientation to their doctor. What about doctors’ disclosure of their own sexual orientation to patients, employers, and/or colleagues? One study found that 95% of medical students did not decide to disclose their sexual orientation when applying to medical school (Merchant, Jongco, & Woodward, 2015). This statistic may be due to fear of discrimination within the workplace, be it from colleagues or patients. A separate report stated that 88% of LGBT physicians had heard their colleagues disparage LGBTQ+ patients (Eliason, Dibble, & Robertson, 2011). The same publication also found that 30% of LGBT physicians (in Canada) had been subjected to homophobic remarks at the hands of patients (Eliason, Dibble, & Robertson, 2011). These discriminatory actions, throughout all levels of the healthcare spectrum, create a complicated situation for all LGBTQ+ people.

As the queer community becomes increasingly comfortable with their respective identities, and seek both standard and specialty healthcare, changes need to be made in the way(s) in which sexual orientation and gender differences are viewed within society. Despite what seems to be an overwhelming prevalence of hatred towards the LGBTQ+ community within healthcare settings, there are ways in which these situations can be improved. The formerly Gay & Lesbian Medical Association, or GMLA, now operates as “Health Professionals Advancing LGBTQ Equality”. This organization works towards “… ensuring health equity for lesbian, gay, bisexual, transgender, queer (LGBTQ) and all sexual and gender minority (SGM) individuals” as well as LGBTQ+ healthcare professionals, by advocating for those marginalized communities and their needs (GLMA.org).

There also seems to be an overarching consensus that, perhaps more-so than advocacy, there needs to be a more comprehensive education, on LGBTQ+ -specific health disparities and vulnerabilities, especially among healthcare professionals. One patient, who identifies as transgender and undergoes Hormone Replacement Therapy (HRT), commented that their doctor was not properly educated on the appropriate testosterone levels that they should have (as a trans-masculine patient) (McPhail, Rountree-James, & Whetter, 2016). With a broader, more inclusive, education for medical professionals, the overall health of the LGBTQ+ community and general population would benefit. In doctors’ knowing more about how to best care for people of all sexual orientations, seeking out a healthcare provider could become a lesser source of stress for LGBTQ+ patients across the board.

Further, even beyond the field of healthcare, there are steps which can be taken to curtail the prejudiced ideas and discriminatory actions that LGBTQ+ individuals currently face. Though segregation has been outlawed in America, LGBTQ+ identities are often isolated, especially within the healthcare sector. One heterosexual individual recognized this separation at an “Alzheimer’s Association” event where LGBTQ+ people, who were impacted by Alzheimer’s, were given separate brochures than those given to participants who identified as heterosexual (Dickens, theodysseyonline.com). The simplest gestures, such as creating one brochure that depicts the human experience, rather than the “heterosexual versus LGBTQ+” experience, would normalize and unite ideas that, through exclusion, are currently causing potentially fear-based harm.

Moving forward, the patient demographic will only become increasingly diverse in expression and identity. Though the need for competent physicians is undeniable, there is also a need for LGBTQ+ representation among healthcare professionals. This requires the normalization of such identities throughout society. Until all identities are represented at the varying levels of healthcare, there will be no such thing as a truly just and well-rounded healthcare system. Though largely focusing on the United States, and other Western countries, these issues are not contained to developed countries. As the world grows and changes, so should our education levels, and sensitivities toward the needs of those who do not identify similarly to us. Without such changes, discrimination will continue to occur, disparities will grow even more stark, and people will go void of necessary healthcare services, at the hands of a system which is supposed to help all those in need.

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