Examining clinicians' experiences providing sexual health services for LGBTQ youth: considering social and structural determinants of health in clinical practice

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Abstract

Although barriers related to lesbian, gay, bisexual, transgender and queer (LGBTQ) youth's experiences accessing sexual health services have been examined in detail, research into the experiences and perceptions of clinicians providing these services has been conspicuously absent. The aim of this article is to explore the perceptions and experiences of clinicians providing sexual health services for LGBTQ youth. Drawing on in-depth, semi-structured interviews, this study examines 24 clinicians' experiences providing sexual health services to LGBTQ youth in five communities in British Columbia, Canada. Our findings reveal how many clinicians provide services to LGBTQ youth with a lack of cultural competency—either implicitly (e.g. by describing heteronormative practices) or explicitly (e.g. by expressing frustration that they had not been sufficiently provided with appropriate training related to LGBTQ youth sexual health). Institutional norms and values were identified as the dominant barriers in the effective provision of LGBTQ-tailored services. Many clinicians find themselves unprepared to provide culturally competent sexual health services that have both the capacity to address individual-level issues (e.g. promoting condom use) while considering (and adapting services to) the broader socio-cultural and structural conditions that can render LGBTQ youth socially vulnerable.

Introduction

Young people who identify as lesbian, gay, bisexual, transgender and queer (LGBTQ) (e.g. <25 years) continue to experience inequitable health and social outcomes compared with their heterosexual peers. For example, epidemiological evidence indicates that LGBTQ youth in the province of British Columbia (BC), Canada, are more likely to have experienced sexual orientation discrimination, used injection drugs, been involved in an unwanted pregnancy, been sexually abused or to have had thoughts of suicide [1–3]. Many LGBTQ youth are exposed to a set of social conditions that influence their health-related outcomes including heteronormative and cisnormative assumptions [4, 5], stigma [6] and social exclusion [7], and thus they constitute what has been described as a socially vulnerable population subgroup [8].

There is a strong public health impetus to improve the inequitable social and health outcomes experienced by LGBTQ youth, and several notable structural interventions have recently been advanced to address the inequities experienced by LGBTQ people in Canada. For example, in 2005, Canada legalized same-sex marriage, and this legislation has been described by some as an intervention with far-reaching impacts [9]. Within some regions of Canada, school boards have institutionalized support for the development of gay-straight alliances—strategic alliances that seek to provide community resources and peer support to LGBTQ students and their heterosexual allies,

thereby providing opportunities to improve the health and social well-being of students attending these schools [10].

From conceptual and theoretical perspectives, primary clinical health care provision for LGBTQ youth can be positioned as an opportunity to intervene at the individual level (e.g. through risk-reduction counseling practices), as well as at a structural level [4, 11] (e.g. by addressing various social-structural determinants that shape LGBTQ youth sexual health and social well-being) [12]. However, as various population-level interventions seek to address LGBTQ inequities, the degree to which clinicians address or consider the determinants of LGBTQ youth sexual health within their clinical practice remains unclear. Much of the previous literature in this area has been focused on the perspectives of young people who identify as LGBTQ, which has been particularly useful in identifying barriers to accessing care. For example, some studies have shown that fears related to breaches of confidentiality present significant barriers for LGBTQ youth accessing sexual health care services [13]. LGBTQ youth may also feel uncomfortable disclosing their sexual identity and/or sexual behavior during a clinical encounter due to the stigma associated with embodying a 'non-heterosexual' and/or 'non-cisgender' identity [4, 14–16]. Within some settings, LGBTQ youth are more likely to avoid their family doctors for fear of having their confidentiality breached [17]. Even when LGBTQ youth do access services, recent research has detailed how they are often assumed to be heterosexual, resulting in missed opportunities for promoting LGBTQ-specific (or -appropriate) sexual health promotion within clinical encounters [4, 14, 15].

Although this and other research have delineated many of the barriers LGBTQ youth face when accessing sexual health services, similar attention to the experiences of clinicians providing these services to LGBTQ youth in Canada is conspicuously absent with a few notable exceptions indicating that some clinicians report that they feel uncomfortable or underprepared when providing sexual health care provision to LGBTQ youth [4, 15]. Thus, we undertook the following analysis to begin to better understand the perceptions and reflections of their clinical interactions and experiences with LGBTQ youth in sexual health care settings.

Methods

Funded by the Canadian Institutes of Health Research, this study was part of a program of research that examines the social determinants of young people's sexual health, particularly as it pertains to their interactions with sexual health care services. Our work is informed largely by postmodern and feminist theoretical approaches in which we critically interrogate various forms of social oppression. Based on these theoretical underpinnings, we designed this study to interrogate the extent to which sexual health service provision responds to structural issues that influence LGBTQ youth (e.g. heteronormativity, heterosexism, homophobia and transphobia). Thus, although we use the term 'LGBTQ' to represent a heterogeneous and diverse group of various gender identities and sexual orientations, we do so in order to distil how clinical experiences may exacerbate health inequities for youth who do not identify as heterosexual or cisgender (and thus derive a differential set of 'costs' and 'benefits' associated with social hierarchies such as heterosexual patriarchy).

Study setting

Data were collected in five communities in BC, Canada: a southern urban community, a southern suburban community, two northern urban centers and a northern rural community. Thus, a broad range of opinions was sought from a number of different health service settings across various BC communities. For the international reader, it is helpful to contextualize how health services—particularly, sexual health services for young people—are provided in the BC setting. In BC, sexual health services (e.g. sexually transmitted infection and HIV testing, reproductive health services) are available through specialized sexual health and/or youth clinics, in addition to general medical clinics, hospital emergency rooms and family physicians.

The Canadian health care system is publicly funded; in BC, a monthly premium to the province's Medical Services Plan is required on a sliding scale based on income level, with a per-person cost of between $0 and $66.50 monthly [18]. However, the youth clinics in our study did not require proof of being registered in the Medical Services Plan. This confidential approach to sexual health care has been shown to decrease perceived barriers to accessing sexual health care [19]. It is important to note here that although health care in BC is publicly funded, physicians often own their practice and bill the province's Medical Services Plan according to a billing schedule; for this and other reasons, although clinics are required to meet specific 'rules' and standards in terms of service provision, clinical interactions can often vary widely based on a clinicians' previous experiences (e.g. clinical experience and training) and protocols associated specifically with their clinics.

Recruitment

Participants were recruited through clinic visits. A purposive sampling strategy was used to select clinicians (nurses and doctors) from clinics that specialized in providing sexual health services by appointment or drop in and which included youth clientele accessing sexual health services in these clinics. Our study received ethics approval from the University of British Columbia.

Interviews

Data were collected using in-depth, semi-structured interviews with 24 clinicians. Before beginning the interview, participants provided a written informed consent and completed a socio-demographic questionnaire. Interviews were conducted by experienced researchers who met regularly with the full research team to discuss emerging themes as well as to engage in interpretive discussions pertaining to how our own experiences and social positions influenced both our interactions with research participants as well as our interpretations of the data challenges as they arose. Interviews concentrated on the clinicians' perceptions and practices when providing sexual health services to youth (defined as <25 years of age), as well as how protocol and risk assessment strategies were perceived to influence their clinical interactions with young people. The interview guide was designed to address a variety of topics that might arise within clinical interactions with youth regarding their sexual health (e.g. risk-reduction counseling experiences, discussions related to sexuality); as the interviews progressed and new issues emerged, interview guides were revised in an iterative fashion to reflect new themes that arose in previous interviews by examining transcripts and field notes, as well as regular research team meetings. The interviews took place in private settings at each clinic; each interview lasted an average of 1 h.

Data analysis

Interviews were recorded, transcribed and accuracy checked by another team member and then uploaded to Nvivo 10 for analysis. Co-authors read and re-read transcripts, employing constant comparative techniques [20]. To begin, we used an open-coding approach in which coding was first organized into 'trees' to group the codes thematically. For example, we iteratively developed codes within the 'trees' as subsequent themes emerged. In doing so, we conducted a thematic analysis with both an inductive analytic approach to develop our initial coding schema and general themes [21] as well as deductive approaches in which our findings were used to compare and contrast the existing literature [22] pertaining to clinicians' experiences providing sexual health services to LGBTQ youth. Consistency of coding (inter-coder reliability) was assessed by team members and any discrepancies were discussed and resolved at research team meetings.

Results

Study participants

We interviewed 5 doctors and 19 nurses (see Table I). Each study participant selected or was assigned a pseudonym, and researchers also assigned

Table I. *Participants' socio-demographic characteristics*

	Male (n = 4, 14%) n (%)	Female (n = 20, 86%) n (%)	Total (n = 24, 100%) n (%)
Age group			
25–40	0 (0.00)	6 (25.00)	6 (25.00)
>40	4 (16.67)	14 (58.33)	18 (75.00)
Ethnicity			
Euro-Canadian	4 (16.67)	20 (83.33)	24 (100.00)
Occupation			
Nurse	3 (12.50)	16 (66.67)	19 (79.17)
Physician	1 (4.17)	4 (16.67)	5 (20.83)

each participant a unique alphanumeric code. Three main themes were identified: (i) experiences providing LGBTQ youth sexual health care within the heterosexual *status quo*, (ii) reflections on clinical practice and the social determinants of LGBTQ youth sexual health and (iii) changing practices or reproducing the heterosexual *status quo*: a variety of responses within day-to-day clinical practice.

Experiences providing LGBTQ youth sexual health care within the heterosexual status quo

We asked clinicians to describe their experiences providing sexual health services to LGBTQ youth, and many immediately expressed frustration that they were not adequately equipped with a clinical skill set to effectively and competently counsel LGBTQ youth about issues related to their sexual health. For example, Eve (3a) explained her frustration providing services for men who have sex with men:

> I feel as if I have a lack of knowledge myself and I don't know where to get more. Providing services for guys who have sex with guys, I don't really know how to make it a more comfortable experience—especially for the younger guys. Maybe they haven't really told anyone other than the person they've been with. I don't have a whole lot of comfort in that area, and where to send them and who's out there for them.

Several clinicians described how providing sexual health services to transgender clients represented a situation that required a significant departure from standard clinical protocol. For example, Rob (0a) explained:

> Trans youth are a population that's sensitive to rejection, or, have been treated badly. Just the whole question of 'Do you still have a penis?' can be really difficult. And it has to be handled really sensitively. I can't say that I'm really always that good at it. Or not as good as I'd like to be.

Exposed within this narrative are the ways in which youth's biological sex and gender identity are influenced by broader (macro-level) social norms that have the capacity to influence (meso-level) clinical interactions, thereby leaving both patient and clinician feeling uncomfortable. Representing complex and 'difficult' clinical (and social) interactions, this nurse acknowledges that he would like to improve his capacity for providing these services—something that would make both himself and his clients feel more comfortable.

Several clinicians explained that they would like to develop outreach programs to respond to the needs of LGBTQ youth, with an aim of promoting uptake of sexual health services. However, these clinicians explained that their clinics lacked the adequate resources and institutional commitments (e.g. finances; human resources) to implement effective LGBTQ youth outreach programming within their communities. For example, Beth (1a) explained:

> I've been talking to [colleagues] and saying, 'Where are all the [LGBTQ youth]. How come nobody is coming to see me?' Unfortunately, financially, we just don't have the capacity to do the outreach that we would like to be doing.

Thus, the lack of institutional support (e.g. training; finances) for providing tailored sexual health services to LGBTQ youth emerged as a dominant theme within our findings. These narratives reveal how sexual health service provision is entrenched

within a system that has not responded to the needs of service providers (e.g. providing the skill set to provide culturally competent services), or the clients they serve. That some health care providers believe they are not serving any LGBTQ youth also brings into question the extent to which their patients are being 'presumed straight'.

Reflections on clinical practice and the social determinants of LGBTQ youth sexual health

We asked clinicians to discuss how their own social positioning might influence their interactions with LGBTQ youth. Within their explanations, some clinicians emphasized that, due to their own heterosexual identity, they could not fully relate or 'identify' with LGBTQ youth and the experiences that flow from these 'non-heterosexual' identities. For example, Moo (15a), expressed a sense of disconnect between her own experiences as a heterosexual woman and the everyday experiences of her young gay men clients:

> I will never be a gay man, and there are just certain things that are attached to being gay. And that, whether it's around your sexuality, or expression of your sexuality, that there's a lot of times that you're more likely to find yourself in a risky situation. And... you know, it's hard to address that. Even if I had two hours with someone, I don't know if that's my area of expertise, right? So I have to be as respectful as possible. Open to talking about it, while recognizing that I can't fix it.

Although this nurse expresses a sense of disconnect between her own social position and that of her gay youth clients, she acknowledges that young gay men may not be afforded sufficient opportunities to discuss their sexuality (both within and outside of clinical interactions). In doing so, she begins to elucidate how social positioning (e.g. gay and heterosexual identities) and structural features (e.g. heterosexism) frustrate her within her own practice, and she acknowledges that she may not have the capacity (e.g. knowledge, cultural competence or time) to sufficiently address these broader influences.

Some clinicians suggested that non-clinical services (e.g. LGBTQ youth support groups) were more appropriate spaces to attend to the needs of LGBTQ youth. For example, Christina (10a) explained:

> If you are not heterosexual you have more room to move into a group where your sexuality is acknowledged and it might be something very formal, like Pride, which is a formal group on campus, or it might be much more informal, like the people you feel comfortable and you hang around with who might understand that you're not heterosexual.

Within these descriptions, clinicians described how the contextual conditions in which youth live might be best improved by ameliorating the social conditions (e.g. improving the social capital within LGBTQ youth's lives), particularly through sectors that operate outside the scope of their clinical practice. As a result, some described how they provided LGBTQ youth with referrals to access these sorts of non-clinical services (e.g. Pride groups).

Several clinicians emphasized that the role sexual health service providers can play in directly addressing heteronormative assumptions related to sexual identity and gender. For example, Rob (0a) from an urban centre explained how his clinic employs a variety of strategies in order to 'normalize' sexual diversity within his clinical interactions with LGBTQ youth:

> We try to treat people, every person who comes in, like a real human being, with as much respect and humour to normalize the process of whatever you're going through, if you're straight, if you're gay, if you're pansexual, if you're into S&M, it's all cool. So I really, without using a hammer, I try to push that point.

For Rob (0a) the emphasis remained on issues related to social processes that could serve to

ameliorate the heteronormative and heterosexist influences on LGBTQ youth sexual health. Within these descriptions, the complexity of addressing both contextual (e.g. heteronormative assumptions), as well as individual-level risk concerns (e.g. adhering to condom use), was frequently distilled:

> Gay kids are still not given permission to be gay, and if you're not given permission to be gay, then it's a huge step even to take care of yourself. Do they need more information? They need so much more than that. They need to know that it's okay and you're still a good person, your mother loves you, and you should love yourself. And then, put a condom on it.

Revealed here are the complex situations in which clinicians in primary care find themselves tasked with responding to both the structural conditions in which health behavior occurs (e.g. within the realm of heterosexual patriarchy), as well as focusing on individual-level behavior change (e.g. risk-reduction counseling). Thus, a variety of different responses emerged in our data in which clinicians distilled the challenges of ameliorating both social and individual risk within clinical interactions.

Changing practices or reproducing the heterosexual *status quo:* a variety of responses within day-to-day clinical practice

In recognizing the institutional limitations in which they work, some clinicians described instances in which they challenged their institution's rules and norms related to LGBTQ sexual health. For example, Beth (1a) described a situation in which she circumvented institutional barriers by breaking the rules at her clinic and 'smuggling' gay sexual health educational resources into the clinic to provide to her gay youth clients:

> I have a book that we smuggled in from the States that goes through gay male sexuality and safety around HIV prevention and stuff in a very graphical, gay male way. We try to keep resources around things that we just have no experience in.

This quote illustrates the degree to which heteronormativity both influences and infiltrates clinical practice; while actively resisting the institutional protocols that reify heteronormative social practices within her clinic setting (protocols that reject sexual resources depicting gay sex), the nurse simultaneously labels the gay material as 'very graphical'.

Other clinicians described the need to modify their 'normal' clinical routine when providing sexual health services for LGBTQ youth. For example, Erica (20) explained that when she provides sexual health services to lesbians, she does not 'push' services as strongly; as she explained:

> There are a lot of barriers for young lesbian women with health care so we try to make it as open as possible, to say, 'Let's go along at your pace, you tell us when you're ready for the [pelvic] exam', and we never push it.

Although we acknowledge previous theoretical work in this field that has critiqued public health practices that systematically monitor women's bodies (e.g. pelvic exams) [23], this nurse's narrative brings into question issues related to health equity and how health care service provision is distributed within and across socially defined population sub-groups (e.g. lesbian women)—particularly among groups who are historically positioned as being socially vulnerable.

Some clinicians explained that the clinical protocol they were required to follow did not adequately align with or respond to the needs of LGBTQ youth—particularly within clinics that required the use of a standardized STI/HIV risk assessment—and a few clinicians described this as being a particular challenge when providing services to transgender youth. For example, Valerie (19a) described her experiences asking transgender clients questions about their biological sex:

> Some people say 'I'm neither'. I'll say 'Well look at my screen. I have to pick one or the other, the screen won't let me go on. Why don't we base it on your genitals?'...It would probably be better to offer as many options as you can give.

Together, some of these narratives demonstrate how heteronormative protocols within some sexual health settings are challenged, whereas other practices continue to reproduce heteronormative and cisnormative assumptions surrounding the intersections of gender identity and biological sex.

Discussion

The narratives within our findings reveal how many clinicians provide services to LGBTQ youth with a lack of cultural competency—either implicitly (e.g. by describing heteronormative practices) or explicitly (e.g. by expressing frustration that they had not been sufficiently provided with training related to LGBTQ youth-specific or -appropriate sexual health). Clinicians included in this study both reified and rejected entrenched normative values and actions related to heterosexual patriarchy. However, regardless of whether clinicians described actions or practices that had the potential to either reproduce or reject hetero- and cisnormative assumptions, an overall theme of frustration arose; generally, this frustration was expressed at the institutional arrangements in which they were trained and practiced (e.g. lack of training and/or resources in order to provide culturally competent sexual health care to LGBTQ youth).

According to the National Collaborating Centre for Determinants of Health in Canada, 'core competencies can contribute to improved health of the public by encouraging evidence-based, population-focused, ethical, equitable, standardized and client-centered care' [24]. Based on the current findings, it appears that the organizational standards in which these clinicians work have failed to adequately provide LGBTQ youth-appropriate competencies to the clinical staff. As such, these findings reveal how clinicians are frequently unprepared in giving consideration in their practice to the 'upstream' determinants of LGBTQ youth health. Providing culturally competent skills to clinicians during their education and as a means of ongoing training are possibilities for increasing clinicians' ability to effectively respond to LGBTQ youth needs [24].

Responding to the inequitable health outcomes experienced by LGBTQ youth requires both 'upstream' structural approaches that attend to the 'fundamental causes' of vulnerability (e.g. trans/homophobia) [8], as well as agentic factors related to individual behavior and agency (e.g. counseling behavioral, cognitive or attitudinal change related to consistent condom use) [25].

Our findings confirm conceptual and theoretical perspectives that position primary clinical health care provision as having the capacity to intervene at both the individual and structural levels [4, 25]. For example, as some of the clinicians in our study described, clinical interactions are inherently social in nature and thus provide opportunities to engage LGBTQ youth in conversations that can serve to deconstruct social structures that contribute to LGBTQ social and health inequalities. Within this field, both approaches are considered essential in order to competently and effectively promote health [24], and within the Canadian setting, strategies to attend to the social determinants of health in clinical settings represent a key priority [26].

Although we agree with others who have argued that offering services at the individual level does not represent a structural intervention [27], we argue that individually oriented health services have the capacity to 'influence' the social practices of individuals and populations [4, 25]. Without conceptualizing clinical practices in a more sophisticated approach, the practice of medicine remains focused solely on the individually driven determinants of health outcomes, thereby remaining somewhat 'desocialized' [28, p. 1690]. Bringing the 'social' into the clinic represents an important opportunity to address influences that render individuals and populations vulnerable to inequitable social and health outcomes; as a result, integrating practices that address social issues (e.g. heterosexism) within clinical practice have the opportunity to decrease health inequity not only among LGBTQ youth but also among older generations of LGBTQ and heterosexual populations. For example, heteronormative sexual health care interactions with heterosexual young men have been associated with experiences that serve to 'hurt everyone'—including

heterosexual men (e.g. clinical risk assessment discourses that alleviate their concerns related to HIV and sexually transmitted infections by virtue of their sexual orientation, rather than other markers of risk such as sexual practices) [4].

Nonetheless, we recognize the challenges associated with attending to the frustration expressed toward institutional barriers. Within the Canadian health care setting, clinics are often owned and managed privately [29], with clinicians paid on a fee-for-service basis. As such, this 'fiscal reality' alone likely contributes to a broad disparity in the complexities associated with accessing appropriate resources in order to improve sexual health care provision for LGBTQ youth (among many other competing interests). However, several exemplary situations were revealed in which clinicians described their practices for providing LGBTQ-appropriate and tailored services. For example, the actions of some of the clinicians in our study who chose to respond outside heteronormative institutional norms to better support the sexual health needs of LGBTQ youth merits acknowledgement; these potentially emancipatory practices and individual efforts are both admirable and encouraging.

There are several limitations to our study, including sampling and participation biases and a relatively small sample that does not fully reflect all variations of sexual health care clinicians in BC. As such, it was not possible to reach theoretical saturation in our data analysis. Nonetheless, our study provides rich insights into how clinicians from various clinical and socio-geographic settings in BC experience the provision of sexual health services to a vulnerable population subgroup, LGBTQ youth.

As a sub-population who 'rarely see themselves reflected in any form of traditional sexual education' [30, p. 373], LGBTQ youth are a 'key' population who are poised to benefit from positive and transformative interactions with sexual health care clinicians. By (re)positioning the clinical interaction as an opportunity to interrogate heteronormative assumptions and practices that shape the broader societal experiences of LGBTQ youth, clinicians can provide pathways toward an array of improved health outcomes.

Conflict of interest statement

None declared.

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