Queering the health care system: Experiences of the lesbian, gay, bisexual, transgender community

Amber Lee*, BDSc(DH), RDH; **Zul Kanji**[§], MSc, RDH

WHY THIS ARTICLE IS IMPORTANT TO DENTAL HYGIENISTS

- Increasing familiarity with the terminologies and language used within the LGBT community can help to create safer, more inclusive practice environments.
- Understanding the barriers to health care faced by the LGBT community may reduce the likelihood of perpetuating discriminatory behaviours.

ABSTRACT

The lesbian, gay, bisexual, transgender (LGBT) community represents a population of people diverse in gender, sex, and sexual orientation. This literature review explores the current research on the health care experiences of LGBT individuals in North America in an attempt to identify the barriers to care that they face and develop strategies to increase their overall health. The health care experiences of LGBT individuals were explored across 7 dimensions: existence, bodily integrity, emotional integrity, worth, uniqueness, expression, and power. The LGBT community has unique health concerns and is at higher risk for mental health conditions, substance use, and suicide. These health disparities have been associated with social discrimination, ignorance, and assumptions made about gender, sex, and sexuality. Such barriers encountered by this population have also led to delayed or discontinued care, non-disclosure of sexuality or gender identity, increased negative health behaviours, and internalized stigma. The experiences that were identified reveal a strong need to reassess and strengthen the cultural sensitivity training and LGBT education provided to health care professionals.

RÉSUMÉ

La communauté lesbienne, gaie, bisexuelle et transsexuelle (LGBT) représente une population diversifiée de gens en ce qui a trait au genre, au sexe et à l'orientation sexuelle. Cette revue de la littérature explore la recherche actuelle sur l'expérience des personnes LGBT en Amérique du Nord en matière de santé, afin de tenter de cerner les obstacles aux soins auxquels elles font face et élaborer des stratégies pour améliorer la santé globale de cette communauté. L'expérience des gens de la communauté LGBT en matière de soins a été étudiée en fonction de 7 dimensions : l'existence, l'intégrité physique et émotionnelle, la valeur de soi, l'individualité, l'expression et le pouvoir. La communauté LGBT a des préoccupations uniques en matière de santé et elle est à risques plus élevés de problèmes de santé mentale, de l'usage de substances et de suicide. Ces inégalités en matière de santé ont été associées à la discrimination sociale, à l'ignorance et aux présomptions attribuées au genre, au sexe et à la sexualité. Telles barrières auxquelles cette population est confrontée ont aussi mené à des soins remis à plus tard ou abandonnés, à la non-divulgation de la sexualité ou de l'identité sexuelle, à la hausse de comportements négatifs en matière de santé, et à la stigmatisation intérieure. Les expériences qui ont été identifiées révèlent un important besoin de réévaluer et de renforcer la formation sur la sensibilisation aux réalités culturelles et sur l'éducation LGBT qui est fournie aux professionnels de soins de la santé.

Key words: barriers, bisexual, discrimination, gay, health care experience, health care providers, lesbian, queer, transgender

INTRODUCTION

The lesbian, gay, bisexual, transgender (LGBT) community refers to a broad spectrum of individuals who do not identify with conventional social norms of gender, sex, and sexuality.[1,2] One of the more comprehensive and inclusive versions of this acronym includes queer, questioning, intersex, pansexual, Two-Spirit, and asexual groups, but LGBTQQIP2SA and other variations have been received with much criticism and confusion, so the community has been often referred to more simply as LGBT.[3,4] As a way of bringing unity to the community, LGBT individuals have begun to reclaim the word "queer" as a more inclusive term for all individuals who identify with the LGBT community.[2-5] In this article, the terms LGBT and queer will be used interchangeably.

Until 1973, the American Psychiatric Association classified homosexuality as a mental illness.[6-8] Even today, while North America has made strides towards LGBT equality, LGBT relationships are considered a criminal offence in 73 countries and are punishable by death in 13 of these countries.[9] The 2014 Canadian Community

*Alumna, Dental Hygiene Degree Program, University of British Columbia, Vancouver, BC, Canada

This manuscript was written in partial fulfillment of the requirements for the BDSc(DH) degree at the University of British Columbia.

[§]Director, Dental Hygiene Degree Program, University of British Columbia, Vancouver, BC, Canada; Doctoral candidate (educational leadership), Faculty of Education, Simon Fraser University, Burnaby, BC, Canada

Correspondence: Amber Lee; amberlee1053@alumni.ubc.ca

Submitted 13 September 2016; revised 18 April 2017; accepted 20 April 2017

Health Survey revealed that 3% of Canadians identified themselves as homosexual or bisexual.[10] Comparatively, in 2012, an estimated 3.5% of Americans identified as lesbian, gay, bisexual or transgender.[11] These percentages are likely underestimates as only those who are comfortable self-identifying and completing these surveys would be captured in the final reports. Although discussion of gender, sex, and sexuality has become more commonplace over the years, particularly within North America, there is still a significant lack of education and awareness of these topics; progress in reducing stigmatization has been slow.[2,12-15] Queer-identifying individuals have historically been subject to discrimination, social stigmatization, harassment, and violence, and continue to confront these barriers today.[2,6,8,16-18] These experiences have been associated with higher rates of substance and alcohol use, disease, mental illness, psychological distress, and suicide among LGBT individuals compared to non-queer-identifying individuals.[2,12,17-25]

The LGBT community comprises groups that are diverse in gender, sex, sexuality, age, race, ethnicity, socioeconomic status, and literacy.[2,18,19,26] The health and health care needs of LGBT persons are affected by behavioural, structural, and social factors including stigma, discrimination, and inadequate health insurance coverage.[2,6,14,16,17,21,22] The unique experiences and needs of this community should be routinely considered in health care policies and practices to improve their overall health and quality of life and reduce health disparities. This literature review explores the health care experiences of LGBT individuals in North America in an attempt to identify barriers to care and to help develop strategies to improve their experiences in the health care system. Identifying the unique experiences of this population will allow health care professionals to recognize the gaps in their current cultural knowledge and avoid perpetuating discriminatory behaviours. Understanding how queer individuals perceive and experience the health care system may help primary health care providers, including dental hygienists, determine appropriate approaches to providing the LGBT community with safe, individualized, and comprehensive care.

METHODS

Articles were retrieved from PubMed, CINAHL, and Google Scholar using the key words lesbian, gay, bisexual, transgender, queer, health care providers, health care experience, discrimination, and barriers. Only full-text articles written in English and available online were included in this review. There were no restrictions placed on the date of publication in order to identify changes over time. Twenty-eight research studies utilizing phenomenological, ethnographic, and case study approaches were included, as well as 1 systematic review, 1 literature review, 1 report, and 2 books.

Defining and understanding the terminology

Before delving into the research on this topic, it is important to understand the terminology used within this community. Clarifying these terms will help to inform a larger cultural understanding of queer issues (Table 1).

Gender

Gender is a social construct of masculinity and femininity based on conventional behavioural and cultural norms.[2,4,5,18,27,28] Gender is often understood as synonymous with "sex," yet sex is a biological classification based on physical anatomy. Gender identity, in contrast, refers to an individual's internal sense of and connection to a certain gender.[2-5,7,27,28] Therefore, gender identity is a construct that only individuals can determine for themselves, and it may be congruent or incongruent with the sex they were assigned at birth.[7] Cis or cisgender describes someone whose gender identity aligns with the sex assigned at birth.[3-5,29] Trans or transgender refers to an individual whose gender identity is incongruent with the sex assigned at birth.[2-5,7,16,29] For example, if an individual is recognized biologically as female at birth and identifies as a woman, then this individual would be considered a cis woman or cisgender woman. If an individual is recognized as a female at birth but identifies as a man, then this individual would be considered a trans man or transgender man. Trans is a broad term used to describe people who are not cis, and includes those who identify as non-binary in addition to trans men and trans women.[29] Non-binary is an umbrella term for those who do not identify with the static, binary classifications of gender.[29] Non-binary individuals may identify with an intermediate gender (e.g., genderqueer), have multiple genders (e.g., bigender, polygender), have a shifting gender (e.g., genderfluid) or have no gender at all (e.g., agender).[3-5,16,29] There is also the concept of "gender expression" which is how people outwardly present their gender through behaviour and physical appearance.[3,4,28,29] Gender expression is often viewed on a spectrum from masculine to feminine.[29]

Sex

Sex is the biological classification of people as female, male or intersex based on their physical body and reproductive capacity.[29] Physical characteristics used to determine sex include primary reproductive organs, chromosomes, and hormonal profile.[2,4,5,18,27,29] Intersex is a term that describes a variety of conditions in which a person's sexual or reproductive anatomy does not conform to the typical configuration of either male or female.[4,5,30] An example of this could be a person who is born with genitalia that appear to be in-between the typical male and female presentation, or a person who presents with mosaic genetics in which both XY and XX chromosomes are expressed.[30] The term intersex has replaced the term hermaphrodite, which is now widely considered to be outdated, inaccurate, and offensive.[4,30]

Sexual orientation

Sexual orientation is a term used to describe one's sexual, romantic, and/or emotional attraction to another person. Currently, there is ambivalence in the literature regarding whether sexual orientation is based on one's gender, sex or a combination of both relative to one's partner.[2,4,5,7,27,31] In order to minimize confusion, this article defines sexual orientation in terms of gender. The authors recognize that the following definitions of heterosexuality and homosexuality are based on the presumption that an individual identifies with one of the traditional binary gender identities. People may be attracted to the same gender (homosexuality), the opposite gender (heterosexuality), multiple genders (e.g., bisexuality, pansexuality) or experience no sexual attraction to others in general (asexuality).[4]

Coming out

Coming out is a phrase used to describe the process of acceptance and acknowledgement of one's own queer identity and also encompasses the process of disclosing this identity to others.[3-5] The terms "closeted" or being "in the closet" refer to a person who is secretive about their identity or is simply not "out" yet.[5] Coming out should be thought of as a continuous, lifelong process as opposed to a single event in time.

Critical theory[32,33]

Examining critical theory in depth is beyond the scope of this article. However, briefly introducing critical theory as it pertains to queer theory is appropriate. The foundations of critical theory lie in the deconstruction and critiquing of institutions, laws, policies, organizations, definitions, and practices to screen for power inequities. Over time, dominant perspectives are taken as truth. Views

Table 1. LGBT terminology

Term	Definition
Gender	The social construction of concepts such as masculinity and femininity in a specific culture at a specific time.
Gender identity	One's internal and psychological sense of one's own gender. Since gender identity is internal, it may not be visible to others.
Gender expression	The use of behaviour, clothing, hairstyle, voice, body characteristics, etc., to outwardly express one's gender. One's gender expression may not necessarily reflect one's gender identity.
Cis or cisgender	Having a non-transgender identity. Used to describe someone whose gender identity aligns with the sex assigned at birth. The prefix cis means "in alignment with" or "on the same side."
Trans or transgender	An umbrella term for people who are not cis. Trans is used to describe someone whose gender identity does not align with the sex assigned at birth.
Non-binary	An umbrella term for those who do not identify with the static, binary (male/female) classifications of gender.
Two-Spirit	A cultural and spiritual identity used by some First Nations people to describe having both masculine and feminine spirits. It can be used to describe people with diverse gender identities, gender expressions, gender roles, and sexual orientation.
Sex	The biological classification of people as male, female or intersex. It is determined by characteristics such as sexual and reproductive anatomy and genetic make-up.
Sexual orientation	Refers to a person's physical, romantic and/or emotional attraction to another person.
Queer	A term becoming more widely used by the LGBT community because of its inclusiveness. "Queer" can refer to a broad range of non-heterosexual and/or non-cisgender identities. It is sometimes used in place of the acronym LGBT. However, this is a reclaimed term that was once and is still used in a derogatory fashion, thus it may make some people feel uncomfortable.
Coming out	The process of becoming aware of one's own queer identity, accepting it, and telling others about it. Coming out, also known as "coming out of the closet," is an ongoing process that may not include everybody in all aspects of one's life. "Coming out" usually occurs in stages and an individual may be "out" in only some situations or to only certain individuals.

that are different from those expressed by the dominant culture are othered (categorized as deviant) and are subsequently oppressed. The purpose of critical theory and critical inquiry is to raise consciousness and correct injustices resulting from ignorance and misconceived ideas by fostering fundamental social change. Such critical paradigms include feminist theory, critical race theory, disability theory, and queer theory. For example, the goal of queer theory is to challenge and shift the normative structure with regard to gender and sexuality. Tenets of queer theory include a belief that society's current understanding of gender and sexuality privileges those who identify as cisgender and heterosexual and marginalizes people in the LGBT community. Since these dynamics are so engrained in the fabric of a society's systems and practices, they are not recognized by most people, particularly members of the dominant majority culture. To address inequities experienced by people in the LGBT community, queer theorists believe that the unique stories of people from this community must be recounted, and researchers must use their findings to create a more just society.

Dimensions of health care experiences

The challenges experienced by LGBT persons when navigating the health care system can be grouped under 7 dimensions, as identified by the foundational work of Stevens.[34] Stevens' dimensional framework has been selected because of its holistic and integrative capacity to summarize complex ideas within multiple health care settings. In addition, its unique narrative study design captures the authentic accounts of health care experiences from a queer perspective.

Existence

The first dimension, existence, concerns the degree to which individuals believe they are treated as human beings.[34] Several researchers have interviewed LGBT persons and discovered that many members of this community feel alienated by and invisible to their health care professionals because of their queer identity.[6,8,34-36] Non-verbal cues such as facial expressions and body positioning were identified as the primary sources of individual discomfort.[34,35] In contrast, positive health care experiences occurred when the health professional's behaviour reflected compassion and empathy, such as the tilting of their head, direct eye contact, and animated speech.[34,37] In a study by Taylor, trans men reported their identity being challenged, feeling unheard, and feeling like a research tool, all of which strained the client–provider relationship.[14]

Bodily integrity

Bodily integrity refers to the level of dignity individuals feel during health care procedures that involve the crossing of personal boundaries, such as during a gynecological exam.[34] When health care providers were respectful of the individual in their vulnerable state and explained every step before and during the invasive procedure, clients reported a positive experience.[34] Negative experiences were mainly described by women who reported rough physical handling by their health care provider, precipitating feelings of violation and trauma.[34,38]

Emotional integrity

Many LGBT persons interviewed in different studies emphasized the importance of emotional integrity.[17,24,34] This dimension describes how safe individuals feel when disclosing information to their health care provider and whether or not they feel that their concerns and feelings are validated.[34] One of the most commonly reported barriers to health care for LGBT people was coming out and experiencing discrimination from their provider.[15,17,26,35] This event was described as stressful, as it placed the individual in a state of emotional vulnerability.[24] The overall quality of the LGBT person's experience was heavily determined by the health professional's reaction to disclosure.[6,24] Acceptance of their identity was rated as extremely important to LGBT individuals and was a determining factor in how they defined a good health care practitioner.[24] In order to preserve their emotional integrity and prevent recurrence of trauma, lesbian and bisexual women reported a preference for seeking medical care from queer health care practitioners.[13]

Worth

Worth is the degree to which individuals feel valued during their health care experience.[34] LGBT persons face social discrimination daily, and some have internalized that stigma.[2,17,24] As a result of these frequent experiences, many LGBT individuals believe that they are not worthy of being helped.[2,17] Consequently, having positive, worth-affirming interactions with health care providers was important in establishing trusting and open client–provider relationships.[2,24,34,37] Minimizing client concerns and avoiding physical contact were viewed as a form of abandonment.[34] Trans men have reported feeling less deserving of gender-affirming interventions due to their androgynous gender expression.[14]

Uniqueness

This dimension explores how deeply the individuality and diversity of one's life experience is recognized by health care providers.[34] If assumptions or offhand judgments based on queer stereotypes were made, then those experiences with health care professionals were reported as negative.[6,13,34,36] It was important for LGBT individuals to have the multidimensional character of their lives recognized and to have their health care provider see them as more than just their gender, sex or sexual orientation.[6,14]

Expression

This dimension focuses on how comfortable individuals feel when expressing themselves, their thoughts, and concerns.[34] It is very closely related to emotional integrity, but a large component of this dimension is determined by the assumptions made by health professionals.[24,34-36] Negative experiences occurred when health care professionals assumed that their clients were heterosexual.[16] Lack of gender-neutral language (written and verbal) also contributed to decreased freedom of expression.[16,37]

Power

This dimension explores the power relationship between client and provider.[34] LGBT individuals reported that being involved in their health care decisions was an important part of feeling empowered and forming a positive relationship with their health care provider.[34,35] Health care professionals who took the time to explain findings and procedures and worked together with their clients created positive experiences, while those who dominated and were insensitive were perceived as cruel.[14,34,35]

Barriers to accessing and receiving care

The literature reviewed identifies 3 barriers that prevent LGBT individuals from accessing health care: discrimination, ignorance, and assumptions.

Discrimination

Discrimination against the queer community prevents many LGBT individuals from utilizing health care services.[19,26] Many study participants felt that coming out to their health care providers would change the quality of care they received due to discrimination.[16] In some cases LGBT individuals may have been at risk for compounded discrimination due to their affiliation with multiple marginalized groups, such as Two-Spirit individuals who identify with both the Aboriginal and LGBT communities.[6,17] The reported reactions of health care providers to an individual's coming out ranged from embarrassment to excessive curiosity, hostile displays, direct rejection, unwarranted pity, condescension, and denial of care.[6,14,15,35,36,39,40]

Two main types of discrimination have been identified: actual and anticipated.[26] Actual discrimination was experienced when health care providers made judgmental or homophobic/transphobic remarks and failed to acknowledge partners as family members during visiting hours.[2,26,36] Same-sex partners would sometimes identify themselves as friends or roommates in order to avoid being treated differently.[26] Participants in the research reviewed also expressed challenges in seeking mental health care as some inexperienced providers viewed homosexuality and being transgender as a mental illness.[36,39] Anticipated discrimination was the expectation of being discriminated against due to existing social stigma and/or prior negative experiences with health care providers.[2,6,19,22,25,26] This form of discrimination had an effect on individuals' willingness to reveal their gender identity and/or sexual orientation and utilize health care services.[6,19,25,26] Both forms of discrimination pose a threat to the health of LGBT individuals and result in emotional distress, inadequate care, and lack of appropriate medical attention.[6,19,26]

In addition, insurance policies and an individual's own sense of self may prevent them from accessing appropriate care.[2,39] For example, some trans men reported difficulty in accessing gynecological care due to lack of insurance coverage and/or body dysphoria.[38,39] For these individuals, receiving a pap smear or breast exam may be emotionally debilitating and dysphoric, so some choose to avoid gynecological care altogether.[39]

Ignorance and lack of knowledge

Lack of knowledge of LGBT-specific health issues and judgmental attitudes of health care professionals were another barrier to health care for LGBT populations.[2,14,36] Some health care professionals appeared unversed in queer terminology, which added to the stress of individuals who felt responsible for educating their health care provider and justifying their identity.[6,12,14,16,19,36] Many queer individuals noted that their health care provider seemed unprepared and acted awkwardly after they came out, avoiding discussion of issues related to sexual orientation when making care plans.[26,35] A study conducted at McGill University on LGBT seniors revealed a "don't ask, don't tell" approach towards sexual orientation in the health care system.[8] This notable discomfort from health care providers made the individuals feel uncomfortable and unable to speak openly about their health concerns.[35,36] There were also reports of a general lack of knowledge of transgender-related health care services, such as hormone therapy.[2,12,14,16,39]

Assumptions made by health care providers

LGBT individuals reported that assumptions about sexual orientation, sex, and gender pervaded health care environments.[34,37] These assumptions manifested in the language used by the health care providers, in written documents, and in pictures and pamphlets around clinical and medical offices.[16,34,35,40] The use of heteronormative language negatively affected the client–provider relationship and created feelings of discomfort and distress among LGBT individuals.[6,8,34-36] LGBT respondents reported that the assumption that everyone is heterosexual and cisgender was a major barrier to forming a trusting relationship with their health care provider.[35,37] Studies revealed that transgender individuals found it challenging to disclose their gender identity since the initial intake forms only offered binary gender options of the traditional notions of male or female.[16,35,39] Furthermore, for trans individuals, having government-issued identification that did not match their gender identity and gender expression was a significant barrier to care.[41]

Impact of barriers

These barriers are associated with several key negative health consequences.

Delayed or discontinued care

Previous negative experiences or perceptions of discrimination within the health care system have caused LGBT individuals to delay seeking health care.[6,16,17,22,31,42] Research has shown that LGBT people are less likely to seek medical care compared to their non-queer counterparts. [2,13,16,19-21,24,39,43,44] LGBT persons also have lower participation rates in preventive health programs.[22,24,37] It was also found that lesbians and bisexual women are less likely to have a family physician and receive regular pap smears and breast examinations.[13,20,21,31] In a recent study of transgender and non-binary individuals, 28% of respondents reported being harassed in health care settings and postponed care due to discrimination.[15]

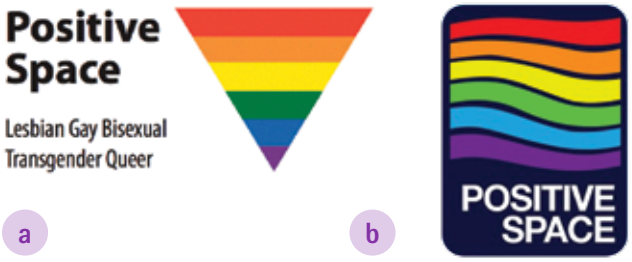
Increased negative health behaviours

Difficulty in accessing health care services for unique LGBT needs, such as information on safe sex practices, has resulted in a higher prevalence of negative health behaviours among LGBT individuals.[17-21,24,25] LGBT individuals have higher rates of smoking, drinking, and substance use.[17-20,24,25] Sexual minorities are also at high risk for sexually transmitted diseases.[18] For transgender individuals, self-medicating with "street therapies" was commonly reported when they could not obtain appropriate hormone therapies from their physician.[39] Particularly for queer men, regular HIV screening was challenging due to the fear of being found positive and suffering from dual stigma related to HIV and being queer.[12,39]

Non-disclosure of gender identity and sexual orientation

The ability of health care providers to enable LGBT individuals to come out and feel safe in the health care environment is essential.[7,17,35,40,42,43] Being out to one's health care provider improves the likelihood of receiving appropriate care and education, including information related to safe sex practices and recommendations for appropriate medical testing.[6,7,24] Research has shown an increased use of medical services from lesbians who have come out to their doctor.[7,31] LGBT persons were reluctant to disclose their sexual orientation for fear of repeated negative experiences or fear that coming out would bias their care.[2,13,16,18,19,22,24,31,35,37,42] Individuals reported extreme anxiety related to coming out in health care settings and feared that disclosure would make them vulnerable to mistreatment and denial of care.[19,24,35,43] Some thought that disclosing their sexuality was risky unless it was clearly relevant.[24,35] Some would not even disclose their identity when it seemed relevant in order to protect their well-being.[19]

Figure 1. Images from the Positive Space Campaign at a) the University of Toronto and b) the University of British Columbia



Feelings of internalized stigma

Experiences of discrimination led individuals to feel unsafe in the health care environment and reinforced feelings of stigma.[2,19] This feeling may cause queer individuals to believe that they are undeserving not only of respect from their health care providers, but also of the same access to care as non-queer individuals.[2] Internalized stigma may also be associated with higher risk of negative health behaviours and consequences such as substance and alcohol use, smoking, suicide, and mental illnesses such as depression and eating disorders.[2,12,17-21,24,25,31]

Strategies for change

Creating a sense of safety for LGBT individuals within health care environments is of primary importance. Not only should general health programs be made more inclusive, but participants in various studies also attested to the value of and need for LGBT-specific health programs and services.[17,40,43] In a study by Brotman et al. on the care of Two-Spirit individuals, the need for more LGBT-supportive individuals in the health care system was stressed.[17] Health professionals should reflect on their own feelings and assumptions regarding gender identity and sexuality and try to assess their own reactions and biases, as well as the potential gaps in their knowledge in order to improve their understanding of LGBT health needs.[8,13,20] LGBT individuals stressed the importance of preparing health care providers to deliver queer-friendly care and use inclusive language.[1,8,13,20,35] A study by Barnoff et al. focused on the health care experiences of lesbians diagnosed with cancer and found that participants wanted the opportunity to connect specifically with other lesbians in the same situation.[43] The need for more LGBT-specific health support programs and information requires further advocacy.[43]

The use of positive space signage and other inclusive signage was also suggested as a way of showing support for the LGBT community.[1,17,19,37,40,45] The rainbow triangle shown in Figure 1 combines two common images used in LGBT communities. The rainbow flag has become a symbol of pride for gender and sexual minorities across the world. An inverted pink triangle was worn by gay prisoners in the

Figure 2. Heteronormative signage used by the Vancouver Park Board in 2014

Nazi concentration camps, and has become a mark of remembrance and pride.[46] Figure 2 is an example of heteronormative signage that defines a family unit as a man and a woman thereby normalizing heterosexuality and excluding or othering those who have same-sex partners. Figure 3 provides an example of more inclusive signage adopted by the Vancouver Park Board that replaced the signage shown in Figure 2.

Participants from various studies emphasized the importance of cultural sensitivity training for health care professionals especially pertaining to LGBT persons who may have experienced trauma in their past.[16,19,35] They also stressed the need for health care providers to collaborate and network with one another to increase their knowledge and skills in working with the LGBT community.[14] A study of LGBT youth also recommended that health care providers remind their clients of professional confidentiality requirements at every appointment, as coming out is a significant issue of safety.[37] In the future, more comprehensive education focused on LGBT health and cultural competency should be integrated into health science and human service entry-to-practice programs.[14,17,20] Understanding the impact of stigma and one's ability to demonstrate empathy through awareness and validation are critical in forming a trusting client–provider relationship.[8,16] Such knowledge can facilitate the development of educational programs, policies, and interventions to decrease the health disparities of the LGBT community.

The Canadian Human Rights Act has prohibited discrimination on the basis of sexual orientation since 1996.[47] Bill C-16, currently undergoing assessment, proposes amendments to the Act to include gender identity and gender expression as prohibited grounds of discrimination.[48] There are currently 7 provinces and 1 territory that recognize gender identity and gender expression in their human rights legislation (Table 2).[49-53] Health care providers must recognize their legal obligation to provide safe and inclusive care to all and the importance of improving their understanding of the health care experiences of the LGBT community.

Gaps in the research

The main limitation or challenge to exploring experiences of the LGBT population is that researchers are only able to study people who are comfortable self-identifying, which excludes the large population of closeted individuals. Additionally, there seems to be a lack of research on other sexual minorities such as pansexuals and asexuals. Most of the research to date has explored the experiences of gay and lesbian individuals. There is a paucity of research addressing the experiences of the bisexual and transgender communities. There is also a notable lack of qualitative and longitudinal studies, which makes understanding shifts in perceptions and experiences over time challenging.

Currently, research suggests a shift from outright discrimination by health care professionals, such as the denial of care, to subtler forms of discrimination, such as the use of non-inclusive language. Overcoming the fear of coming out to their health care providers continues to be a barrier for LGBT individuals in accessing appropriate health care. There is also a paucity of research on the impact of queer stigmatization on the health and well-being of LGBT individuals, particularly in the Canadian setting.[17] Furthermore, none of the reviewed literature touched on the experiences of queer individuals in the dental setting. Most of the qualitative research has focused on experiences with physicians and nurses. Little if any information is known as to how queer people experience oral health care services. Further investigation to determine the differences in disparities across subsets of queer identities (e.g., age, race, culture) would also be valuable in order to identify other barriers to care associated with compounded discrimination.[31]

Figure 3. Revised inclusive signage adopted by the Vancouver Park Board in 2016

a

b

CONCLUSION

This article provides a glimpse into the health care experiences of the LGBT community in North America, as they pertain to existence, bodily integrity, emotional integrity, worth, uniqueness, expression, and power. Barriers to care include discrimination informed by ignorance and assumptions made by health care providers resulting in delayed or discontinued care, increased negative health behaviours, non-disclosure, and internalized stigma. Further qualitative investigation into the experiences of individuals who identify with lesser known sexualities and non-binary gender identities should be conducted. The health care experiences of queer people of colour as well as different ages and races also require further investigation. LGBT individuals are at a disproportionate risk for a wide range of medical concerns as well as mental and psychological distress resulting from deep-rooted social discrimination. Findings from the research reviewed reveal an urgent need to analyse and reform the cultural competency education provided to health care professionals in regards to caring for members of the LGBT community. Efforts to minimize suffering and increase feelings of comfort and safety within health care environments should be made in order to improve the overall health and quality of life of this community.

CONFLICT OF INTEREST

The authors have declared no conflicts of interest.

Table 2. Human rights legislation in Canada

	Prohibited grounds of discrimination		
Jurisdiction	**Sexual orientation**	**Gender identity**	**Gender expression**
British Columbia	1992	2016	2016
Alberta	2009	2015	2015
Saskatchewan	1993	2014	–
Manitoba	1987	2012	–
Ontario	1986	2012	2012
Quebec	1977	2016	2016
New Brunswick	1992	–	–
Nova Scotia	1991	2012	2012
Prince Edward Island	1998	2013	2013
Newfoundland and Labrador	1995	2013	2013
Yukon	1987	–	–
Northwest Territories	2002	2002	–
Nunavut	1999	2017	2017
Canada	1996	Bill C-16	Bill C-16

REFERENCES

1. Ard KL, Makadon HJ. *Improving the health care of lesbian, gay, bisexual and transgender people: Understanding and eliminating health disparities.* Boston: The Fenway Institute; 2012.
2. Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* Washington, DC: National Academies Press; 2011.
3. Loyola University Maryland. LGBTQ terms and definitions [Internet]. Available from: www.loyola.edu/club/spectrum/lgbtq-terms-and-definitions
4. Qmunity. *Queer terminology from A to Q.* Vancouver, BC: Qmunity; 2013. Available from: qmunity.ca/wp-content/uploads/2015/03/Queer_Terminology_Web_Version__Sept_2013__Cover_and_pages_.pdf
5. University of California at Berkeley, Gender Equity Resource Center. Definition of terms [Internet]. Berkeley, CA: UC Berkeley; 2013. Available from: geneq.berkeley.edu/lgbt_resources_definiton_of_terms#agender
6. Brotman S, Ryan B, Jalbert Y, Rowe B. The impact of coming out on health and health care access: The experiences of gay, lesbian, bisexual and Two-Spirit people. *J Health Soc Policy.* 2002;15(1):1–29.
7. Bradford JB, Cahill S, Grasso C, Makadon HJ. Policy focus: *Why gather data on sexual orientation and gender identity in clinical settings.* Boston: The Fenway Institute; 2012. Available from: www.lgbthealtheducation.org/wp-content/uploads/policy_brief_why_gather.pdf
8. Brotman S, Ryan B, Cormier R. The health and social service needs of gay and lesbian elders and their families in Canada. *Gerontologist.* 2003;43(2):192–202.
9. Carroll A. *State-sponsored homophobia. A world survey of sexual orientation laws: Criminalisation, protection and recognition.* Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA); May 2016. Available from: http://ilga.org/downloads/02_ILGA_State_Sponsored_Homophobia_2016_ENG_WEB_150516.pdf
10. Statistics Canada. Same-sex couples and sexual orientation... by the numbers [Internet]. 2014. Available from: www.statcan.gc.ca/eng/dai/smr08/2015/smr08_203_2015#a3
11. Gates GJ, Newport F. LGBT percentage highest in DC, lowest in North Dakota. Gallup [Internet]. 2013. Available from: www.gallup.com/poll/160517/lgbt-percentage-highest-lowest-north-dakota.aspx
12. Finkenauer S, Sherratt J, Marlow J, Brodey A. When injustice gets old: A systematic review of trans aging. *J Gay Lesbian Soc Serv.* 2012;24(4):311–30.
13. Barbara AM, Quandt SA, Anderson RT. Experiences of lesbians in the health care environment. *Women & Health.* 2001;34(1):45–62.
14. Taylor ET. Transmen's health care experiences: Ethical social work practice beyond the binary. *J Gay Lesbian Soc Serv.* 2013;25(1):102–20.
15. Cornelius JB, Carrick J. A survey of nursing students' knowledge of and attitudes toward LGBT health care concerns. *Nurs Educ Perspect.* 2015;36(3):176–78.
16. Bauer GR, Scheim AI, Deutsch MB, Massarella C. Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: Results from a respondent-driven sampling survey. *Ann Emerg Med.* 2014;63(6):713–20.e1.
17. Brotman S, Ryan B, Jalbert Y, Rowe B. Reclaiming space-regaining health: The health care experiences of Two-Spirited people in Canada. *J Gay Lesbian Soc Serv.* 2002;14(1):67–87.
18. Rawat R. Multi-dimensional burden of lesbian, gay, bisexual, and transgender (LGBT) community: Health perspective. *AASCIT.* 2015;2(6):320–25.
19. Quinn GP, Sutton SK, Winfield B, Breen S, Canales J, Shetty G, et al. Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) perceptions and health care experiences. *J Gay Lesbian Soc Serv.* 2015;27(2):246–61.
20. Diamant AL, Wold C, Spritzer K, Gelberg L. Health behaviors, health status, and access to and use of health care: A population-based study of lesbian, bisexual, and heterosexual women. *Arch Fam Med.* 2000;9(10):1043–51.
21. Aaron D, Markovic N, Danielson M, Honnold J, Janosky J, Schmidt N. Behavioral risk factors for disease and preventive health practices among lesbians. *Am J Public Health.* 2001;91(6):972–75.
22. Mitra S, Globerman J. Facilitators and barriers to health care for lesbian, gay and bisexual (LGB) people. *Rapid Review #79.* Toronto, ON: Ontario HIV Treatment Network; 2014.
23. Joint United Nations Programme on HIV/AIDS (UNAIDS). Ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people [press statement]. Geneva: UNAIDS; 2015. Available from: www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/september/20150929_LGBTI#_ftnref1
24. Durso LE, Meyer IH. Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sex Res Social Policy.* 2013;10(1):35–42.
25. Alvy LM, McKirnan D, Du Bois SN, Jones K, Ritchie N, Fingerhut D. Health care disparities and behavioral health among men who have sex with men. *J Gay Lesbian Soc Serv.* 2011;23(4):507–22.
26. Zuccaro L. The health care experiences of LGBT seniors. *Transition* (a publication of The Vanier Institute of the Family). 2014;44(3):14–15.
27. van Anders SM. Beyond sexual orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory. *Arch Sexual Behav.* 2015;44(5):1177–1213.
28. Rainbow Health Ontario. Media reference guide discussing trans and gender-diverse people [Internet]. Available from: www.rainbowhealthontario.ca/wp-content/uploads/2016/01/Media-Reference-Guide-Trans-and-Gender-Diverse-People1.pdf
29. Trans Primary Care. Language and terminology [Internet]. Available from: www.rainbowhealthontario.ca/TransHealthGuide/intro-terms.html
30. Intersex Society of North America. What is intersex? [Internet]. Available from: www.isna.org/faq/what_is_intersex
31. Tjepkema M. Health care use among gay, lesbian and bisexual Canadians. *Health Reports.* 2008;19(1):53–64.
32. Evans NJ, Forney DS, Guido FM, Patton LD, Renn KA. *Student development in college: Theory, research, and practice.* 2nd ed. San Francisco, CA: Jossey-Bass; 2010.

33. Sullivan, Nikki. *A critical introduction to queer theory.* New York, NY: NYU Press; 2003.

34. Stevens PE. Lesbians' health-related experiences of care and noncare. *West J Nurs Res.* 1994;16(6):639–59.

35. Harbin A, Beagan B, Goldberg L. Discomfort, judgment, and health care for queers. *J Bioeth Inq.* 2012;9(2):149–60.

36. Saulnier CF. Deciding who to see: Lesbians discuss their preferences in health and mental health care providers. *Social Work.* 2002;47(4):355–65.

37. Law M, Mathai A, Veinot P, Webster F, Mylopoulos M. Exploring lesbian, gay, bisexual, and queer (LGBQ) people's experiences with disclosure of sexual identity to primary care physicians: A qualitative study. *BMC Fam Pract.* 2015;16:175.

38. Lambda Legal. *When health care isn't caring: Lambda Legal's survey on discrimination against LGBT people and people living with HIV.* New York, NY: Lambda Legal; 2010. Available from: www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf

39. Xavier J, Bradford J, Hendricks M, Safford L, McKee R, Martin E, et al. Transgender health care access in Virginia: A qualitative study. *Int J Transgend.* 2013;14(1):3–17.

40. MacDonnell JA, Daley A. Examining the development of positive space in health and social service organizations: A Canadian exploratory study. *J Gay Lesbian Soc Serv.* 2015;27(3):263.

41. Bauer GR, Zong X, Scheim AI, Hammond R, Thind A. Factors impacting transgender patients' discomfort with their family physicians: A respondent-driven sampling survey. *PLoS One.* 2015:1–16.

42. van Dam MAA, Koh AS, Dibble SL. Lesbian Disclosure to Health Care Providers and Delay of Care. *J Gay Lesbian Med Assoc.* 2001;5(1):11–19.

43. Barnoff L, Sinding C, Grassau P. Listening to the voices of lesbians diagnosed with cancer: Recommendations for change in cancer support services. *J Gay Lesbian Soc Serv.* 2005;18(1):17–35.

44. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. Injustice at every turn: A report of the national transgender discrimination survey [Internet]. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011. Available from: www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf

45. Eliason MJ, Schope R. Does "don't ask don't tell" apply to health care? Lesbian, gay, and bisexual people's disclosure to health care providers. *J Gay Lesbian Med Assoc.* 2001;5(4):125–34.

46. Positive Space, University of Toronto. Posters & stickers [Internet]. 2015. Available from: positivespace.utoronto.ca/resourcesposters/posters/

47. Hurley MC. *Sexual orientation and legal rights.* Ottawa: Library of Parliament; 2007. Available from: www.lop.parl.gc.ca/content/lop/researchpublications/921-e.pdf

48. Bill C-16. *An act to amend the Canadian Human Rights Act and Criminal Code.* 1st Sess, 42nd Parl, 64-65 Elizabeth II, 2015–2016 (as passed by the House of Commons, 18 Nov 2016). Available from: www.parl.gc.ca/HousePublications/Publication.aspx?DocId=8609176&Language=E&Mode=1

49. Spencer C. A brief Canadian history of laws affecting and gays and lesbians [Internet]. 2008. Available from: www.canadianelderlaw.ca/Gay%20Timeline.htm

50. Cossman B. Bill C-16 – No, it's not about criminalizing pronoun misuse [Internet]. 2016. Available from: sds.utoronto.ca/blog/bill-c-16-no-its-not-about-criminalizing-pronoun-misuse/

51. Ministry of Justice, Government of British Columbia. BC Human Rights Code to include explicit protection for gender identity, expression [news release]. 2016 Jul 25. Available from: https://news.gov.bc.ca/releases/2016JAG0025-001352

52. Bill 103. *An Act to strengthen the fight against transphobia and improve the situation of transgender minors in particular.* 1st Sess, 41st Leg, 2016 (Chapter 19). Quebec: Québec Official Publisher; 10p. Available from: www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2016C19A.PDF

53. Ostroff J. Nunavut protects transgender rights in unanimous vote [Internet]. *The Huffington Post Canada.* 2017 Mar 15. Available from: www.huffingtonpost.ca/2017/03/15/nunavut-transgender-rights_n_15386394.html