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Intersectionality and the LGBT Cancer Patient

Penny Damaskos, PhD, LCSW, OSW-C [Director],
Social Work, Memorial Sloan Kettering Cancer Center, New York, NY.

Beau Amaya, RN, BSN, OCN [Nurse Leader],
Memorial Sloan Kettering Cancer Center, New York, NY.

RuthAnn Gordon, MSN, FNP-BC, OCN® [Coordinator],
Clinical Trials Nursing, Memorial Sloan Kettering Cancer Center, New York, NY.

Chasity Burrows Walters, PhD, RN [Director]
Patient and Caregiver Engagement, Memorial Sloan Kettering Cancer Center, New York, NY.

Abstract

Objectives: To present the ways in which race, ethnicity, class, gender, and sexual orientation interact in the context of cancer risk, access to care, and treatment by health care providers. Cancer risk factors, access to care, and treatment for lesbian, gay, bisexual, and transgender (LGBT) patients are discussed within the context of intersectionality and cultural humility.

Data Sources: Peer reviewed articles, cancer organizations, and clinical practice.

Conclusion: LGBT patients have multiple identities that intersect to create unique experiences. These experiences shape their interactions with the health care system with the potential for positive or negative consequences. More data is needed to describe the outcomes of those experiences and inform clinical practice.

Implications for Nursing Practice: Oncology nurses have an obligation to acknowledge patients' multiple identities and use the practice of cultural humility to provide individualized, patient-centered care.

Keywords

LGBT; cancer; intersectionality; cultural humility; sexual minority; gender minority

The conditions in which people are born, grow, live, work, and age, collectively referred to as the social determinants of health, present a complex matrix understood to produce health disparities.[1,2] Commitments to address these disparities are evident at both the national [3]and international levels, yet disparities based on determinants such as race, ethnicity, class, and gender persist.[1] Furthermore, the recognition of lesbian, gay, bisexual, and transgender

Address correspondence to: Penny Damaskos, PhD, LCSW, OSW-C, Director, Social Work, Memorial Sloan Kettering Cancer Center, 1275 York Ave., New York, NY 10065. damaskp1@mskcc.org.

(LGBT) individuals as minority populations in 2016 by the National Institutes of Health adds to this discourse, calling attention to the complexity of the understanding of health disparities. [4]

The way in which social determinants produce inequities may be understood through the lens of intersectionality.[5] Originating in the study of women and people of color, the intersectional approach has expanded to study a range of factors including race, ethnicity, class, gender, and more recently, sexual orientation.[5] To that end, this article will discuss the role of those factors, defined in Table 1,[6–9] as they relate to cancer risk, access to care, and treatment by health care providers (HCP). Case studies are provided to illustrate these connections in the clinical arena.

Intersectionality

Intersectionality is a theoretical framework that proposes individuals have multiple, overlapping identities, and the understanding of the interconnectedness of those identities can help us to recognize how systemic injustice and social inequality occurs. [5,10–12] Intersectionality suggests discriminatory practices within society, such as racism, classism, sexism, homophobia, and transphobia, do not act independently of one another; rather they interrelate, creating interconnecting systems of oppression and discrimination.[5,13,14] In addition, when marginalized individuals interact with large social systems, such as educational, political, legal, and health care systems, they can experience discrimination and further marginalization on multiple levels.[10,15] For example, a lesbian, Native American physician might experience micro aggressions and more overt discriminatory practices in the workplace than her straight, white female colleagues, which could include career-limiting rejections, such as being steered away from prestigious mentorship opportunities because “she was not a right fit.”

Intersectional Approach to LGBT Health and Cancer Care

LGBT populations are a large and diverse group of individuals of different ages, experiences, ethnic, cultural, and socioeconomic backgrounds. As sexual (eg, lesbian, gay, bisexual) and gender (eg, transgender, non-binary, and gender-nonconforming) minorities, LGBT people have experienced discrimination and marginalization by the health care system.[15,16] Current health care practices may result in assessments that overlook the many racial, socioeconomic issues, sexual, and gender identity concerns that overlap.[10,15] By utilizing the framework of intersectionality, HCPs can allow for a more complex and individualized understanding of LGBT patients and consequently provide better care overall. Furthermore, health assessments that are inclusive of all aspects of an individual’s psychosocial and medical histories will allow for a comprehensive understanding of their cancer risks, screening behaviors, treatment adherence, and adjustment to survivorship. For example, transgender men should be asked about a family history of breast cancer and discuss genetic testing, self-breast examinations, and screenings to assess their overall risks for the development of the disease. If the HCP does not discuss best practices, it will put the patient at risk for late-stage discovery of the disease.

Utilizing such assessments will likely provide a framework to better understand how sexual and gender identities intersect with race, class, ethnicity, and multiple identities.[10,16] In health care, we strive to provide excellent, patient-centered care to minimize the disjointed care that can often characterize the patient experience. Utilizing the framework of intersectionality and respectful questioning of patients can minimize assumptions about an individual's minority status by the HCP and should inform the clinical dialogue, allowing for both unique and complex social identities lived by all LGBT individuals.[15]

Intersectionality and Access to Care

There has been much research about social determinants in regards to access to health care and negative health outcomes based on sex, race, and class in the United States.[15] These health disparities, however, are often viewed as separate rather than interconnected entities.[17] Access to care for LGBT people can be made more difficult because of lack of insurance coverage, fear of discrimination, and an unwelcoming health care system.[10] Early detection increases cancer survival rates, yet LGBT people are shown to have higher uninsured rates and either avoid or delay care because of the cost of care,[18] leading LGBT persons to receive cancer care at later stages, resulting in a worse prognosis and outcome.[1,9] Likewise, previous experience of discrimination from a health care encounter can delay a patient seeking care.[19] For example, studies have indicated that lesbian and bisexual woman delay cervical cancer screening and transgender persons delay overall health care because of previous negative interactions with the health care system and HCP.[16,20] The limited research available suggests LGBT populations, like other minority populations, routinely experience barriers to access medical care. However, more research is necessary to better understand how race, socio-economic status, sexual orientation, and gender identity intersect and contribute specifically to barriers in access to cancer care.

Intersectionality recognizes that people experience their lives through different intersecting identities and these factors can contribute to barriers in care and result in poorer health outcomes for LGBT populations.[15] HCPs should be aware of the multiple dimensions that make up a whole person to help understand their lived experience. LGBT people who also are racial and ethnic minorities have a number of different stressors that affect their health because they occupy multiple marginalized groups.[21]

> Consider the following example of Regina, a 28-year-old Hispanic transgender woman who has been using hormones since she was 17, who recently relocated to a city in the Midwest with her partner. She had previously lived in a large city in the Northeast where, after an exhaustive search, she was able to obtain hormone therapy at a LGBT health center; however, in her new city there is not a similar center. Regina needs to continue on hormonal therapy but is hesitant to seek care because of the history of discrimination she experienced during previous interactions with the health care system. She is considering getting hormones illegally to continue her therapy, both to avoid discrimination and the accompanying stress.

Intersectionality and Cancer RiskCancer remains a leading cause of death across the globe. According to the World Health Organization,[22] there is potential for a 70% increase of

newly diagnosed patients by 2019. The risks for cancer vary among minority groups,[23] and the intersection of access to health care, education, and discrimination/stigma play an important role in overall health for patients belonging to more than one minority group. Cancers that may disproportionately affect LGBT populations include breast, cervical, anal, colorectal, endometrial, lung, and prostate cancers.[21,24] Providers should consider using an intersectional framework as a lens for addressing and recognizing cancer risks in these groups.[25] For example, the evidence suggests that lesbians may be at higher risk for breast cancer because of a higher prevalence of certain risk factors, including nulliparity[26–28]; however, when considering the overall burden of a cancer diagnosis, race and class should also be considered. Research on LGBT health has shown that that some LGBT patients live with higher rates of poverty than the general population[29] and are at higher risk for certain cancers that are often diagnosed at a late stage.[10] Consideration of the intersection of socio-economic status, race, and risk factors for LGBT patients remains an imperative assessment factor for HCPs when providing medical care.

Additional considerations for cancer risk and intersectionality include health care concerns of the HIV-positive patient. HIV populations experience a high cancer burden, with non-Hodgkin lymphoma, Kaposi sarcoma, anal cancer, and lung cancer remain the most common.[30] When caring for the HIV-positive patient, an assessment for signs and symptoms of these cancers and others should be considered.

Just as HCPs include assessments of smoking history in addition to other high-risk behaviors when conducting a comprehensive assessment of LGBT people, they should also include questions inclusive of an individual's intersecting histories and identities that could contribute to the risk and development of cancer. Conducting an assessment guided by respectful and inclusive questioning would provide the HCP with information about behaviors and potential cancer risks. For example, if an Asian-American lesbian presents to her HCP with pelvic pain, abnormal bleeding, and pain on urination, it is important to include questions regarding psychosexual history as part of the clinical assessment to rule out the possibility of cervical cancer. Likewise, if a white transgender man presents to a HCP with similar symptoms it is important to include a psychosexual history because a transgender man may still have a cervix and could be at risk for developing cervical cancer. In both instances, assumptions by the HCP about the LGBT person could lead to missed diagnoses, incomplete assessments, inadequate care, and poor survival.

Informed by intersectionality, the HCP could seek to learn about the individual in the clinical arena, based not on assumptions (eg, lesbians and transgender men are not at risk of cervical cancer) but on their actual, lived history. Reluctance to inquire about an individual's entire and often complex life could put these individuals at risk. With the above example, a cursory assessment might result in treatment of an infection with a course of antibiotics rather than a more complete assessment inclusive of the possibility of malignancies such as cervical cancer.

To decrease cancer risk, several strategies should be used in the consideration of intersectionality, starting with access to screening and early detection. Therefore, targeted screening guidelines should be made available for certain cancers. For example, the

American Cancer Society recommendations specify that women from 45 to 54 years of age should have an annual mammogram and men beginning at age 50 are advised to conduct prostate screenings, regardless of sexual orientation.[31] However, these recommendations are not inclusive of transgender men with breast tissue nor of transgender women with prostates. The images and target of cancer screenings is generally hetero-normative and is exemplified by the use of the pink ribbon as the predominant marketing symbol in breast cancer screening; lacking awareness, butch lesbians would be less likely to identify with the campaign, even though many may be at increased risk for the disease. Because of this narrow marketing, awareness of the importance of breast cancer screenings for all people with breast tissue is challenged.[27] In addition, African American men with family members who had prostate cancer are recommended to begin screening at an earlier age, highlighting the intersection between race and cancer risk.[31,32] African American men are at higher risk for the development of the disease than white men and screening for colorectal cancer can significantly lower the risk of detection a late stage.[33] When this disparity based on race and gender is compounded by sexual orientation, practitioners need to use special considerations. If an African American gay man presents to a nurse with rectal bleeding and recent changes in bowel movements, the nurse should conduct an assessment inclusive of screening for both rectal and colon cancer because, as a gay man who is also African American, he is at higher risk for both diseases.[4,6]

Additional barriers within the health care system contribute to cancer risks for LGBT persons, such as inconsistent documentation of sexual orientation and gender identity in cancer registry data and across health care settings. Because this data is used to identify health disparities, gaps in the research perpetuate knowledge deficits about LGBT cancer incidence and risks.[32] The invisibility of LGBT persons in cancer screening campaigns contributes to the persistent knowledge deficit about LGBT cancer care.[8,27,35] Using the lens of intersectionality can help HCPs better understand how the intersections of race, class, and gender identity can pose a challenge to utilization of screening for sexual minorities, contributing to their health disparities.

Intersectionality, Treatment, and the Need for Medical Education

Few HCPs indicate that they have adequate knowledge about the health care needs of LGBT patients, reporting that they receive neither adequate training in their medical curriculum nor subsequent training to care for this population.[35] Recent studies examining the inclusion of training around LGBT health care revealed a lack of training in nursing school curriculum as well.[19,36,37] The health care needs of LGBT people, including cancer risks and comorbidities, need to be included in the education of HCPs for optimal care of this diverse population. The persistent gaps in training among HCPs can result in uninformed assessments and missed opportunities that prevent the provision of optimal care to LGBT patients and, consequently, impact their survival.[19] LGBT populations are people of every race, religion, class, age, and socioeconomic group. HCPs need to provide an individualized plan of care and assess people inclusive of their multiple, intersecting identities.

The lack of adequate training of the HCP contributes to the lack of research and outreach regarding cancer risks and treatment for this group.[35] One study that examined sexuality for

people with colostomies indicated that LGBT patients undergoing colostomy surgeries receive less counseling about sexual health after surgery compared with heterosexual patients.[38]

Open and respectful communication with their HCPs is an important determinant of adequate and continued care for LGBT persons. This is evident in the research that indicates lesbian and bisexual woman report receiving negative and unsympathetic treatment by their HCP, which contributes to an ongoing sense of mistrust and fear of discrimination. In addition, LGBT persons have reported receiving mental health referrals after coming out to their HCP.[39]

When providing care to LGBT patients, HCPs should be aware that individuals belonging to multiple socially marginalized groups may present with mistrust and fear of the health care system and, consequently, perpetuate greater disparities in cancer care, such as the potential for inadequate screening practices for lesbians who are potentially at greater risk for lung cancer because of higher incidence of smoking.[40] Treating the patient as a whole person while conducting comprehensive assessments mindful of the impact of race, class, and sexual orientation, as well as the individual's interaction with the health care system, is the basis for compassionate, holistic care.[7]

Implications for Practice with the Help of Cultural Humility

Cultural humility recognizes the power imbalances inherent in the HCP–patient dyad and provides an alternative approach to paternalistic and hierarchical medical practices.[41] Cultural humility posits that openness, self-awareness, egoless, and supportive interactions marked by self-reflection and self-critique of the HCP should become the basis of care for LGBT patients. The consistent practice of cultural humility represents a change not only in the way of life for HCP but in the way the patient and HCP communicate.[41] Cultural humility, based on humble, respectful, and reflective interactions between the HCP and patients contribute to a culture change that can permeate all aspects of health care.[41] The concepts of cultural humility can provide an additional framework useful in the direct application of the principles of intersectionality in the clinical setting. Intersectionality and cultural humility provide deeper awareness of and sensitivity to the many cultural factors that contribute to the health of the individual in the clinic or hospital bed. This case example illustrates how cultural humility and intersectionality provide the guidance within the clinic environment:

> An Asian American transgender woman, Randy, enters a clinic for prostate cancer screening. Because she has experienced discrimination through previous interactions with the health care system because of both her racial and gender identities, she asked a friend to accompany her to the appointment. When Randy entered the screening clinic and went to the registration desk, the registration staff person did a slight double take as she confirmed her appointment. Randy was given paperwork to complete and asked to sit down to wait to be called into her appointment. Sitting in the waiting room with other men staring at her was initially

uncomfortable, but both Randy and her friend ignored them and spoke to one another and were watchful that no one approached them in a sudden manner.

After a while, the nurse came into the waiting room and called Randy into the exam room. During the interview the nurse noted in the “gender” section Randy had written in “transgender” instead of checking off a box for “male” or “female.” The nurse apologized for the non-inclusiveness of the form and indicated that it was in the process of being updated. She then asked Randy her preferred pronoun, and when Randy replied “she” it was noted in her chart. The assessment included a full medical history, including family cancer history and Randy’s cancer screenings. As the appointment continued, Randy and her friend visibly relaxed when speaking with the nurse.

When the physician entered the room to discuss the screening and reason for appointment, he was brusque and impersonal in his questioning and often rushed Randy in her responses. The nurse could see that Randy and her friend were increasingly uncomfortable and as the appointment continued she responded in one-syllable answers. At one point, when the physician left the room to respond to a page, the nurse excused herself and followed him. Having worked with him for years she knew the physician usually related to his patients in an open and friendly manner, so this was a complete change in his manner.

After a conversation that included a frank discussion about his discomfort when he learned Randy was transgender, the physician admitted to not knowing about transgender health needs and feeling embarrassed by his own deficits. The nurse educated him on how to respectfully ask Randy questions to better understand her medical needs. They re-entered the room and the physician apologized for having left abruptly. He made eye contact with Randy, asked her additional questions about her health and life, listened respectfully, and answered her questions in detail. She concluded the appointment with a handshake and assurance that the screening would go smoothly and the promise of excellent care.

The nurse advocated for Randy with the physician and confronted his discomfort while educating him on how to ask questions in a respectful and thoughtful manner. The physician admitted to his lack of expertise and, instead of seeing it as a deficit, re-engaged Randy with openness resulting in a supportive interaction.

Conclusion

Intersectionality is a necessary framework to understand the social determinants of LGBT health care, cancer risks, and access to care. When HCPs use an intersectional framework to inform their care of LGBT patients, it expands their understanding of the social and cultural factors that contribute to an individual’s identity. Recommendations to decrease cancer risks and improve access to care and cancer treatments as well as survival for LGBT people include: (1) expanded research of LGBT issues that includes intersecting identities, social determinants, and their influence on cancer prevention incidence, screening, treatment, and survival; (2) increase access to cancer screenings and outreach education that is inclusive of intersecting identities for all LGBT people and promotes positive health behaviors; (3)

trainings for all HCPs based on the principles of cultural humility and informed by intersectionality to provide the framework for holistic, compassionate, and excellent care of the LGBT person with cancer.

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TABLE 1.

Glossary of Terms

Race	Race refers to a group of socially constructed categories associated with an array of cancer disparities[6]
Class	Class refers to the socioeconomic conditions in which a person lives. Class continues to be a source of inequalities in cancer incidence and survival[7]
Gender	Gender is a social construct predictive of certain cancer disparities.[8] Historically understood as a binary construct (eg, man and woman), contemporary discourse regards gender along a continuum. As such, gender in this article refers to the range of identities, such as cisgender, nonbinary, and transgender
Cisgender	A person whose gender aligns with the sex they were assigned at birth
Nonbinary	An umbrella term to describe a person whose gender does not fit the man/woman binary
Transgender	An umbrella term to describe persons whose gender does not align with the sex they see assigned at birth
Sexual orientation	Sexual orientation refers to whom a person is attracted to romantically, sexually, and emotionally. People who identify as sexual minorities, such as gay, lesbian, and bisexual, experience disparities across the cancer continuum[9]