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Encouraging patients to disclose their lesbian, gay, bisexual, or transgender (LGBT) status: oncology health care providers' perspectives

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Abstract

A compelling touted strategy for reducing discrimination towards lesbian, gay, bisexual, and transgender (LGBT) patients is improving communicative competence of health care providers (HCPs); however, evidence base for describing communication practices between HCPs and LGBT patients is scarce. The purpose of this study was to qualitatively examine HCP experiences and perspectives as they relate to patient sexual orientation and gender identity (SOGI) disclosure, perceived communication and structural/administrative challenges in interactions with LGBT patients, and suggestions for improving care of LGBT patients. The sample consisted of 1,253 HCPs, who provided open-ended responses to an online cross-sectional survey conducted at a Comprehensive Cancer Center in the Northeastern United States. The open-ended responses were inductively and deductively coded for key themes and subthemes. The results demonstrated an array of useful communication strategies employed by oncology HCPs to encourage LGBT patients' SOGI disclosure (direct questions regarding sexual orientation, use of the term "partner," and using correct pronouns), communication and structural/administrative challenges faced by HCPs in providing care (HCP own fears and biases, transgender patient care, insurance issues, and procedural challenges for LGBT patients), and suggested recommendations from oncology HCPs to improve their care delivery for LGBT patients (more provider-based training, improving awareness of LGBT-friendly resources, establishing trusting relationships, and not assuming sexuality or gender identity). These findings have implications for developing and evaluating training programs to improve LGBT sensitivity and communication among HCPs, and encourage SOGI disclosure in an open and judgment-free health care environment.

Keywords

Communication, Health care providers, LGBT, Oncology, SOGI disclosure

Implications

Practice: Multiple communication strategies can be used by oncology health care providers (HCPs) to encourage sexual orientation and gender identity (SOGI) disclosure and create a welcoming and safe environment for lesbian, gay, bisexual, and transgender (LGBT) patients.

Policy: Communication skills training for improving SOGI disclosure among LGBT cancer patients should be developed and participation encouraged for oncology HCPs.

Research: Future research should utilize interviews and/or focus groups with LGBT oncology patients to obtain their perspectives and more descriptive data on communication interactions with HCPs.

INTRODUCTION

Sexual orientation and gender minority individuals, commonly described under the umbrella lesbian, gay, bisexual, and transgender (LGBT), are a diverse group of persons with respect to gender, sexual orientation, race/ethnicity, and socioeconomic status [1, 2]. The different population groups represented by "L," "G," "B," and "T" are distinct, and each group has its own unique set of health and cancer risk factors and disparities [2, 3]. Research in the past two decades suggests that one unifying health care issue that exists for LGBT individuals is cancer disparities, highlighted by the fact that LGBT individuals are at a higher risk for certain cancers compared to the general population. For instance, multiple studies indicate that lesbian and bisexual women have an elevated risk for breast and gynecologic cancers compared to women in general because of higher prevalence of risk factors. These include but are not limited to, nulliparity or not bearing an off-spring [4], high alcohol consumption, tobacco use and smoking, and high rates of obesity [2, 5, 6]. Similarly, gay and bisexual men have an elevated risk for anal cancer, due to prevalence of human papillomavirus and that they have greater likelihood of having multiple sexual partners [7–9]. Additionally, gay and bisexual men tan more frequently and report higher rates of skin cancer than heterosexual men [10].

Despite extremely limited data on cancer prevalence and risk factors for transgender populations [11], small case reports indicate that transgender men on

testosterone therapy may be at increased risk for ovarian cancer [12, 13], and transgender women taking feminizing hormones may develop prostate cancer [14, 15]. Overall, cancer risks in the LGBT community are also elevated due to lower rates of cancer screening and discrimination in health care, ranging from refusal of care, bias or incorrect assumptions, to overt derogatory and stigmatizing statements, lack of health care providers' (HCPs') awareness and insensitivity to the unique needs of this community, inequality in the workplace, and health insurance issues [2, 16–19].

One of the recommended initiatives for reducing discrimination towards LGBT patients is to improve communicative competence of HCPs [20]. In order to undertake efforts to develop a communicative competence intervention for HCPs, it is important to understand both the nuances of communication that occur between HCPs and LGBT patients as well as challenges in communication, with particular attention to patient sexual orientation and gender identity (SOGI) disclosure. As such, the focus of this study was to qualitatively examine HCP experiences and perspectives as they relate to patient SOGI disclosure.

SOGI disclosure with HCPs

SOGI disclosure can be understood as verbal revelation of personal information, feelings, and experiences in relation to sexual orientation and/or gender identity [21, 22]. SOGI disclosure and resultant documentation in health care has been touted as an important step by the National Academy of Medicine and Joint Commission to address LGBT health disparities [23]. The process of SOGI status disclosure by LGBT patients to their respective HCPs is dependent on multiple factors including their relationship with the HCP, their perception of the information as stigmatizing or risky, and their anticipation of the HCP reaction [24].

Barriers to SOGI disclosure

A qualitative systematic review and meta-synthesis of the literature on experiences and unmet needs of LGB cancer patients generated the following overarching themes pertaining to sexual orientation disclosure to HCPs: lack of appropriate opportunities for disclosure, patient perception of sexual orientation being irrelevant or not important to their cancer care, fear of homophobia or discrimination, unhelpful HCP behaviors (dismissive language, arrogance, making disparaging remarks, displaying a lack of interest in the patient, reluctance to address LGB sexuality, and non-inclusion of same-sex partners/spouses), and heteronormative attitudes (i.e., the implicit assumption that all individuals are heterosexual), inadequacy of available support groups, and unmet needs for patient-centered care [25]. In addition, LGB patients often reported feelings of anxiety, invisibility, isolation, and frustration throughout the cancer care continuum [25]. A more recent mixed-methods systematic review to elucidate barriers and facilitators of sexual orientation disclosure experienced by LGBT adults in health care settings identified four overarching themes including the moment of disclosure, expected outcome of disclosure, the health care professional, and the environment or setting of disclosure. The most prominent themes were the perceived relevance of sexual orientation disclosure to care, the communication skills and language used by health care professionals, and the fear of poor treatment or reaction to disclosure [16]. Similar studies regarding communication barriers for gender identity disclosure for transgender patients are lacking.

Research regarding HCP perspectives on communication with LGBT patients is scarce, but growing. A recent integrative review examined nurse and midwife attitudes, knowledge, and beliefs regarding the health care needs of LGBT patients and concluded that HCPs' heteronormative attitudes (i.e., the implicit assumption that all individuals are heterosexual) and a lack of HCP education regarding LGBT health care issues related to inadequate care provision for LGBT patients [26]. The mounting evidence that describes HCP comfort with encouraging and supporting SOGI disclosure seems to be undermined with traditional heteronormative attitudes, further highlighting the need for HCP education and training in creating both an LGBT-safe (non-discriminatory) and an affirming health care environment.

Potential benefits of SOGI disclosure

SOGI disclosure presents itself as a double-bind experience for LGBT patients. Although disclosure may offer an opportunity for openness to discuss specific issues and concerns [27–29], it may also lead to risk of discrimination and inequitable treatment by HCPs [30–33]. On the other hand, non-disclosure may add to the stress of having cancer and poor psychological well-being [34]. Despite clear advantages of SOGI disclosure, a significant proportion of the LGBT patients refrain from disclosing or purposefully conceal sexual identity to HCPs [34, 35].

Creating safe health care experience for LGBT oncology patients

The onus of encouraging SOGI status disclosure often lies with the HCPs; however, LGBT patients also report conducting informal research or "screening" HCPs to assess their attitudes regarding sexual orientation, their knowledge and comfort in discussing health care issues important to LGBT patients, and the overall safety and inclusiveness of the health care environment [25]. Prior literature on the practice implications and recommendations to provide a message of acceptance and inclusion to LGBT

patients includes communication strategies such as using the word "partner," inquiry about significant relationships and patient's family structure, appropriate use of pronouns, and not assuming heteronormativity [24, 25].

Many national health care organizations have also developed practice recommendations and guidelines for creating LGBT safe health care experiences. The National Academy of Medicine released a report on the health of LGBT people in 2011 [2], which spurred a broader interest among health care scholars and professionals on the issue of LGBT health disparities. Around the same time, The Joint Commission forwarded a field guide on advancing effective communication, cultural competence, and patient- and family-centered care for the LGBT community that includes recommendations including strategies, methods, and practice examples designed to help hospital care for LGBT patients [36]. In the field of oncology, a position statement on cancer health disparities research jointly published by the American Association for Cancer Research, the American Cancer Society, the American Society of Clinical Oncology, and the National Cancer Institute states the goal is to: "...promote cooperation among investigators in all areas of the cancer health disparities research community, to ensure that cancer research benefits all populations and patients regardless of race, ethnicity, age, gender identity, sexual orientation, socioeconomic status, or the communities in which they live." (p. 3076) [37]. One of the key recommendations specifies that HCPs, patients, and the public should be educated regarding the rationale for and importance of collecting sociodemographic data, even though some of the data may be perceived as potentially sensitive such as SOGI-related questions. As such, the focus of this study was to qualitatively examine HCP experiences and perspectives as they relate to patient SOGI status disclosure, perceived communication challenges and structural/administrative challenges in interactions with LGBT patients, and HCP suggestions for improving communication and care of LGBT patients.

METHODS

This study was a part of a larger project on LGBT patient health care and was conducted at a Comprehensive Cancer Center in the Northeastern United States. This project was deemed as exempt by the Institutional Review Board.

Participants and procedures

An online link to the survey was sent to all HCPs in the institution. With a 35% response rate, 1,253 HCPs completed the online survey (the online link was sent to 3,627 HCPs). Seventy-four percent of the participants (n = 927) were female, and approximately 80% of the participants self-identified as White (n = 842; 80%). The participants included physicians (e.g., oncologists, cardiologists, geriatricians; n = 187; 15%), advance practice professionals (including registered nurses, physician assistants, nurse practitioners, and certified registered nurse anesthetists; n = 981; 78%), and others including psychologists (n = 41, 3%).

HCPs received an email with a web link to complete an anonymous survey assessing their knowledge, beliefs, and communication behavior regarding LGBT populations. A mix of closed-ended and open-ended questions were used; knowledge, beliefs, and communication behaviors were measured with closed-ended measures, and experience and challenges related to SOGI disclosure were gathered by open-ended questions. Quantitative analysis of the data has been published elsewhere [38], and this study provides an analysis of the qualitative responses.

Four open-ended questions were asked to understand oncology HCPs' experience and challenges around engaging LGBT patients in SOGI disclosure: "How do you encourage patients to disclose their LGBT status? Provide examples of what you may say," "What specific challenges have you faced/foresee facing in communication with LGBT cancer patients?" "What are some of the structural/administrative challenges (e.g. insurance issues, front line staff etc.) that you have faced in communicating with LGBT patients?" and "What suggestions do you have that might assist oncology professionals to care for/manage LGBT patients?"

Data analysis

Consistent with prior qualitative research, the analysis of the open-ended responses was performed through a thematic text analyses approach [39] followed by inductive data analysis [40].

Thematic text analysis

All the co-authors were involved in the coding of the open-ended data. When reviewing the data, the coding team focused on describing and interpreting participant comments regarding oncology HCPs' experience and challenges around engaging LGBT patients in SOGI disclosure. The analysis strategy involved a combination of independent and collaborative analysis, as described below. First, a random subset of responses was selected for each of the open-ended questions and the coding team collaboratively developed code categories based on the random sample. Then, each coding team member independently coded each response based on the given categories, capturing their interpretation of the underlying meaning of the response. After each team member completed their independent coding of the subset of responses, the team met to review the coding, mutually agreed to codes and their definitions, and reached consensus

about how to apply the created codes to the data. This process generated four code books (one for each of the four open-ended questions) consisting of descriptive and interpretive concepts identified during review of the open-ended data [39]. Data saturation was reached by approximately the 50th response for each of the questions. Therefore, we further conducted an inductive content coding for the remaining data.

Inductive content coding

The unit of analysis for inductive content coding was an individual participant's open-ended response. A coding team consisting of three coders was employed for analyzing each of the four open-ended questions. Two members in each coding team independently coded all the responses pertaining to the respective question being analyzed, and the third team member resolved the discrepancy between the coders through team discussions. The number of valid responses for each of the questions varied, and ranged from 395 and 459 (i.e., 31.5%–36.6%) participants, who provided complete responses to the four open-ended questions, respectively (from a total of 1,253 participants who attempted the survey).

RESULTS

The results are divided into four subsections, corresponding to each of the four open-ended questions. Supplementary Tables 1–4 provide a description of the themes, sub-themes, definitions, and exemplary quotes relevant to how HCPs encourage patients to disclose their LGBT status, communication challenges with LGBT patients, structural/administrative challenges with LGBT patients, and suggestions to assist oncology professionals to care for/manage LGBT patients, respectively.

How HCPs encourage patients to disclose their LGBT status

A total of 442 (35.3%) participants provided responses to this question. Two broad themes describe the approach oncology HCPs take in encouraging patients to disclose their LGBT status: direct questioning and language use.

First, HCPs described engaging with LGBT patients by asking them clear and direct questions and included four sub-themes: direct questions pertaining to their sexual orientation (n = 167, 37.78%), questions about family structure/significant relationships (n = 139, 31.45%), inquiry about patients being sexually active (n = 53, 11.99%), and gender identity (n = 49, 11.09%). When describing how they encourage SOGI disclosure, some HCPs described using a process to question patients about significant others, while allowing them the comfort to disclose at their own pace and at their comfort level (see example quotes from HCPs next, pertaining to each of the four sub-themes):

> I allow patients to disclose as they feel comfortable. If family members are at the bedside I ask "How is this person related to you?" and allow them to disclose if the person is their spouse, significant other, etc. (ID #1240)—direct question regarding sexual orientation
>
> Who do you live with? Who would help take care of you if you were unwell? (ID #19)—question about family structure/significant relationships
>
> Are you sexually active? (ID #17)—inquiry about being sexually active
>
> Not sure if it is right or wrong, but I just simply ask every patient the same things…how would you identify yourself? (ID #59)—direct question regarding gender identity

The second prominent theme that emerged related to specific terms or statements used with patients, with four sub-themes: use of the term "partner" (n = 106, 23.98%) in encouraging patients to disclose their sexual orientation, use of words and phrases that HCPs use to communicate that patient is in a safe and welcoming health care institution (n = 56, 12.67%), use of open-ended questions not pertaining to the question categories defined so far (n = 18, 4.07%), and asking patients clearly about their preferred pronouns, particularly related to encouraging gender identity disclosure with transgender patients (n = 15, 3.39%). The following examples highlight each of these four sub-themes respectively:

> Do you have a partner or significant other? (ID #126)—use of the term "partner"
>
> I may ask the patient to introduce the friend or family member. I ask if there is a "special someone" in there (their) life. I discuss high risk behaviors briefly and then offer the patient the choice to discuss further. I never assume. I also do not want to be disrespectful and ask open ended questions. When discussing a healthcare proxy I will ask the relationship towards the person. I reassure that this is New York City and we have experience in care of a multitude of cultures and backgrounds. (ID #573)—use of statements that communicate a safe and welcoming practice environment
>
> There is an impact on sexuality after this surgery. What specific concerns do you have or is there anything I need to know to guide you appropriately? (ID #457)—open-ended questions
>
> What gender pronoun do you prefer? (ID #171)—using the correct pronouns

In many instances, HCP responses included more than one approach to encouraging LGBT disclosure. The two kinds of open-ended questions that HCPs generally asked included generic open-ended questions or open-ended questions regarding concerns, questions, etc. Both the strategies signal use of helpful statements and judgment-free language by HCPs to help encourage SOGI disclosure. The strategies used by HCPs to ask about preferred pronouns included

both inquiry of gender pronoun preferences as well as HCP effort to refrain from using gender-specific pronouns to signal openness. Safe practice environment was conveyed using both clear elicitation of supportive statements, and beliefs and thoughts to avoid.

Communication challenges with LGBT patients

A total of 449 (35.8%) participants provided responses to this question; out of which 69 (15.4%) HCPs noted no challenges or were not sure of any relevant challenges in communicating with LGBT patients. Four broad themes describe the common communication challenges that oncology professionals face, have faced, or anticipate facing in their interactions with LGBT patients: HCP limitations, fears, and biases, HCPs perceptions about the LGBT patents' fears, situations of non-acceptance and/or non-disclosure, and transgender patient care.

First, HCPs acknowledged their own fears, limited knowledge, biases, and assumptions about the LGBT patients, and described these limitations in five different sub-themes: lack of knowledge regarding the needs of the LGBT patient/community (n = 87, 19.38%), discomfort to discuss disclosure or risk assessment for both HCP and the patient (n = 82, 18.26%), HCPs fears of offending the LGBT patient by saying something wrong or inappropriate to both LGBT patients and heterosexual patients (n = 29, 6.46%), HCP inability to understand the unique needs of the LGBT patients, and may treat "all patients the same" (n = 24, 5.35%), and HCP's own biases and prejudices that may lead to incorrect assumptions about the LGBT patients and therefore, lead to sub-optimal care for the patients (n = 23, 5.12%). Lack of knowledge was highlighted not just as a challenge but also an opportunity for some provider-level trainings to learn more about the LGBT patients including their challenges, concerns, and barriers to care. The following quotes from HCPs highlight the five sub-themes, respectively:

> A potential challenge can be if your unaware of particular needs that may need to be addressed. Lack of knowledge can lead to care that isn't tailored to the patient. (ID #1167)—lack of knowledge regarding the needs of the LGBT patient/community
>
> Assumptions that both parties bring to the table before any interaction has taken place. (ID #21)—dual (HCP-patient) discomfort
>
> Risk of offending anyone. Risk of making a straight person feel uncomfortable that I asked what their sexual orientation is. Changing the culture to ask if you are in a committed relationship/"is your spouse with you?" instead of asking "are you married"/is your (opposite gender spouse type) here? (ID #406)—HCPs' fear of saying something wrong
>
> No challenge at all if you don't focus or emphasize the differences of people. Everyone in my eyes are the same. (ID #179)—HCP notes that all patients are same
>
> To avoid thinking about stereotypes or have expectations about behavior, attitudes, etc. is also challenging. (ID #178)—HCPs' biases and assumptions

The second theme that emerged regarding HCPs' communication challenges with LGBT oncology patients involved HCPs' perceptions regarding LGBT patient fears, discomfort, and distrust. The trepidations of the LGBT patients were described in three sub-themes by the HCPs: patients' fear of differential treatment by their HCP upon LGBT status disclosure by the patient (n = 36, 8.02%), general discomfort and/or unease regarding LGBT status disclosure (n = 30, 6.68%), and LGBT patients' mistrust of the health care system, particularly owing to their past bad experience or mistreatment by HCPs (n = 21, 4.68%). Again, although these challenges were described as hurdles creating a gap in communication and rapport formation between LGBT patients and HCPs, there are clear implications for developing provider-based trainings to provide a safe and affirming health care system for LGBT patients. The following quotes from HCPs underscore these three sub-themes, respectively:

> They are guarded, assume I will be biased towards their life choices. (ID #51)—patients' fear of differential treatment upon LGBT disclosure
>
> The difficulties I foresee when treating these individuals is based on them already not feeling comfortable to disclose their status, thus feeling much more guarded, and ultimately less honest with themselves and their practitioner. (ID #587)—LGBT patients' discomfort
>
> Reluctance to disclose sexuality/gender/orientation; general unease and closed communication based in distrust of the healthcare system. (ID #114)—mistrust of the healthcare system

Third, communication challenges were described in situations of non-acceptance, and/or non-disclosure, such as when the communication interaction between patient, partner, and patients' parents/family is uncomfortable or strained (n = 13, 2.90%), and when patient has not disclosed partner/health care proxy information, or when partner is not recognized or given full involvement in the care of their significant other (n = 6, 1.34%). Though these challenges were not brought up frequently, they do indicate a need for the health care system to be supportive in a way that allows for the patient to comfortably disclose their LGBT status, and HCPs should enlist the help of partners or significant others in the care of the LGBT patient.

Finally, specific communication challenges that pertained only to transgender patients were described, and included a spectrum of challenges (n = 54, 12.03%). Some included challenges with respect to room assignments when a transgender patient is admitted, sensitive procedural issues (e.g., transman

requiring a pap smear, transwoman for a prostate check-up), hormone continuation during chemotherapy, and others. It was also noted that many HCPs had not had interactions with transgender patients, and so the challenges noted were more hypothetical than real. For instance, an HCP described communication challenges with a transgender person with a gender-specific disease (e.g., breast or prostate):

> I think I'd separate LGB from T. I think that societal acceptance and individual comfort with trans patients is different than LGB. And I also think that the medical issues are more complex, especially if one takes care of gender-specific diseases (breast, prostate), and someone of the opposite identification comes in for treatment... (ID #202)—transgender/gender identity discussion/issue

Structural/administrative challenges with LGBT patients

A total of 395 (31.5%) participants provided responses to this question; out of which 279 (70.63%) HCPs noted no challenges or were not sure of any relevant structural/administrative challenges in communicating with LGBT patients. Many of the challenges noted as structural/administrative challenges were repetitive responses noted as communication challenges and are not further presented here; only the unique structural/administrative challenges are described. Overall, three broad themes describe the structural/administrative challenges that oncology professionals face, have faced, or anticipate facing in their interactions with LGBT patients: challenges pertaining to insurance issues, challenges at the time of LGBT patient hospital admission, and challenges associated with performing medical procedures for LGBT patients.

First, insurance issues were described by HCPs, particularly relating to LGB patients (n = 28; 7.09%) and transgender patients (n = 8, 2.02%). For LGB patients, non-recognition of partner or spouse, and lack of insurance due to unknown marital status, was highlighted as a potential challenge. For transgender patients, the difference in information related to sex assigned at birth and gender identity were identified as challenges with insurance companies. For instance, one HCP described a situation where a transgender patient's insurance company refused to pay a hospital bill because the patient presented as a male but was born a female, as illustrated below:

> I once took care of a transwoman whose insurance listed her male name, so all of her medical information was under this male name. She loathed that fact. We went out of our way to address her by her female name. It was awful that her medical ID could not match who she was as a person. (ID #876)—insurance issues with transgender patients

The second structural/administrative challenge highlighted by HCPs included challenges at the time of patient admission, and in particular, two specific challenges: medical and intake forms are not LGBT friendly, and may not have questions pertaining to sex at birth, gender identity, and/or sexual orientation (n = 14, 3.54%), and lack of clarity faced by front-line staff in the proper use of pronouns, preferred name, and gender for transgender patients (n = 14, 3.54%). These challenges are highlighted in the quotes below:

> Since gender is not cut and dry I think that there needs to be a place for staff to indicate that the patient was male at birth but now identifies as female. But again this is something that should not have to be gone over every admission just as you would not ask a patients race over and over again. That can be frustrating to the patients. (ID #1017)—medical/intake forms
>
> The structural challenge I have seen from the front line staff was to address the transgender patient with the birth name and NOT by the name the patient wished to be called. (ID #555)—patient identification issues for transgender patients

Finally, challenges related to performing medical procedures for LGBT patients were noted by the HCPs, and these included two sub-types of challenges: procedural challenges with transgender patients (n = 8, 2.02%) and procedural challenges with LGB patients (n = 2, 51%). The procedural challenges described for transgender patients also included rooming issues, particularly in case of shared patient rooms.

> I once had a patient, being admitted to a female room and immediately isolated to a room by herself because while her Medicaid ID had Female on her card, the driver's license still had male. Created a very unfortunate and unpleasant experience for this patient. (ID #1132)—procedural challenges with transgender patients
>
> When patient is lesbian and has told you that she has not had sex with a male, yet we still order a urine preg test when coming in for a procedure that uses anesthesia if she is aged 11–50. (ID #355)—procedural challenges with LGB patients

Suggestions to assist oncology professionals to care for/manage LGBT patients

A total of 459 (36.6%) participants provided responses to this question. Three broad themes describe the suggestions that oncology professionals provided to other HCPs to care for and manage LGBT patients: recommended training and education, creating conducive and welcoming environment, and specific dos and don'ts with LGBT patients.

First, HCPs noted education and training recommendations for other HCPs. A large number of HCPs clearly noted the need for more

provider-based training (n = 175, 38.13%), followed by a verbal appeal to HCPs to educate themselves about issues in the LGBT community (n = 39, 8.50%), and awareness of LGBT-friendly resources (n = 11, 2.40%). Most of the recommendations for training were general suggestions, but some HCPs provided a very specific kind of suggestion for trainings, such as recommending a nurse champion that shares her experience as an HCP and a transgender female. In addition, some HCPs described specific content of trainings and education that could be provided to the HCPs to increase their sensitivity and optimize care for LGBT oncology patients. Furthermore, HCPs also noted that such training could be provided in different formats, for example, in-person, as a seminar, in conferences, as grand rounds, and various other forums. These three sub-themes are highlighted in HCP quotes below:

> LGBT competency IN-PERSON trainings. I believe that computer-based trainings are insufficient; I have seen colleagues breeze through them without engaging with the material. In-person trainings can allow for a space for people to ask questions and really have a chance to learn. (ID #112)—provide staff training
>
> ...Increase one's knowledge to better understand issues/concerns that may be unique to the LGBT patient. (ID # 251)—educate self about these issues
>
> I don't know what specific resources are out there that I should be referring LGBT patients to specifically so more info on that would be helpful. (ID #106)—awareness of LGBT resources

Second, HCPs provided suggestions for creating a safe (non-judgmental) and affirming environment for LGBT patients in four different ways: creating open/judgment-free environments where patients are free to express themselves by encouraging HCPs to be open-minded and use non-judgmental language (n = 119, 25.93%), treating all patients equally (i.e., fairly with dignity and respect) regardless of LGBT status (n = 39, 8.50%), establishing trusting relationships and good rapport with the LGBT patients (n = 8, 1.74%), and respecting patient wishes in terms of discussing their LGBT status around others (n = 6, 1.31%). Most of the recommendations for creating open/judgment-free environment were general suggestions, but some HCPs provided very specific kinds of suggestions, such as keeping an open mind, wearing rainbow pins, and displaying rainbow stickers on work stations and/or in exam rooms and treatment rooms. For instance, see the exemplary quotes next as illustrative examples for the four sub-themes:

> Having rainbow stickers on work stations and/or in exam rooms and treatment rooms can be comforting to LGBT patients and make them more apt to be open about discussing their issues. (ID #410)—create open/judgment-free environment
>
> We have to be open minded. Nurses are inherently open minded and neutral. We treat everyone the same. All patients receive patient centered care. It is our ethical duty to treat everyone the same and to speak out when we see any deviation. (ID #110)—treat all patients equally
>
> Creating a trusting open relationship. Being there for them and proving it. That will encourage them to open up and confide in you as a healthcare provider. (ID #143)—establishing trusting relationship
>
> Take a sexual history when the patient can comfortably express themselves – e.g., not when entire family is in room to discuss treatment plan. (ID #17)—respecting patient privacy

Finally, a few of the HCPs provided specific "do" and "don't" strategies that HCPs should adopt and/or avoid, and included the following four sub-categories: asking about status at the norm/including it in social history (n = 26, 5.67%), not assuming sexuality or gender identity (n = 18, 3.92%), encouraging expression of patient concerns (n = 11, 2.40%), and hearing directly from LGBT community members (n = 6, 1.31%). For instance, some HCPs recommended how the HCPs can broach SOGI questions, while others recommended adding it on the intake forms where patients fill out demographic information. The quotes below demonstrate these four sub-thematic strategies:

> ...In addition, making it a required part of the social history for all providers of adolescents and above. (ID #205)—asking about status as the norm/include in social history
>
> When dealing with any patient their spouse should be referred to as their partner rather than assuming it is a wife or a husband just because of the person's gender. (ID #390)—not assuming sexuality or gender identity
>
> Encourage the patient to verbalize concerns in relation to their sexuality and receiving treatment. (ID #381)—encourage expression of patient concerns
>
> Let's hear from the LGBT community about their experiences. (ID #360)—hear directly from LGBT community members

DISCUSSION

This study qualitatively examined HCP experiences and perspectives as they relate to patient SOGI status disclosure, perceived communication challenges and structural/administrative challenges in interactions with LGBT patients, and HCP suggestions for improving communication and care of LGBT patients. Multiple themes and sub-themes were described by HCPs that have significant implications on improving the medical care of LGBT patients. In reviewing the responses, some themes overlapped between the strategies HCPs use to encourage SOGI disclosure and suggestions they

made to other oncology professionals to care for and manage LGBT patients such as creating a welcoming and safe practice environment, and including direct questions regarding SOGI status in medical intake forms.

One encouraging finding demonstrated the use of multiple strategies by HCPs to promote SOGI disclosure. These strategies included use of direct questions regarding sexual orientation, family structure/significant relationships, gender identity, and inquiry about being sexually active; and use of language that conveys a safe and affirming health care environment including use of the term "partner," asking open-ended questions, and using correct pronouns. These multi-pronged strategies used by oncology HCPs align with prior literature [16, 25] that provides practical recommendations in creating a welcoming and safe environment where LGBT patients feel comfortable opening and disclosing their concerns and needs. Prior research from LGBT patient perspectives also signals complementary results. In a study regarding sexual orientation disclosure to HCPs from LGB patient perspectives, results indicated that disclosure occurred around the initial contact with the HCP, and the two contexts that created disclosure opportunities included patient–provider introductions and patient history-taking. This disclosure could be characterized as basic in nature (i.e., patients may mention the presence of a partner or explain that sexual activities occur with same-sex others, but refrain from further elaboration), presented casually (i.e., patients assume a casual tone or intentionally frame the disclosure as information not worthy of much response), and/or presented indirectly (i.e., patients may prefer to use pronouns for partners that suggest LGB status rather than disclosing explicit statements) [24].

A particular challenge that presented itself in multiple settings included the theme of "treating all patients the same". On one hand, "treating all patients the same" was touted as a standard of high-quality patient care by HCPs because HCPs have an ethical obligation to treat all patients fairly with respect and dignity, regardless of LGBT status. And while this is incredibly important, it fails to individualize treatment and may signal a heteronormative attitude. Framing of "treating all patients the same" mindset implies an equitable patient care towards all patients, it may signal a heteronormative attitude, whereby the HCPs use the same yardstick to address patient concerns, without focusing on their unique needs. This issue has also been referenced in literature as LGBT invisibility, and a blind eye to LGBT patients' unique needs and concerns [41]. A growing body of literature regards "treating all patients the same" as a form of unhelpful behavior in care of LGBT patients, and calls for ending health care disparities by encouraging SOGI disclosure through thoughtful, non-judgmental discussion and history-taking [42].

This study clearly presented some challenges in the care of transgender patients, as different from the challenges of caring for an LGB patient. Specific medical, administrative, and communication issues such as room sharing assignments when a transgender patient is admitted in the hospital, procedural difficulties, and identification and addressing transgender patients were noted as challenging. Acknowledgment of these challenges signals that HCPs are deliberating about these issues and need guidance on appropriate responses/ways to address these issues. Transgender patients face greater discrimination in health care, as compared to heterosexual and LGB patients [43], leading to lower access to health care among transgender individuals [44]. Further elaborated by Hein and Levitt [44],

> Although the Affordable Care Act prohibits discrimination on the basis of sex and/or gender identity, in any hospital or health program that receives federal funds and The Joint Commission requires that discrimination on the basis of gender identity is prohibited to maintain accreditation, this information isn't widely known and many transgender patients still experience discrimination. (pp. 31–32)

Many structural and administrative issues were described by the HCPs, with clear implications or practical recommendations that could be adopted by hospitals and health care institutions, such as medical intake forms including SOGI questions, clear elicitation of preferred pronouns and preferred name, and encouraging LGBT sensitivity training for all health care staff. These recommendations are in agreement with those forwarded by the U.S. government organizations. The U.S. Government's initiative Healthy People 2020 encourages the collection of SOGI data for LGBT research to accurately identify specific characteristics and risk behaviors which will then inform later research to decrease disparity gaps in LGBT health care [45].

The lack of knowledge and education around LGBT health care needs was presented as a key communication challenge and consequently, the need for more education and training was highlighted. This finding demonstrates that HCPs acknowledge their knowledge deficit and are open to more instruction in this area. Many national health care organizations—American Association for Cancer Research, American Medical Association, the American Cancer Society, American Society of Clinical Oncology, and National Cancer Institute and other nonprofit organizations such as Fenway Institute, Gay and Lesbian Medical Association Health Professionals Advancing LGBT Equality, the National LGBT Cancer Network, and the World Professional Association for Transgender Health—recognize the importance of improving HCP knowledge about LGBT patient care and have policy

recommendations for improving the LGBT sensitivity and communication among HCPs.

Limitations

Several limitations are worth noting. First, the study was conducted at a single institution in northeast United States and results may not be generalizable to other oncology care settings. Although there has not been a comparative study of LGBT cancer care across varied geographic locations in the United States, prior research informs us that while significant proportions of LGBT people living on either coast have access to an LGBT community health center, the central states are largely under-served [46]. Future studies should expand the purview of research to other cancer care institutions, to identify other communication challenges associated with SOGI disclosure. Second, there were some notable differences in the respondents, particularly related to demographics. Most of the participants were female and White. We do not know if men and minority HCPs did not respond to the survey because of some inherent biases or attitudes. Not having an equal distribution of demographic participants is a study limitation, and we should be more purposeful in oversampling certain demographic sub-groups in our future studies. Third, the format of the study (i.e., an online survey) may have inhibited some HCPs from responding in a more elaborate manner, particularly to describe examples of scenarios where communication challenges in care of LGBT patients prevented quality patient care; therefore, suggesting a need for in-depth qualitative interviews or focus groups. Perhaps, the anonymous nature of the survey may have also increased some individuals' comfort in providing response. Finally, all responses were self-reports from HCPs and may describe response bias in selecting only a limited group of participants. Future research could utilize interviews and/or focus groups with LGBT oncology patients to obtain their perspectives and more descriptive data on communication interactions with HCPs. In addition, researchers could employ more naturalistic approaches to examining HCP–LGBT patient communication such as audio recording of consultations or patient interviews/focus groups to unravel communication patterns.

CONCLUSIONS

The results of this study demonstrated an array of useful communication strategies employed by oncology HCPs to encourage LGBT patients for SOGI disclosure, communication and structural/administrative challenges faced by HCPs in providing care ot LGBT patients, and suggestions and recommendations to oncology HCPs to improve care delivery for LGBT patients. Overall, a clear need for education and training on LGBT sensitivity was highlighted in this study, and is in tandem with the Healthy People 2020 [45] recommendation that emphasizes increasing access to quality health care for LGBT populations as a priority for further research and intervention.

SUPPLEMENTARY MATERIAL

Supplementary material is available at *Translational Behavioral Medicine* online.

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Compliance with Ethical Standards

Conflict of Interest: None declared.

Ethical Approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. For this type of study, formal consent was not required.

Welfare of Animals: This article does not contain any studies with animals performed by any of the authors.

Informed Consent: Given that the study used anonymous data collection procedures, the study was granted exempt status by the Institutional Review Board. Informed consent was not obtained from individual participants; however, they were informed that by completing and submitting this survey, they were indicating their consent to participate in the study.

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