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Exploration of the Patient Experiences of a University LGBTQ+ Community: A Preliminary Analysis

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Abstract

PURPOSE: This qualitative study aimed to explore the lived experiences of people from a university LGBTQ+ community to inform health professional training in the interprofessional education setting.

METHODS:

Focus groups and semi-structured interviews from the University of the Pacific LGBTQ+ community were conducted by the researchers. Participants were recruited through campus-wide notification and fliers. Focus groups were held virtually on Zoom. Participants were asked to de-identify any identifying information. Informed consent and basic demographic information were obtained electronically. Participants were asked to reflect on personal experiences of their interactions within the healthcare system. The focus groups consisted of open-ended questions addressing the participants' positive and negative healthcare experiences and how they felt their healthcare providers could have improved. The recordings were transcribed and coded for preliminary analysis.

RESULTS:

Seven students, faculty and staff participated in this study. Several themes emerged from the focus group interviews: 1.) Patient inclusion in shared decision-making 2.) Avoiding stereotypes 3.) Need to educate on whole-person care 4.) The importance of empathy.

CONCLUSION:

This study provides valuable insight into the unique needs of the LGBTQ+ community. The results reinforce the need to educate healthcare profession students on aspects of LGBTQ+ health to ensure a patient-centered approach.

Keywords

LGBTQ+ health, Cultural Humility, Cultural Competency, Cultural Empathy, Health Disparities, Health Inequities

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LGBTQ+ persons have faced a litany of disparate care, health disparities and inequities during their lifetime. Examples include being misgendered, not receiving adequate preventative services for multiple health concerns, including sexual health, absolute or extrinsic discrimination, not allowing a spouse to be part of end-of-life care [1-6]. Frequently, the healthcare inequities are founded by a lack of cultural competency or humility, empathy, and bias, both unconscious and conscious.

The LGBTQ+ community faces many healthcare obstacles. These include but are not limited to access to appropriate health services, competent providers, homophobia/transphobia, adequate preventative care, end-of-life care, supportive providers, fear of discrimination, etc [1-6]. A solid provider-patient rapport is vital to facilitate open and honest communication. Several studies reviewed note that we are not just in need of competent providers but providers who also display cultural humility and empathy [1-6]. Competency without humility does not improve the healthcare obstacles the LGBTQ+ community faces. "…cultural competency, with its focus on the attainment of knowledge about patients' cultural identities, is limited in its reach in enabling providers to connect with patients and understand their own cultural positionality"[6]. It is imperative that contemporary definitions of patient-centered care emphasize the vital integration of cultural sensitivity and humility in patient-provider communication, interactions, and quality evaluations [6]. It is likely pointless to try to quantify cultural competency because it suggests that quantitative analysis and understanding of patient backgrounds are sufficient for delivering excellent care to marginalized communities.

Purpose

While understanding the patient population is undeniably crucial, establishing a genuine connection with patients and fostering culturally sensitive interactions requires more than just acquiring knowledge [6]. The goal of this research is to describe and summarize the University of Pacific LGBTQ+ community's healthcare experiences and their recommendations for improvement. By understanding prior healthcare experiences of the Pacific LGBTQ+ community and soliciting suggestions for improving the patient-provider relationship, educational tools can be developed to help healthcare professionals achieve this goal. Once the tools have been developed, a curriculum focused on increasing cultural competency and empathy across all healthcare disciplines can be implemented, thus decreasing, and hopefully eliminating disparities for the LGBTQ+ community.

Methodology

Research Questions and Design

The purpose of this qualitative study was to explore the health inequities for people who identify as lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+). The study's research questions were: (a) What health inequities are of concern among the LGBTQ+ community? and (b) What changes in the healthcare system would those in the LGBTQ+ community like to see? These findings will then be used to design a quantitative measure in a subsequent project that will address health disparities in the LGBTQ+ community.

The study design was the utilization of small focus groups led by a team of two researchers. Participants in these focus groups were students, faculty, and staff from the

University of the Pacific who identify as part of the LGBTQ+ community. They were asked a series of questions regarding their healthcare experiences.

Participant Recruitment

Participants were recruited from the University of the Pacific student body, faculty, and staff. Emails, flyers, and word of mouth were utilized as a strategy for this recruitment. Potential participants were directed to contact the Principal Investigator of the study via email for questions. During these discussions, participants were provided several dates/times to sign up for a focus group, as well as provided the informed consent form.

Data Analysis Approach

Transcripts were reviewed by the researcher conducting this analysis and summarized according to each participant with careful attention to note specific experiences directly or perceived to be related to being LGBTQ+ person. Transcripts were then summarized and coded (similar answers, such as reaction, tone of voice, provider body language, were grouped.) The coded answers were then grouped by the number of participants who noted these answers within their group. These were then categorized by which question prompted the response (positive experiences, negative experiences, and how can we improve healthcare clinician education/what do you wish your provider would do better). An “other” category was also noted for those items that the participants deemed important in healthcare but not associated with being LGBTQ+. The other category was not used in this study data set for analysis. The “How can we do better category” was then stratified as most important (6-7 participants noted the answers), very important (3-5 participants noted the answers), and important (1-2 participants noted the answers) to the participants.

Results/Data Analysis

Sample Description

The study collected data on eight (8) study participants. Seven (7) participants had their information included in the analysis. One participant's data was not included as it was discovered after their focus group that they did not meet inclusion criteria, as they did not identify as a member of the LGBTQ+ community. Participant ages ranged from twenty-four to sixty-eight. There were four self-identified men, two women, and one transgender male. Four identified as bisexual, and three as gay. There were three students and four faculty members. The following table (Table 1) notes the self-reported ages, sexual orientation, gender identity, and student/faculty designation by participant.

Table 1 (Demographics)

Participant	Age	Gender Identity	Sexual Orientation	Classification
2001	62	Transgender man	Bisexual	Student
2002	35	Man	Bisexual	Student
3001	68	Man	Gay	Faculty
4001	27	Woman	Bisexual	Student
5001	48	Man	Gay	Faculty
5002	24	Man	Gay	Faculty
7001	45	Woman	Bisexual	Faculty

Data Collection

The data was collected over five focus groups conducted by teams of two researchers over the video software Zoom. The focus group interviews lasted between approximately 16 minutes (shortest interview) and 75 minutes (longest interview). Participants were asked to provide informed consent, and all study-related questions were answered prior to the focus group commenced. Participants were advised that the focus group was being recorded and that after transcription occurred, they would be sent the transcription for review to ensure their remarks were captured appropriately. Two focus groups contained two participants, while the other three had only one participant. Focus groups contained students or faculty/staff but did not contain both within the same group to allow for as much anonymity as possible. Participants were permitted to disable their computer's camera if desired. It was requested that they change their screen names to the participant ID provided while in the participant waiting room. They were advised that they could leave the interview at any time without notification and did not have to answer any questions they did not wish to answer. They were then asked a series of open-ended questions regarding their healthcare experiences, including what made them positive or negative and how they could have been improved upon to make them better. They were also asked what characteristics a healthcare provider shows affirmation of their identity, how that could change a patient's experience, what new professionals or students could educate themselves about regarding the LGBTQ+ community, and what types of resources should be used when teaching health professionals and health profession students that could help them provide care in a more affirming manner. Demographics, including age, gender identity, and sexual orientation were also obtained.

Table 2 – Interview Questions

Interview Questions	**Sub-Questions**
Question 1: Tell us about a particularly positive, **affirming** healthcare experience you had as a member of the LGBTQ+ community	What did that provider say or do? How did that interaction make you feel?
Question 2: Tell us about a healthcare experience that was **not affirming** as a member of the LGBTQ+ community.	What did that provide/healthcare system do that made you feel that way? What would you suggest they do differently?
Question 3: What are some things that you would want new healthcare professionals to educate themselves about in terms of working with the LGBTQ+ community?	What would you like your provider to say or do (and action) that would make a difference? How would this change someone's experience?
Question 4: What characteristics do you see/perceive in a healthcare provider that communicate respect or indicate that they are affirming of your identity?	What would a provider like this say or do that shows respect and affirmation? In what ways would this change someone's experience?
Question 5: What resources would help health education students and trainees provide more affirming care to members of the LGBTQ+ community?	Name specific resources (books, websites, trainings, etc.) that would be helpful. How would this resource make for a better healthcare experience?
NOTE: Overarching questions are enumerated above: Question #1 should be asked first and read verbatim. The additional questions need not be asked explicitly and may emerge from the conversation with the group. The interviewers will ensure that the information is discussed at some point during the group interview. Follow-up probes (lettered question) need not be read verbatim and are provided as a way to encourage participants to elaborate on their responses.	

Results

The participants' responses show that their healthcare experiences, positive and negative, have provided them with numerous suggestions where healthcare clinicians can improve their healthcare delivery. Positive experiences included clinicians who were considerate, affirming, genuine, nonjudgmental, asked/used preferred names and pronouns, had good and relatable communication, were good listeners and perceptive, and made them feel like a "regular patient." Negative experiences that shaped their improvement suggestions included transphobia, homophobia, deadnaming, and feeling judged. Additional negative experiences noted by the participants included clinicians who made assumptions, were reactionary, poor communicators, were poorly or under-educated in LGBTQ+ topics, did not offer LGBTQ+ treatments or vaccines for diseases prevalent in the population, those clinicians who were aloof and not genuine or compassionate, and some who outed their patients.

Avoiding assumptions regarding their LGBTQ+ patients was the greatest suggestion. Six of seven participants made it very clear that this was important to them and that educators need to ensure that healthcare students are adept at this quality. They also overwhelmingly recommended (six of seven participants) the need for students (and current clinicians) to be well educated and informed on all aspects of LGBTQ+ health/lifestyle and recommended utilization of LGBTQ+-specific healthcare organizations, journals, conferences, podcasts, and continuing medical education courses.

The next set of improvement suggestions was described by five of seven participants or four of seven participants. They wanted their practitioners to be genuine, find a connection with their patients, and "get to know them." The participants suggested that clinicians ask and use

preferred names and pronouns and for the clinician to use theirs when making initial introductions. They want their practitioners to be non-reactionary to information the LGBTQ+ person provides and make sure the tone of voice and body language are affirming and not judgmental. Participants encourage their clinicians to ask about relevant sexual histories. An often-cited recommendation by the participants was to spend time outside of practice with LGBTQ+ persons, watch LGBTQ+ related films, documentaries, television shows, and read LGBTQ+ books, biographies, history, etc., to familiarize themselves with LGBTQ+ community needs.

The final set of recommendations indicated by at least one participant was to ensure that clinicians are compassionate, understanding, and have an open mind. Recognize the potential subconscious/unconscious biases during encounters and work to eliminate them. Aim to put aside beliefs that may be contradictory to the care the patient may need. Do not label patients or discuss them loudly with others. Do not deadname (calling a transgender patient by their birth name after they have changed their name as a part of their gender transition) your patients. Be careful with casual talk in how you address people; for example, instead of saying you guys (which could be distressing for a transgender female), say you all or something similar/generic. Be open and willing to listen to what each individual patient needs and act accordingly. See the "whole" patient and do not just focus on the LGBTQ+ aspect unless asked. Make sure the clinician/office appears affirming (i.e., welcoming environment, wall décor, LGBTQ+ friendly information in the provider bio on the website, LGBTQ+ OUT provider lists, display LGBTQ+ health certifications on the office wall, etc.). Ensure the use of inclusive language and provide inclusive medical questionnaires. Finally, during training, use video discussions with LGBTQ+ persons for students to see and become comfortable during interviewing.

Seven participants provided data for inclusion in this study during their focus group. Their data was captured via transcription of their Zoom focus group meeting and their answers to demographic questions on the data platform Qualtrics. Five focus group transcripts containing all seven participant discussions were reviewed and contained 176 pages. Summary tables noting this data are as noted below in Tables 3, 4 and 5.

Table 3 (Positive Experiences)

Coded words/phrases	**Category**	**Number of Participants Noting It in Their Responses**
Considerate	Positive Experience	3
Made me feel I was just a regular patient	Positive Experience	3
Non-judgmental/Non-confrontational	Positive Experience	3
Affirming/Identifies as LGBTQ+/Asks about preferred name/pronouns	Positive Experience	3
Caring/Compassionate/Patient	Positive experience	2
Genuine	Positive Experience	2
Good Listener/Perceptive	Positive Experience	1
Relatable/Good Communication	Positive Experience	1

Table 4 (Negative Experiences)

Coded words/phrases	Category	Number of Participants Noting It in Their Responses
Transphobia, Homophobia, Judgment, Deadnaming	Negative Experience	4
Poor communication/poorly educated about LGBTQ topics	Negative Experience	3
Made assumptions	Negative Experience	2
Reactionary	Negative Experience	1
Forced Outing	Negative Experience	1
Not Genuine	Negative Experience	1
Aloof/Not compassionate	Negative Experience	1
Vaccines (i.e., monkeypox) not provided to LGBTQ+ students who wished for them	Negative Experience	1

Table 5 (What Participants Deemed Important) (dark green = most important, light green = very important, yellow = important)

Coded words/phrases	Category	Number of Participants Noting It in Their Responses
Don't Assume, Ask Questions	How can we improve?	6
LGBTQ+ Health Organizations, LGBTQ+ Journals, Conferences, Podcasts, CME, Health Education	How can we improve?	6
Be genuine, get to know patient, find connection	How can we improve?	5

Ask preferred name, pronoun and use pronouns in introduction to new patients	How can we improve?	5
non-reactionary, tone of voice, body language	How can we improve?	4
spend time with LGBTQ+ persons, watch LGBTQ+ films, documentaries, shows, read LGBTQ+ books, biographies, history,	How can we improve?	4
Ask relevant sexual history	How can we improve?	4
Have compassion, be understanding, be open-minded	How can we improve?	2
Don’t label	How can we improve?	2
Recognize possible subconscious biases	How can we improve?	2
Careful with casual talk	How can we improve?	2
Use inclusive language	How can we improve?	2
LGBTQ+ friendly information provider bio, LBGTQ+ Out provider lists, LGBTQ+ office décor, Display wall certificates (LGBTQ+ health certifications), Have a welcoming office environment	How can we improve?	2
Open and willing to listen to patient needs and act upon them	How can we improve?	2
Don’t discuss patients loudly	How can we improve?	1
Use video discussions with LGBTQ+ persons during training	How can we improve?	1
See the "whole" patient, not just gay	How can we improve?	1

Put aside beliefs contradictory to care	How can we improve?	1
Medical Questionnaires with all SO/GI or places to write in if not there	How can we improve?	1
Don't deadname	How can we improve?	1

Data Analysis Procedures

Given that the purpose of this study is to describe the positive and negative healthcare experiences of LGBTQ+ persons at the University of the Pacific and what they deem important ways to improve our healthcare delivery and education, data analysis followed these themed descriptions. Initial categories of each summary were stratified by the questions asked to the participants (positive experiences, negative experiences, and how we can do better). The "how can we do better" category contained information gleaned from the answers regarding how the participants felt their providers could have done better and questions pertaining to how we can improve healthcare clinician education and resources.

The final categories were then further stratified by the number of participants who noted the coded words/phrases within their interview. There were four coded words/phrases out of eight in the positive category, and three of the seven participants discussed it in their interviews (Table 3). These were words/phrases used to describe their positive experience with healthcare clinicians. In the negative category, there was one coded word/phrase out of eight where four participants noted it in their interview and one of eight where three participants discussed it (Table 4). In the "How can we improve?" category, it is noted that six of seven participants discussed two of twenty coded phrases within their interviews, which were subcategorized and

deemed most important. Those deemed very important included five of twenty coded phrases, of which two were noted in five of seven interviews, and three were noted in four of seven interviews (Table 5). The subcategory deemed important boasts thirteen of twenty coded words and phrases, of which seven were discussed by two of seven participants, and six were noted by at least one of the seven participants. These data, along with the specific coded words and phrases, are described above in Tables 3, 4, and 5.

Reliability, Validity, Errors, and Limitations

A panel of eight researchers, including an expert in qualitative research and focus groups, collaborated to write the protocol and questions and demographic questions utilized within the focus groups. Mock interview and training sessions were conducted before initiating research focus groups. An interview script with specific language and questions was provided to each interviewer. Teams of two researchers conducted each focus group to ensure completeness and thoroughness as well as to ensure that the protocol and question script were followed. Initially, only this author conducted transcript review and coding for this interim analysis; however, all researchers will participate as we continue to move forward. Data collection for this interim analysis was stopped at seven participants as no further participants had signed up for a focus group at the time of the analysis.

Discussion

Interpretation of Findings

In the focus groups, members of the LGBTQ+ community discussed the different attributes they held of high importance in their clinicians. These included good communication and asking

questions without assumption. They also included wanting their clinicians to be prepared with the most up-to-date and evidence-based medicine available regarding LGBTQ+ healthcare. Providers who are non-judgmental, affirming, compassionate, genuine, a good listener, were of major significance. Recommendations included understanding the LGBTQ+ experience by learning LGBTQ+ history through documentaries, reading, or spending time with LGBTQ+ persons. The study participants described negative experiences and the need to ensure clinicians communicate effectively by avoiding labels and recognizing the influence of bias in non-verbal cues and word-choice. They prefer clinicians not to be reactionary nor make assumptions and those who recognize the significant impact that building a genuine rapport and relationship with them can have on their overall health and well-being.

The findings of this study suggest many ways of improving the LGBTQ+ patient experience to improve equity and decrease disparities when it comes to healthcare. The participants have provided a framework from which to work to meet the needs of this community. They have provided a guide to working clinicians, as well as educators, to improve education for future clinicians to increase cultural competence and practice with cultural humility. Going forward, it is up to clinicians and educators to lay a foundation and begin the groundwork to ensure the LGBTQ+ communities' needs are met so disparities and inequities may be decreased and ultimately eliminated.

Study Limitations

Limitations of this current analysis include a small data set and only one initial coder. One coder may introduce unintended bias to this initial interim analysis. Regarding demographics, questions relating to gender identity and sexual orientation were presented to the participants

regarding how they currently express themselves. This would not necessarily capture those who may not identify with their sex assigned at birth or who may have at one point in their life identified as another gender identity/expression or sexual orientation even if the data points they were discussing occurred during a time when they identified differently.

Recommendation for Action

From the data analyzed and the current literature, there is room for improvement in communication, cultural competency, and humility in those already practicing and in the education of health professional students. Moving forward, through continuing education opportunities as well as laying an educational foundation for students, there is an opportunity to meet the needs that this community has expressed. By doing so, we can eliminate the disparities and inequities the LGBTQ+ community has faced throughout history. There is potential that the findings from this study can be applied to all healthcare disciplines to meet the population's needs.

Recommendations for Further Study

While the initial results of this study have shown what the LGBTQ+ community at this local university feel it is essential for clinicians to know and students to be taught, further studies are needed. Recommendations include expanding this initial analysis to include more input from the broader LGBTQ+ community (locally and throughout the state and even the country) to see if the early findings remain consistent. Additionally, the current curriculum in health science professions needs to be understood better in terms of its structure and content. To do this, surveys regarding LGBTQ+ subject matter, including depth and breadth and time spent reviewing this content, would need to be sent to the directors and academic coordinators across

healthcare disciplines to ensure inclusivity. Once this information can be analyzed, and taking into consideration the analysis from this study, a curriculum can begin to be written.

Once the curriculum is written, additional studies utilizing this curriculum would need to be conducted to see if it is truly having an effect on cultural humility and cultural competency surrounding the LGBTQ+ community. Initially, this could be done in a few different programs across different health science professions or many different programs within a singular health science profession. If the new curriculum can be shown to have an impact on influencing students within their professional education, it could then potentially be rolled out to other professional classrooms and even into professional continuing education courses. By incorporating this into professional healthcare education and post-graduate professional healthcare education courses, our goal of decreasing health disparities and inequities in the LGBTQ+ community by improving cultural humility and cultural competency can come to fruition.

Finally, suppose the successful throughput of these studies does show a positive influence and increase in health equity for the LGBTQ+ community. In that case, it may be possible for other communities experiencing similar disparate and inequitable conditions to replicate and duplicate success. In doing so, may provide improved cultural competency and cultural humility for other minority communities and ultimately improve and eliminate their health disparities and inequities.

Conclusion

While providing instruction on cultural competency of the LGBTQ+ community used to be deemed enough to deliver adequate healthcare, it is of utmost importance that as we move

forward with health professional education, we establish a curriculum that works to build a foundation of understanding of LGBTQ+ history, disparity, and inequity and foster a sense of humility surrounding it [6]. If, as clinicians, we do not possess a deeply rooted cultural humility surrounding the LGBTQ+ or any minority or disparate community, we will be unable to solidify the important and desperately needed rapport and trust with those patients. Without that rapport, trust, and understanding, no amount of cultural competency will decrease and eliminate the inequities and disparities these communities face. One without the other will not accomplish the improved health outcomes and elimination of disparities and inequities we aim to achieve. We must cultivate and master both to truly make a difference.

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