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EDITORIAL

Intersectionality and Shared Decision Making in LGBTQ Health

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There is much more to an individual's identity than their sexual orientation or gender identity. Members of sexual or gender minority (SGM) groups are simultaneously members of a multitude of other social groups, each adding to that person's individuality. SGM people are a diverse group of people of different ages, faiths, and ethnic, cultural, and socioeconomic backgrounds with different languages of origin, family structures, abilities, and health needs. Care of all patients, including those who identify as SGMs, needs to consider the importance and uniqueness of individual identities and experiences and take into account the complex interactions among multiple identities. Intersectionality acknowledges the multidimensional aspects of identity, inclusive of historical, structural, and cultural factors and their relationships with domination, oppression, and discrimination.[1] Medicine, in general, has been slow to acknowledge the health significance of intersectionality, but a growing body of evidence demonstrates the importance of intersections of race and ethnicity with gender identity[2] and sexual orientation and their impact on access to care, health risk profiles, and health outcomes.[3]

Heterosexist and racist microaggressions experienced by SGM racial/ethnic minority individuals, particularly in clinical settings, affect health-related behaviors, service utilization, and both mental and physical health.[4] In addition, intersectionality research with SGM populations has shed light on the impact of multiple minority identifications on health and health-related behaviors, including HIV testing in Latino youth,[5] social media use and HIV risk in black and Latino youth,[6] HIV-prevention efforts among Mexican migrants,[7] sexual health among adolescent Latinas,[8] and substance abuse among sexual minorities.[9]

This issue of *LGBT Health* includes two articles that contribute to this literature and illustrate how intersectional issues, such as ethnic heterogeneity, stigma, multiple minority group identity, and discrimination, affect shared decision-making (SDM) processes and health outcomes for Asian American and Pacific Islander SGMs[10] and Latinos who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ).[11] The articles focus on SDM as a model of patient–provider communication and propose recommendations and strategies to improve cultural competency, communication, and SDM in clinical settings.

Failure to consider all dimensions of patients' identities can miss the health risks[3] and resiliency factors[12] related to their individual configurations of multiple identities. Thus, an intersectionality perspective provides a framework for a more comprehensive understanding of patients' health and healthcare needs.[13,14] Practicing medicine through the lens of intersectionality proactively considers patients' diverse identities and how the sociocultural factors associated with membership in multiple minority groups can affect their health risks and healthcare experiences, including provider–patient interactions such as information sharing and disclosure, and ultimately health decision making and health outcomes. Patient-centered care emphasizes the importance of each patient's individuality and uniqueness. An intersectionality perspective should not lead to assumptions about one's patients based on the minority groups with which they identify, but should inform the clinical interview/dialogue so that the potential impact of intersectionality can be explored.

SDM is recognized as an important component of patient-centered care.[15–17] In the SDM process, patients and providers share information and discuss diagnostic and treatment options, and patients are encouraged to express their personal preferences and values to inform clinical decisions.[18–20] Patient input in the formulation of treatment plans is associated with increased adherence and improved health outcomes.[21] SDM that incorporates an intersectionality perspective can improve the care of SGM patients who also identify as racial or ethnic minorities. Research in the United States indicates that patients from different racial/ethnic and cultural backgrounds appraise their decision-making process less positively than those who are white and born in the United States and may need to be encouraged to participate in decision making through partnership building and supportive communication approaches.[22] Providers who appreciate the heterogeneity of SGM racial/ethnic individuals in their care, listen attentively and without judgment to each patient about their specific healthcare needs, and consider their values, preferences, and beliefs can form

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patient–provider relationships based on trust, respect, and understanding.[11,23] This, in turn, can facilitate information sharing and open and effective communication as well as empower patients to engage in SDM and participate actively in the decision-making process.[11,19,23] At the same time, however, clinicians must respect the limits of each patient's desire to participate in different aspects of decision making. For example, in selecting a particular chemotherapeutic regimen, many patients might prefer to defer to the oncologist's judgment, while others might desire detailed knowledge of the potential benefits, risks, and side effects of each available option. Furthermore, reluctance to engage in SDM must be differentiated from limitations based on language barriers and education.

As healthcare professionals, we advocate for our patients and their health. SDM that incorporates the perspective of intersectionality is one more way to engage LGBTQ patients, including those with multiple minority identities. Ultimately, this approach empowers our patients to be active participants in their care.

Author Disclosure Statement

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