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Interactions Between Health Professionals and Lesbian, Gay and Bisexual Patients in Healthcare Settings: A Systematic Review

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ABSTRACT

The ways in which health professionals (HPs) interact with individuals from sexual minorities can impact their perception of the health service and influence engagement. This systematic literature review aimed to identify and synthesize the qualitative literature exploring interactions between HPs and lesbian, gay and bisexual (LGB) patients in healthcare settings. A search strategy was developed and applied to CINAHL and Medline, inclusion criteria were then applied to results by two screeners with good agreement. Thematic analysis was carried out on papers meeting the inclusion criteria in three stages, beginning with coding the text line-by-line, developing descriptive themes and finally, analytical themes. Electronic searches identified 348 papers with 20 of these meeting the inclusion criteria. Thematic analysis found five themes; HPs' lack of knowledge regarding LGB specific issues, identification of sexual orientation, discomfort in interactions, LGB patients' experience of heteronormative attitudes and perceived judgment or other negative attitudes.

KEYWORDS

Healthcare; health professionals; sexual orientation; experiences; health; interactions; LGB

Introduction

It is generally acknowledged that health inequalities exist amongst sexual minorities, including the lesbian, gay and bisexual (LGB) population (Marmot, 2010). Research shows that LGB individuals experience worse physical health outcomes than their heterosexual counterparts (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010; Fredriksen-Goldsen et al., 2014). For example, rates of HIV amongst gay and bisexual men are higher, with 44 times as many contracting the virus compared to heterosexuals (Centers for Disease Control and Prevention, 2019). Other physical health disparities include higher rates of disability, cancer and obesity, asthma and cardiovascular disease (Boehmer, Bowen, & Bauer, 2007;

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Conron, Mimiaga, & Landers, 2010; Dilley et al., 2010; Hatzenbuehler, McLaughlin, & Slopen, 2013; Wallace, Cochran, Durazo, & Ford, 2011). Evidence also suggests a higher prevalence of mental health problems in this population, including issues such as psychological distress and potential for suicidal thoughts (Chae & Ayala, 2010; Conron et al., 2010; Wallace et al., 2011).

In 2019, the United Nations (UN) called for the need to educate healthcare providers as to the health inequities faced by lesbian, gay, bisexual, transgender and intersex (LGBTI) people (United Nations, 2019). Given the presence of such inequities, engagement with healthcare services is particularly important for this population. One factor which can influence engagement with healthcare services is the way in which healthcare staff interact with patients (Elliott et al., 2015; Petroll & Mosack, 2011). LGB patients can at times experience discrimination in healthcare settings, which may contribute to decisions as to whether to engage with healthcare services when needed (Eckstrand & Potter, 2017; Irvin et al., 2014; Jackson, Agénor, Johnson, Austin, & Kawachi, 2016). For example, being denied examination or treatment, not being taken seriously, or fear of discrimination leading to the patient not attending a medical appointment (Hirsch, Löltgen, & Becker, 2016).

An understanding of both LGB patients' and health professionals' perceptions of interactions within the healthcare setting, can provide valuable insight into experiences of both parties, and indications as to areas for intervention. This systematic literature review aimed to identify and synthesize the qualitative literature exploring the nature of interactions between HPs and lesbian, gay and bisexual patients in healthcare settings. The defined research question for this systematic review was "What is the nature of interactions between HPs and lesbian, gay and bisexual patients in healthcare settings?"

Methods

A systematic review of qualitative studies was conducted from February 2019 until March 2020, following PRISMA-P guidelines for conducting and reporting reviews (Moher et al., 2016). The review process is outlined in Figure 1. The University of Edinburgh did not require ethical approval for literature review as no new research would be carried out. All information included was already publicly available.

Inclusion criteria

When developing inclusion criteria, the "SPIDER" framework was used to ensure all aspects were considered (Table 1) (Cooke, Smith, & Booth, 2012). This framework was chosen as opposed to the commonly used "PICOS" framework due to the qualitative nature of the literature review (Booth & Cleyle, 2006).

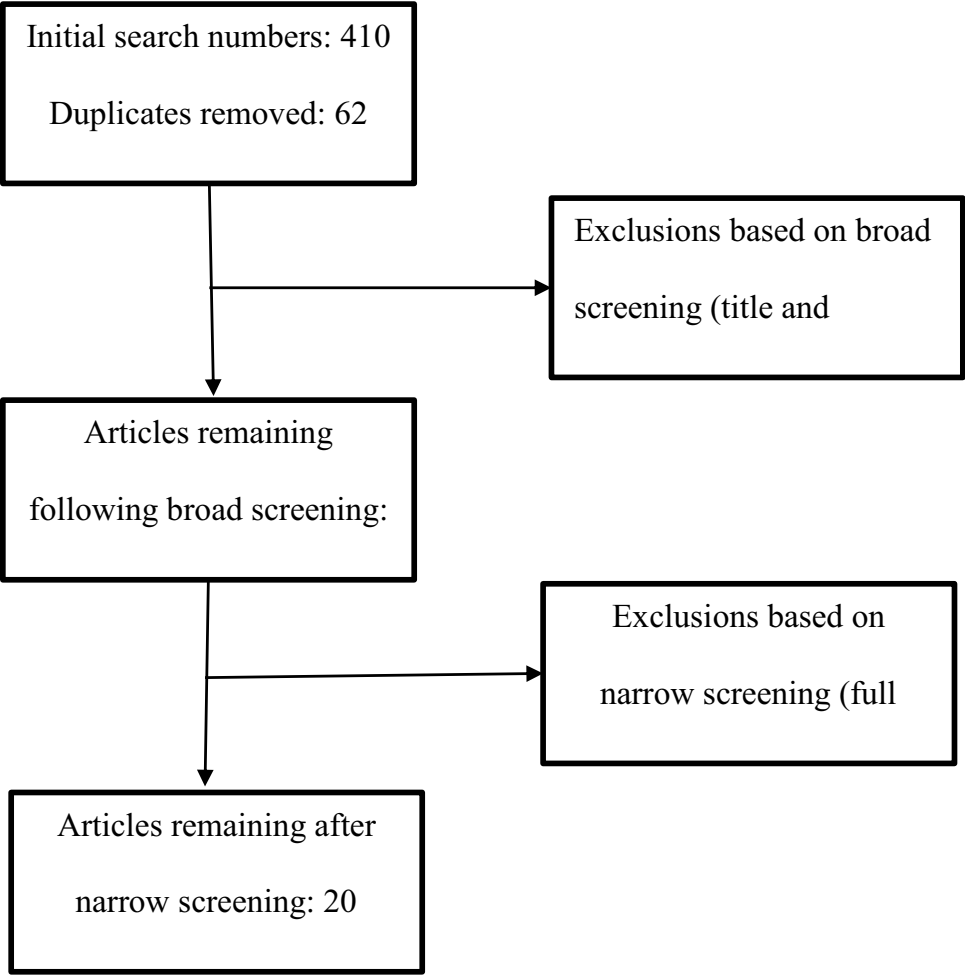


Figure 1. PRISMA flow diagram.

Table 1. Search String

1. Experience* OR interaction* OR attitude* OR talk* OR knowledge OR perception* OR belief* OR support* OR comfort*
2. Health professional* OR nurse* OR doctor* OR clinician* OR physician*
3. Sexual orientation OR sexual preference OR sexual identity OR sexuality
4. LGB OR lesbian* OR gay* OR bisexual* OR LGBO OR LGB OR Homosexual* OR Men who have sex with men OR MSM OR women who have sex with women OR WSW OR queer
5. 1 AND 2 AND 3 AND 4

Populations and phenomenon of interest

Studies were included if they reported either LGB and/or HP perspectives. Both perspectives were included to allow a richer understanding and holistic view of the topic. No age limits were applied. The phenomenon of interest is the perceptions, experiences and interactions between LGB and HPs. It was decided that papers that included data from transgender individuals could be included but the data that would be extracted would be limited to LGB. This is with the understanding that transgender individuals often have notably different and more challenging health experiences than their LGB counterparts (Macapagal, Bhatia, & Greene, 2016).

Study design

The review included peer-reviewed studies reporting qualitative research that utilized semi-structured interviews or focus groups. These methods encourage a deeper understanding, promoting flexible conversation and in-depth analysis (Polit & Beck, 2006). Additionally, semi-structured focus groups and interviews allow for fuller, more spontaneous answers to be given and therefore, more reliable, less biased conclusions, whilst following a loose structure. Surveys and formal structured interviews were excluded. Intervention studies were excluded since the review was focused upon LGB and HP perceptions of healthcare interactions and not the effectiveness of interventions.

Delimiters

Only studies from the last 10 years were included (i.e. 2010 onwards). We considered only those studies using English language or those that included an English translation although no geographical boundaries were set.

Search strategy

A search strategy was developed by two researchers. Four key terms were agreed between the researchers, these are; experience, health professional, sexual orientation and LGB. Synonyms and other linking words were then added to each key term drawing on terms used in relevant research and related terms. The search terms were combined and search string applied to the CINAHL and Medline databases (Table 2). The search was carried out in February 2019 and then again in March 2020 to update the review for publication.

Applying the inclusion criteria

Papers were screened by title, abstract and full paper. The full text was obtained for 50 papers. Of the 50 papers, 30 studies were excluded as they

Table 2. SPIDER framework

Sample	When considering qualitative studies, the sample size is not the most important issue as qualitative data is used to explore certain experiences by individuals and is not intended to be generalisable. The population of interest was HPs and/or LGB community.
Phenomenon of Interest	The concept being researched is the perceptions, experiences and interactions between two groups of people. In this case it was either HPs and their interaction with the LGB community, or vice versa. The setting is the healthcare setting.
Design of research	The research question is aiming to examine the current state of the interactions between HPs and the LGB community, not an intervention or variable placed by a research team. Therefore, only studies that were considering the current situation were included, not those staging an intervention.
Evaluation	The experiences, perceptions and attitudes will be examined.
Research type	The type of qualitative data chosen was focus groups and interviews as these allow fuller, more spontaneous answers to be given and therefore, more reliable, less biased conclusions. Surveys and structured interviews were excluded.

were either intervention studies ($n = 4$), questionnaire studies ($n = 21$), or focused upon areas for improvement rather than previous interactions or experience ($n = 5$). A second researcher screened 10% of studies at title, and abstract (22/25, 7/7), and all studies at full paper (30/30) with good agreement. Any disagreements were resolved by discussion.

Analysis

Thematic analysis was carried out in three stages, beginning with coding the text within each paper line-by-line. These codes were then used to develop descriptive themes and finally, analytical themes (Thomas & Harden, 2008). A table was generated to assist comparison and analysis of papers (Table 3).

Quality assessment

Methodological quality was assessed using the Critical Appraisal Skills Programme (CASP) qualitative checklist (CASP, 2019). The average score for the body of research appraised for this literature review is 8.15, suggesting that the quality is relatively high (Table 4). Quality of included papers was scored by two reviewers, with good agreement. One aspect which papers scored poorly on was the recruitment of participants. Many of the studies recruited their participants at LGB specific locations, such as PRIDE fairs or on LGB websites and groups. This method of recruitment reduces the representativeness of the sample as the individuals will be most likely active and open about their sexuality. Individuals who are exploring their sexuality or have not informed relatives and loved ones of their sexual identity may not have been reached in sufficient numbers. This is an inevitable limitation of this kind of study.

Table 3. Studies

Author, Title, Setting	Sample, Design	Aim	Findings
(Agénor et al., 2015) Exploring the Cervical Cancer Screening Experiences of Black Lesbian, Bisexual, and Queer Women: The Role of Patient-Provider Communication USA	18 lesbian, bisexual and queer black women 4 Focus Groups Discussion Data analysed with thematic analysis	To understand the facilitators of and barriers to cervical cancer screening in this population.	4 themes emerged: - HP communication style/demeanor - Heteronormative assumptions - Heterosexism, racism and classism - HP background (both professional and sociodemographic) The cervical cancer screening experiences of black LBQ women would be improved by training all health care providers in same-sex sexual health, offering opportunities for clinicians to learn about the effects of various forms of discrimination on women's health care, and increasing the presence of LBQ women of color in health care settings.
(Bjarnadottir et al., 2019) Assessing Sexual Orientation and Gender Identity in Home Health Care: Perceptions and Attitudes of Nurses USA	Nurses 88% female (acknowledged to be same ratio as workforce) 2/3 white Interviews and Focus Groups were both utilized.	This study aimed to explore home health care nurses' attitudes, perceptions and experiences related to routine collection and documentation of sexual orientation and gender identity data.	3 themes emerged: - assessment of sexual orientation or gender identity - documenting sexual orientation and gender identity - training and resources Nurses emphasized wanting to provide everyone with the same quality of care and wanted documentation to inform the care. Conclusions: Results from this study can help inform the development of training materials and resources to enable nurses to collect patients' sexual orientation and gender identity data.
(Bjorkman & Malterud, 2009) Lesbian women's experiences with health care: a qualitative study. Norway	128 Lesbian Women Qualitative data based on written stories. Web based open ended questionnaire from a convenience sample of self-identified lesbian women. Data were analysed with systematic text condensation. Interpretation of findings was supported by theories of heteronormativity.	To explore lesbian women's healthcare experiences specifically related to sexual orientation to achieve knowledge which can contribute to increased quality of healthcare for lesbian women.	3 themes emerged: - Perspective of awareness (does the HP think of/facilitate disclosure) - Attitudes towards homosexuality/ respect - Medical Knowledge (do HPs have enough specific knowledge) Conclusion: To obtain quality care for lesbian women, the healthcare professional needs a persistent awareness that not all patients are heterosexual, an open attitude towards a lesbian orientation, and specific knowledge of lesbian health issues. The dimensions of awareness, attitude, and knowledge are interconnected, and a positive direction on all three dimensions appears to
(Burton et al., 2019) "Things are different now but": Older LGBT adults' experiences and unmet needs in healthcare USA	10 LGBT individuals 5 gay, 5 non-disclosed Interviews	The aim of this study was to increase understanding of the experiences and needs of older LGBT adults when accessing care.	3 themes emerged: - "Outness" - "Things are Different Now" - "Additional Resources" These describe participant comfort with being "out"; how treatment they received changed over time, and needed services or other options from the community Conclusion: While many older LGBT adults are accustomed to navigating social mores to avoid negative experiences, nurses as well as other health care providers must be prepared to create trusting relationships with these individuals to provide truly comprehensive care

(Continued)

Table 3. (Continued).

Author, Title, Setting	Sample, Design	Aim	Findings
(Chapman et al., 2012) A descriptive study of the experiences of lesbian, gay and transgender parents accessing health services for their children. Australia	11 interviews with LGT parents Both couples and individuals. Descriptive qualitative study. Semi-structured face to face interviews. Thematic analysis	To explore the experiences of LGTB families accessing healthcare for their families.	3 themes emerged -Managing healthcare experiences -Attitudes -Transforming bureaucracies Negative experiences included encountering homophobia or transphobia and being required to educate health professionals. Positive experiences occurred when both parents were acknowledged as having an equal say in their child's health care. Conclusion. Many health professionals lack the skill or knowledge to meet the needs of lesbian, gay and transgender families. Health services are required to ensure that all policies and procedures are inclusive of all family constellations and that staff receive relevant and up-to-date sensitivity training and create an environment that is respectful of all family groups.
(Fish, Williamson, & Brown, 2019) Disclosure in lesbian, gay and bisexual cancer care: towards a salutogenic healthcare environment Britain	LGB 18 men, 12 women Interviews	The aim of this study is to explore the conditions under which a sample of British LGB cancer patients revealed their sexual orientation in hospital settings to enable a more nuanced approach to understanding disclosure in this context.	3 themes emerged: - Authenticity as a driver for disclosure in cancer care - Partners as a (potential) salutogenic resource - Creating safe, healing environments conducive to disclosure. Conclusion: Our findings enable a more nuanced approach to understanding disclosure in this context. This study contributes to the literature through its articulation of the salutogenic potential of disclosure (if responded to appropriately) for LGB patients as individuals, in relationship to their partners or carers and the role of creating a visible healing-oriented optimal environment to promote quality of life and recovery.
(Haider et al., 2017) Emergency department query for patient centred approaches to sexual orientation and gender identity: the equality study Baltimore, Maryland, and Washington DC	Mixed Methods: <u>Qualitative interviews</u> -53 patients -26 healthcare professionals <u>Online survey</u> -1516 potential patients (50/50 straight/LGB) -429 emergency HCPs (50/50 nurse & doctor) 50/50 African American and Caucasian	To identify the optimal patient centred approach to collect sexual orientation data in emergency healthcare settings. Qualitative interviews – to obtain perspectives of HCPs on sexual orientation data collection Survey – to gauge pts' and HCPs willingness to provide or obtain sexual orientation information	3 themes emerged: - Medical relevance - Normalisation - Recognition Providers understood need if medically relevant, while patients thought it was relevant to every Emergency Department encounter. Interviews suggested that pts were less likely to refuse than providers expected. 10% stated they would refuse, 78% of providers thought patients would refuse. Bisexual individuals are more likely to refuse. 'If you are counted, you are visible, a form of recognition'

(Continued)

Table 3. (Continued).

Author, Title, Setting	Sample, Design	Aim	Findings
(Harbin, Beagan, & Goldberg, 2012) Discomfort judgement and healthcare for queers Halifax, Nova Scotia, Canada	19 women who self-identified as 'queer' (10 lesbian, 5 bisexual, 1 queer, 2 transgender, 2 other – ranged from 23-73) 9 family physician's self-identified as working with LGBTQ patients (8 women, 1 man) Women – 90min face-to-face interview Physicians – 60min interview asked about their experiences and where they felt most and least confident in their practice Team discussed narratives and creating memos to distill each participants story, began to code the data but also continue the narrative whole story reflection.	To explore how routine practices of healthcare can perpetuate or challenge the marginalisation of 'queers.'	Both sets regularly noted the importance of feeling comfortable in their interactions with each other. Physicians were aware of homophobia and were trying hard to work against it. Women felt more discomfort than physicians, suggested as a result of fear that they will not receive quality care due to sexuality. Both avoided discomfort by 1) avoiding each other 2) putting like with like (i.e. queer with queer providers) 3) not discussing anything uncomfortable 4) not expressing discomfort 5) denying difference (i.e. treat all the same) 6) becoming 'happy in your skin'. Patients leave when uncomfortable, so it's important enough to target. Discomfort linked with judgement. Suggests that removing discomfort works best when patient and physician work together to relieve discomfort.
(Heyes, Dean, & Goldberg, 2016) Queer Phenomenology, Sexual Orientation, and Health Care Spaces: Learning From the Narratives of Queer Women and Nurses in Primary Health Care Canada	Interviews with both Queer and Nurses. 19 Queer women 12 Nurses: 11female 1male	To frame our understanding of the experiential narratives drawn from interviews with self-identified queer women and nurses in primary health care. To examine the ways in which primary care providers potentially perpetuate, sustain, challenge, or transform the oppression of queer women in the context of their clinical care.	3 themes emerged: - Creating spaces for possibility - Orientation as trajectory - Power and prejudice: manging difficult spaces Our interviews with queer women participants and primary care nurses offer an implicit critique of heteronormative health care space, temporality, and power relations, as they form the lived experiences of our participants. We conclude by pointing to the limits of our methodology in exposing the larger relations of power that dictate experiences of heteronormative health care. Authors stated that drawing broad conclusions from interviews was 'naïve'.

(Continued)

Table 3. (Continued).

Author, Title, Setting	Sample, Design	Aim	Findings
(Keleş, Kavas, & Yalim, 2018) LGB+ Individuals' Perceptions of Healthcare Services in Turkey: A Cross-sectional Qualitative Study. Turkey	55 LGB individuals Face to face in depth interviews. Do you think LGB individuals have been neglected in terms of their access to healthcare services? Thematic analysis	To assess how activist LGB individuals, reflecting on their own bodies, sexuality, and gender evaluate their experiences when receiving healthcare services.	The findings were evaluated within the framework of access to healthcare service theme related to healthcare service demand context. Additionally, the 'interaction with physicians' theme was addressed in the context of physician–patient/counselee relationship. LGBT+ individuals state that they are exposed to stigmatizing and segregating discourses by healthcare professionals, which might pose an obstacle for adaptive health-seeking behaviours. These results suggest that physicians' professional approach has a considerable influence on LGBT+ individuals' capacity for utilizing healthcare services.
(Knight et al., 2014) Examining clinicians' experiences providing sexual health services for LGBQ youth: considering social and structural determinants of health in clinical practice British Colombia, Canada	24 clinicians (5 doctors and 19 nurses) providing sexual health services to LGBQ In depth, semi-structured interviews Data analysis Constant comparative techniques, open coding approach then organised into trees as themes emerged. In doing so, a thematic analysis was conducted.	To explore the perceptions and experiences of clinicians providing sexual health services for LGBQ youth.	Many clinicians provided services to LGBQ youth with a lack of cultural competency. (i.e. implicit – describing heteronormative practices, or explicit – expressing frustration about lack of education and training. Institutional norms and values were identified as the dominant barriers in the effective provision of LGBQ tailored services. Clinicians feel unprepared to provide culturally competent sexual health services. Clinicians felt their heterosexuality left them unable to identify or relate to LGBQ patients. Clinicians aware of lack of space to talk about sexual orientation
(Lee, Taylor, & Raitt, 2011) 'It's not me, it's them': How lesbian women make sense of negative experiences of maternity care: A hermeneutic study Scotland	8 lesbian women Interviews	The paper is a report of one aspect of a hermeneutic study of lesbian women's experiences of maternity care, specifically interpretations of negative experiences. The aim of the main study was to describe lesbian women's experiences of maternity care, specifically interpretations of negative experiences.	The participants not only described their experiences of maternity care as being positive but also offered examples of negative experiences. These were analysed separately to explore the ways in which the women made sense of them in the context of an otherwise positive experience. These experiences were expressed in ways that distanced the negative and that seemed to rationalize behaviour or ascribe it to the health professional. Conclusions. Negative encounters with health professionals are processed by women in a way that protects their overall experience. Health professionals in maternity care should consider the impact of negative responses to lesbian mothers and the effect that it has in reducing the overall quality of this significant life event.

(Continued)

Table 3. (Continued).

Author, Title, Setting	Sample, Design	Aim	Findings
(McCann & Sharek, 2014) Challenges to and opportunities for improving mental health services for LGB people in Ireland: A narrative account Ireland -mental health service	125 did the survey - 20 used for phone interview Found by LGB and mental health organisations, including hospitals and clinics. 75% were from Ireland, 70% single, 45% gay and 45% lesbian, one bisexual. 15% transgender Qualitative Exploratory design. Survey and semi-structured interviews. Interview 45min-1hour over 3-month period. First 2 transcripts were open coded, then coding guide developed to analyse remaining transcripts	To examine the experiences of LGB people concerning mental health services in Ireland. The objectives included uncovering positive and negative experiences: identifying potential barriers, opportunities and gaps within mental health service; and highlighting evidence of good practice that might inform future mental health policy directives.	Some reported positive experiences. Patients hoped for holistic services. Participants would like to see existing provision changed and reviewed – more responsive to needs of LGB. (i.e. increasing access, providing knowledgeable and responsible practitioners, allowing for a range of therapeutic approaches. Suggested media campaigns to reduce stigma and discrimination and also suggested equality training. Good practice guidelines should be put in place. Acknowledged minority stress and suicide risks – therefore educate in schools. Paper suggests nurses are at forefront to reduce discrimination and bias.
(Müller, 2017) Scrambling for access: availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa. South Africa	16 semi structured interview 2 focus groups 14 individual interviews Qualitative study comprised of 16 semi structured interviews and 2 focus group discussions with LGB health service users. Data analysed within the UN international covenant on economic, social and cultural rights general comment 14	This study analyses the experiences of LGB health services users using South African public sector healthcare	All interviewees reported experiences of discrimination by healthcare providers based on their sexual orientation and/or gender identity. Participants recounted violations of all four elements of the UN General Comment 14: 1) Availability: Lack of public health facilities and services, both for general and LGBT-specific concerns; 2) Accessibility: Healthcare providers' refusal to provide care to LGBT patients; 3) Acceptability: Articulation of moral judgment and disapproval of LGBT patients' identity, and forced subjection of patients to religious practices; 4) Quality: Lack of knowledge about LGBT identities and health needs, leading to poor-quality care. Participants had delayed or avoided seeking healthcare in the past, and none had sought out accountability or complaint mechanisms within the health system. Conclusion: Sexual orientation and gender identity are important categories of analysis for health equity, and lead to disparities in all four dimensions of healthcare access as defined by General Comment 14. Discriminatory and prejudicial attitudes by healthcare providers, combined with a lack of competency and knowledge are key reasons for these disparities in South Africa. Keywords:

(Continued)

Table 3. (Continued).

Author, Title, Setting	Sample, Design	Aim	Findings
(Neville et al., 2015) Perceptions towards lesbian, gay and bisexual people in residential care facilities: a qualitative study. New Zealand	Focus Groups with care workers 47 care workers 45female 2male	To explore the perceptions of care staff working in residential care homes towards older lesbian, gay and bisexual people.	3 themes emerged: - Knowing me, knowing you - Out of sight out of mind - It's a generational thing Subtle and explicit homophobia were outlined in all themes. Care staff felt unprepared to give specific care to LGB people. Conclusion. This small-scale New Zealand study identifies that the residential care sector is not always supportive, or prepared, to provide a care service to those people identifying as lesbian, gay and bisexual.
(Pellegrini et al., 2015) <i>'Never in all my years'</i> nurses education about LGB health USA San Francisco Bay area	268 practicing nurses Convenience sample Interview (conducted by undergraduates) 3 main questions 1) does your organisation provide training for key staff members in LGB patient-centred care? 2) Have you received training or orientation regarding care of LGB? 3) How prepared/ comfortable are nurses working with LGB patients?	To assess the current state of the art of LGB sensitive nursing practice	Most nurses (80%) revealed that they had no education of training on LGB health issues. These gaps in knowledge and discomfort in practice may adversely affect patient care. LGB training needs to start in nursing schools. 30% reported discomfort - often linked to lack of education. Used 'we treat everyone the same' as a rationale for not learning. Some respondents stated stereotypical beliefs about LGB (e.g. us v them, "regular" patients)
(Rufino et al., 2018) Disclosure of Sexual Orientation Among Women Who Have Sex With Women During Gynecological Care: A Qualitative Study In Brazil. Brazil	Interviews with 34 women who have sex with women (WSW)	To investigate the experiences WSW have after disclosure of sexual orientation during gynecological care in Brazil.	WSW described negative experiences/ environments when disclosing. Gynecologists displayed heteronormative attitudes and did not ask about sexual orientation. The reactions of gynecologists were discriminatory, resulting in abbreviated consultations and un-comfortable gynecological exams. This study suggests that gynecologists missed an opportunity to use WSW's sexual orientation disclosure to offer specific care to them. Conclusion: The results point out the need for a change in medical training and guidelines to assist WSW in the country. Rufino

(Continued)

Table 3. (Continued).

Author, Title, Setting	Sample, Design	Aim	Findings
(Rutherford et al., 2012) Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities Canada	Mental Health clinicians Interviews with Mental health clinicians: psychiatry (n = 2); social work (n = 3); psychotherapy (n = 2), and psychology (n = 1). All providers self-identified as members of LGBT communities. 5 female 3male	To describe the common elements of the lived experiences of a phenomenon, in this case health care providers' development of expertise in LGBT mental health.	Lack of LGBT education and resources for delivering mental health services was highlighted. Provider recommendations included the introduction of mandatory LGBT health content in education curricula that addresses basic LGBT-related terminology, appropriate interview questions to facilitate the disclosure of sexual orientation and gender identity, information regarding the health impact of hetero- sexism and homophobia, and specific health care needs of sexual and gender identity minority people. Most agreed that being LGBT was not necessary to provide supportive, appropriate care for LGBT individuals. CONCLUSIONS Data from this study suggest there are few opportunities for medical providers to access training and gain expertise in the provision of care to LGBT people. Additional research is needed to consider whether the lack of LGBT health content in medical and psychiatric training programme curricula indirectly contributes to the health disparities experienced by these populations.
(Sefoloshia et al., 2019) Reframing Personal and Professional Values: A Substantive Theory of Facilitating Lesbian, Gay, Bisexual, Transgender and Intersex Youth-Inclusive Primary Health Care by Nurses Reframing Personal and Professional Values: A Substantive South Africa	Interviews with nurses 7 participants 7 female	The aim of this study was to develop substantive theory focused on the basic social processes involved in facilitating LGBTI youth inclusive PHC in an urban area in SA. The research objectives were to: ● Explore and describe the experiences of nurses regarding caring for LGBTI youth in PHC clinics. ● Explore and describe the basic social processes involved in facilitating LGBTI youth inclusive PHC.	The theory was developed: "reframing personal and professional values" which is outlined in three phases. Phase 1 illuminates subtle and covert ways that nurses used to identify value-laden tension and conflict as barriers to LGBTI youth-inclusive care. Phase 2 and 3 reflect thoughtful and reflexive strategies that nurses used to facilitate nurse-patient interaction to resolve value-laden tension and conflict. The substantive theory provides a way of improving the healthcare and health-seeking behaviour of LGBTI youth.

(Continued)

Table 3. (Continued).

Author, Title, Setting	Sample, Design	Aim	Findings
(Stover, Hare, & Johnson, 2014) Healthcare experiences of lesbian, gay, and bisexual college students : Recommendations for the clinical nurse specialist USA	Focus Groups with LGB individuals 11female 7male	The purpose of this study was to describe the healthcare experiences of lesbian, gay, and bisexual college students (ages 18Y24 years) in the local college community. A specific aim of the study was to describe the factors (e.g., healthcare system, patient, provider, clinical encounter) that influence this experience.	1 main theme - comfort during the clinical encounter 3 subthemes - personalizing the clinical encounter - deciding to disclose and social stigma - seeking support of self-identified sexual orientation Participants provided recommendations that are helpful to clinical nurse specialists to promote positive clinical encounters. Implications for clinical nurse specialist practice and recommendations for further research are addressed.

Results

Characteristics of included studies

In total, 20 studies were included (Agénor, Bailey, Krieger, Austin, & Gottlieb, 2015; Bjarnadottir et al., 2019; Bjorkman & Malterud, 2009; Burton, Lee, Waalen, & Gibbs, 2019; Chapman et al., 2012; Fish, Williamson, & Brown, 2019; Haider et al., 2017; Harbin, Beagan, & Goldberg, 2012; Heyes, Dean, & Goldberg, 2016; Keleş, Kavas, & Yalim, 2018; Knight, Shoveller, Carson, & Contreras-Whitney, 2014; Lee, Taylor, & Raitt, 2011; McCann & Sharek, 2014; Müller, 2017; Neville, Adams, Bellamy, Boyd, & George, 2015; Pellegrini, Mankovitz, Eliason, Ciano, & Scott, 2015; Rufino, Madeiro, Trinidad, Rodrigues dos Santos, & Freitas, 2018; Rutherford, McIntyre, Daley, & Ross, 2012; Sefolosha, Van Wyk, & Van Der Wath, 2019; Stover, Hare, & Johnson, 2014). Six studies were conducted in the United States of America (USA), four in Canada, two in South Africa and the United Kingdom (UK) and one in each of Australia, Brazil, Ireland, New Zealand, Norway and Turkey. Eleven studies focused upon patient perspectives only. Of these, five focused on people who identified as lesbian, gay bisexual or transgender (LGBT), two focused on each LGB and lesbian and one of each on women who have sex with women (WSW) and people who identify as lesbian, gay or queer (LBQ). Six studies focused on HPs. Of these, three focused on nurses, and one on each of care workers, mental health providers and clinicians (this included a combination of doctors and nurses). Three studies included perspectives from both patients and HPs. These studies included nurses, clinicians, physicians and LGB. Focus

Table 4. Quality Appraisal

Author/ Title	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Total
(McCann & Sharek, 2014)	y	y	y	y	y	n	y	y	n	y	8
(Harbin et al., 2012)	y	y	y	n	y	n	n	y	y	y	7
(Haider et al., 2017)	y	y	y	y	y	y	n	y	y	y	9
(Knight et al., 2014)	y	y	y	y	n	n	y	y	y	y	8
(Pellegrini et al., 2015)	y	y	y	n	n	y	n	y	y	y	7
(Keleş et al., 2018)	y	y	y	n	y	n	y	y	y	y	8
(Müller, 2017)	y	y	y	n	y	n	y	n	n	y	6
(Chapman, Wardrop et al., 2012)	y	y	y	n	y	n	y	y	y	y	8
(Bjorkman & Malterud, 2009)	y	y	y	y	y	y	y	y	y	y	10
(Neville et al., 2015)	y	y	y	y	y	n	y	y	y	y	9
(Burton et al., 2019)	y	y	y	n	y	n	n	y	y	y	7
(Sefolosh, 2019)	y	y	y	n	y	y	y	y	y	y	9
(Bjarnadottir et al., 2019)	y	y	y	y	y	n	y	y	y	y	9
(Fish, Williamson, & Brown, 2019)	y	y	y	n	y	n	y	y	y	y	8

(Continued)

Table 4. (Continued).

Author/ Title	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Total
(Rufino et al., 2018)	y	y	y	n	y	n	y	y	y	y	8
(Lee, Taylor, & Raitt, 2011)	y	y	y	n	y	y	y	y	y	y	9
(Heyes, Dean and Goldberg, 2016)	n	y	y	n	y	y	y	y	n	y	7
(Stover, Hare, & Johnson, 2014)	y	y	y	y	y	y	y	y	y	y	10
(Rutherford et al., 2012)	y	y	y	y	y	n	y	y	y	y	9
(Agénor et al., 2015)	n	y	y	n	y	n	y	y	y	y	7

groups were used in three studies, semi-structured interviews in 14 studies, web-based stories in one study and mixed qualitative methods in two studies.

It is important to note that the authors excluded data from transgender individuals throughout this review. This was due to an understanding that transgender health experiences are different and often more negative than LGB patients (Macapagal et al., 2016). This understanding was supported by some statements in the papers included in this review. One transgender patient said *“it’s wasn’t the sexual orientation”* showing her differentiating between the issues associated with transgender and those associated with sexual orientation (Harbin et al., 2012). One HP also said, *“it’s the transgender that makes me uncomfortable”* again separating the two concepts and showing more negativity toward the transgender individuals (McCann & Sharek, 2014). Further research should be done in this area to understand the specific experiences of transgender patients.

Themes

Five themes were identified. These are; lack of knowledge, identification of sexual orientation, discomfort, heteronormative attitudes and judgment/negative attitudes.

Lack of knowledge by health professionals

Data from HPs suggest an awareness of lack of knowledge in relation to specific LGB health issues. For example, HPs said, *“some of our reactions come from pure ignorance”* or *“I feel as if I have a lack of knowledge myself,”* *“that’s something we should have a bit more education on,”* *“I don’t really know how to ask”* (Harbin et al., 2012; Knight et al., 2014; Neville et al., 2015; Rutherford et al., 2012; Sefolosha et al., 2019). Terminology was often highlighted as a specific issue (Rutherford et al., 2012; Stover et al., 2014). Some HPs expressed frustration in their inability to answer questions and their desire to promote positive interactions with the LGB community (Bjarnadottir et al., 2019; Harbin et al., 2012; Knight et al., 2014; McCann & Sharek, 2014; Pellegrini et al., 2015). Conversely, others stated that providing training would insinuate that LGB patients are *“different”* and therefore could encourage negative attitudes (Bjarnadottir et al., 2019; Harbin et al., 2012; Pellegrini et al., 2015).

The HP perspective can be substantiated by the perspective of the LGB individuals. LGB patients disclosed interactions with *“inexperienced”* physicians, and made comments such as *“I felt as if she didn’t know how to deal with a gay couple,”* and *“they didn’t know how to act”* showing that patients are aware of the lack of knowledge and experience their HP has (Bjorkman & Malterud, 2009; Chapman et al., 2012; Fish et al., 2019; Keleş et al., 2018; Müller, 2017; Rufino et al., 2018). Patients stated a desire for HPs to be more

knowledgeable and to receive training specific to address their needs (Agénor et al., 2015; Bjorkman & Malterud, 2009).

Disclosure of sexual identity

The evidence regarding need for recognition of someone's sexual identity was conflicting. Some HPs reported treating everyone the same no matter their sexual orientation and therefore did not see disclosure as necessary (Harbin et al., 2012; Pellegrini et al., 2015). Some stated *"they would have the same needs," "I don't think sexual orientation should have ... any play in it [healthcare]," "It's not something I have to get into"* (Bjarnadottir et al., 2019; Haider et al., 2017; Harbin et al., 2012). Some HPs admitted that they avoided asking questions about sexual orientation *"We've got a question on sexuality on our admission forms, and they've never been completed"* (Neville et al., 2015). Other HPs suggested that they need only know if it is clinically relevant as it could otherwise be considered *"invasive"* and that it was the responsibility of the patient to disclose (Sefolosha et al., 2019). One HP said it was *"none of my business"* to know about sexual orientation (Haider et al., 2017). Some nurses also shared concern that if they asked or amended care plans due to sexual orientation then the care they gave would not be equal (Bjarnadottir et al., 2019).

Conversely, when LGB individuals were asked about the importance of disclosing sexual orientation, they stated that it should be integrated into routine questioning. One said she had been taught *"how important it is to tell your health professional, not to conceal"* (Rufino et al., 2018). Some patients argued that *"if you are counted, you are visible," "it's best to know all about it"* (Haider et al., 2017). Other patients said *"unless you are open about your sexuality you can't expect to be treated holistically"* (Fish et al., 2019). There were some LGB participants who did not *"think it's necessary"* to tell their HP their sexual orientation, but often, this was out of fear of rejection. One patient shared the opinion that they *"didn't feel any need to tell them that I am gay"* (Burton et al., 2019). While others said *"I'm afraid that I'm going to possibly ruin this great relationship we have"* and *"I was nervous about telling her"* (Agénor et al., 2015; Stover et al., 2014). Some patients acknowledged the importance of being ready to disclose if necessary but not initiating the conversation, *"I don't explain it. If it comes up, I mean it comes up"* *"I'm glad he asked because I wouldn't have brought it up"* (Burton et al., 2019; Stover et al., 2014).

Discomfort

Both HPs and LGB individuals acknowledged comfort and discomfort during interactions. HPs disclosed that they felt discomfort when they didn't know how best to provide care, with HPs saying *"I honestly don't think many are*

prepared or comfortable when working with this population” (Harbin et al., 2012; Pellegrini et al., 2015; Rufino et al., 2018). Patient views supplement the HPs with patients saying *“she was uncomfortable with us,” “The physician was very embarrassed”* (Fish et al., 2019; Rufino et al., 2018). One patient said *“If they can manage not to start shifting in their seat . . . I appreciate it,”* showing the low expectations that some patients may have for their HP (Stover et al., 2014). Some LGB participants mentioned the rainbow symbol, suggesting that if this was displayed, it may make them feel more comfortable *“okay maybe I can bring this up”* (Fish et al., 2019; Heyes et al., 2016; Stover et al., 2014). While others also suggested that having their HP identify as LGB helped improve their comfort *“someone like me,” “I felt much more comfortable . . . after he told me that”* although all these participants agreed that this was not necessary (Agénor et al., 2015; Stover et al., 2014).

Discomfort and comfort were also linked to disclosure of sexual orientation. Some patients reported that they felt more comfortable and able to discuss further issues with their HP if disclosure had been a positive experience (Keleş et al., 2018; McCann & Sharek, 2014). One study showed that patients *“like doctors who ask questions”* as this made disclosure *“straightforward”* and increased comfort (Stover et al., 2014). Some patients described a fear of rejection which fostered discomfort, which in some cases led patients to conceal their sexuality from staff. One patient said *“I will play along”* when perceived as heterosexual as it would reduce discomfort (Harbin et al., 2012; Müller, 2017). Several participants went on to describe the impact that comfort and discomfort had on their experience. One patient talked about a situation where their HP mentioned their sexuality in front of other staff members and he *“asked to leave the room because I felt so uncomfortable”* (McCann & Sharek, 2014). Another patient said *“I never felt comfortable bridging that into her becoming a resource for my kind of overall sexual health”* (Agénor et al., 2015). These situations of discomfort caused patients to miss out on healthcare and advice, showing the danger of discomfort. Often when HPs are feeling discomfort the patient may perceive judgment which also indicates the harmful nature of an interaction where either party feels uncomfortable (Harbin et al., 2012). This *“judgment”* can ruin the therapeutic relationship and hinder communication between patient and HP (Bjarnadottir et al., 2019; Harbin et al., 2012; Sefolsha et al., 2019).

This concept of discomfort was often accompanied by a debate over who is responsible for comfort. One study quotes an HP suggesting that discomfort is contagious, *“if I’m not comfortable . . . will probably add to their discomfort or create discomfort”* (Harbin et al., 2012). This statement was corroborated by a patient saying *“I think that that they need to make them feel comfortable”* when asked about their healthcare provider (Burton et al., 2019). Other data in the literature suggests that both patients and HPs believe that the patient must be responsible for ensuring comfort for both

parties. One patient said *“if you’re just upfront”* then the HP will feel comfortable while a HP stated that patients should be *“clear about what their needs are”* to encourage comfort for both (Harbin et al., 2012). Another patient said *“you really do have that responsibility”* when discussing her role in educating her HP and removing some level of discomfort (Chapman et al., 2012). Others stated that *“the more [comfortable] someone is with themselves, the more willing they will be to share with others”* suggesting that disclosure and comfort are both the responsibility of the patient (Stover et al., 2014).

Heteronormative attitudes

Patients describe various presumptuous and heteronormative behaviors, i.e. HPs assuming that all individuals are heterosexual unless told otherwise. Some participants stated clearly *“hetero-normatives,” “why do you always assume people are straight?”* (Heyes et al., 2016; Rufino et al., 2018; Stover et al., 2014). One participant said *“I learn that this coming out process is almost an everyday occurrence”* (Burton et al., 2019). Some patients described issues where HPs would incorrectly assume a relationship, *“Nobody treated us like a couple,” “asked if Heather’s partner was my daughter”* (Heyes et al., 2016; Lee et al., 2011). These issues of disclosure highlight the presumptive heteronormative attitudes that LGB individuals must amend.

Sometimes heteronormative attitudes emerge when an HP is trying to improve comfort levels for their patient, they will ask about relationships, presuming that boys will have girlfriends and girls will have boyfriends (McCann & Sharek, 2014). Some patients experienced the more extreme end of heteronormative behavior, with HPs challenging parenthood because the HP did not understand that a child could have two mothers *“she has two mothers. Well how can that be?”* (Harbin et al., 2012; Heyes et al., 2016). Several patients described situations where they had to explain themselves because their clinician or the clinical environment displayed a heteronormative approach with regards to contraception or sexual activity *“they give out condoms but no latex gloves or dental dams,” “she told me to have safe sex . . . I didn’t tell her than I don’t have sex with men”* (Agénor et al., 2015; Heyes et al., 2016). One said they felt they had to *“explain and emphasise being different”* (Bjorkman & Malterud, 2009).

Heteronormative attitudes were not just that of the individual HP but were seen in the organizational structure of the healthcare setting. For example, forms that parents must completed having space for mother and father, leaving a same sex couple to feel marginalized (Chapman et al., 2012; Heyes et al., 2016). In one case, patients stated they did not trust the complaints system, as judging by the explicit discriminatory attitude of their HP, they could not expect the system to challenge it (Müller, 2017).

There was limited evidence from studies with HPs acknowledging the issue of heteronormativity. Only one HP recognized, *"It is assumed that the patients will be heterosexual"* (Pellegrini et al., 2015). Among the research a small number of HPs state their attempts to normalize any sexuality, with one clinician saying *"we try to treat people ... like a real human being ... if you're straight, if you're gay, if you're pansexual ... it's all cool"* (Knight et al., 2014).

Negative attitudes and judgment

Many LGB participants described experiencing negative attitudes. Some of the studies reported *"negative attitudes"* as an emerging theme from their research (Bjorkman & Malterud, 2009; Keleş et al., 2018). When discussing negative attitudes, much of the research highlighted judgment as a specific issue. It is suggested across studies that negative attitudes lead to maltreatment or difficulties with accessing healthcare.

Judgment is often perceived from non-verbal cues. Some patients discussed how healthcare providers looked at them *"as if we're sick," "this man could not even look at [them], to acknowledge [their] presence," "looking at me like I've got 6 heads," "she hardly looked me in the eye" and "look at me differently"* (Burton et al., 2019; Heyes et al., 2016; Müller, 2017; Rufino et al., 2018; Stover et al., 2014). Other studies reported participants stating other non-verbal cues *"I noticed a certain distance, a coldness," "rude and unpleasant," "started talking to me differently," "stood so far away from me"* (Lee et al., 2011; Rufino et al., 2018; Stover et al., 2014). One participant stated *"we feel judged"* (Müller, 2017), while other patients seemed surprised at the lack thereof, *"she didn't judge ... she was great"* (Agénor et al., 2015; Chapman et al., 2012). Another patient suggested they were *"lucky to get somebody who was understanding,"* implying they may expect the opposite (McCann & Sharek, 2014).

Some HPs were explicit in their opinions of homosexuality when speaking about their own family *"I won't accept it," "I would be horrified,"* but suggested if it was in work *"it's alright here"* (Neville et al., 2015). Other HPs talked about LGB patients vs *"regular"* patients and described witnessing *"snickering"* between colleagues implying an underlying discriminatory attitude (Pellegrini et al., 2015). The research sometimes concluded that HPs were judging unconsciously by suggesting LGB sexual orientation was a *"phase"* and that they would eventually grow out of it (Harbin et al., 2012; Stover et al., 2014). Other studies suggested that HPs may have negative attitudes but they should not let this affect their care *"can't let our personal ideas about it colour the way we treat our patients," "not to be judgemental"* (Bjarnadottir et al., 2019; Sefolosha et al., 2019).

In cases of extreme judgment, some patients describe struggles with accessing treatment. This may manifest in logistical hurdles such as poor communication from HPs. One patient stated *"they refuse you in different ways,"*

“everything was a reason to spend less time with me” (Keleş et al., 2018; Rufino et al., 2018). Some LGB patients gave examples of HP treatment *“I felt I didn’t get any sort of aftercare”* but then tried to justify HP behavior *“I think that’s just how she was”* (Lee et al., 2011). The judgment was occasionally illustrated as more extreme, leading to maltreatment and direct refusal *“I’m not going to give you a pelvic exam”* (Rufino et al., 2018). In some cases, patients described refusal of treatment specifically due to their sexual identity *“this is not the place for you,” “I don’t do artificial insemination for dykes”* (Müller, 2017; Rufino et al., 2018).

Both patients and HPs described interactions where beliefs and religion began to create a negative atmosphere (Keleş et al., 2018; Müller, 2017; Sefolosha et al., 2019). One patient disclosed that when he declared his sexuality, his physician perceived it as an *“evil spirit”* and recounted being read *“scriptures from the bible”* (Müller, 2017). One HP said *“I believe God created Adam and Eve and . . . that’s how it should be”* (Sefolosha et al., 2019). Both studies were based in South Africa.

Discussion

This qualitative synthesis identified five interrelated themes across 20 studies. These themes represent perspectives emerging from both health professionals (HPs) and LGB patients and have implications for LGB healthcare.

HP lack of knowledge appeared to be related to the healthcare experience of most LGB individuals and HPs included in this review, with all studies emphasizing the importance of educating healthcare staff on LGB issues as a key strategy to improve healthcare interactions. It was suggested that HPs may benefit from sensitivity training or specific discussions related to how their professional code may link to interactions with LGB individuals (Sefolosha et al., 2019). This is consistent with previous quantitative studies (Mayock, Bryan, Carr, & Kitching, 2008). Lack of knowledge was related to a recurring theme of negative attitudes and judgment. This ranged from body language to direct refusal of care. Some HPs acknowledged negative attitudes but sometimes, discomfort or lack of knowledge left LGB patients feeling that their HP held negative attitudes toward them. Educational strategies may help with reducing heteronormative attitudes and behaviors, and reduce the likelihood of patients feeling judged, marginalized and misunderstood, harming the therapeutic relationship (Sefolosha et al., 2019).

The words *“comfort”* and *“discomfort”* appeared in almost every research paper included in this review, both by patients and clinicians, highlighting this as a key theme. One study indicated that creating an environment of comfort was vital to developing a therapeutic relationship and valuing human dignity (Sefolosha et al., 2019). This issue is essential in healthcare as an atmosphere of positive communication and empathy can influence

health outcomes, as shown by a plethora of research shown in a systematic review and meta-analysis (Howick et al., 2018). Comfort may be fostered when the HP displays specific knowledge about LGB health issues and does not assume heteronormative approaches to healthcare. This feeling of comfort may also facilitate the removal of fear for patients to disclose sexual orientation. Intervention strategies to reduce discomfort should be explored.

Most patients stated they thought disclosure of sexual orientation was vital to appropriate healthcare while some HPs did not believe this to be necessary. Within these studies, most LGB participants were recruited from active LGB groups and centers, suggesting that these individuals are open about their sexual orientation. There may therefore be a percentage of “closeted” LGB individuals who were not represented in this research. LGB identity is a risk factor for both physical and mental health concerns, and every health interaction is an opportunity to promote health. Understanding an individual’s sexual orientation is as important as knowing their age or ethnicity (Fredriksen-Goldsen et al., 2014). Within the UK, the National Health Service (NHS) advise that all patients aged 16 years or older are asked about their sexual orientation in the same way individuals would be asked about ethnicity (Humphreys, 2017). Our findings suggest that work needs to be done with HPs to emphasize the importance of awareness of sexual orientation for appropriate healthcare.

The studies identified covered a wide geographical range, with some studies in some localities reporting extreme negative LGB experiences. South Africa is the only country in Africa that has legalized same-sex marriage (Masci, Sciupac, & Lipka, 2017). However, the studies in this review from this country reported extremely negative LGB experiences (Müller, 2017; Sefolosha et al., 2019). This may be due to general attitudes to homosexuality across many parts of Africa, with research from Uganda, Nigeria, Senegal and Ghana showing that 96% think homosexuality should not be accepted (Masci et al., 2017). It is important to consider culture and laws when exploring this evidence base. There are many countries that still treat homosexuality as an illegal practice and, in the extreme, there can be death penalties. Accordingly, there will be locations where this research is not appropriate and cannot be expected to influence society.

The review has a number of strengths. Each theme that arose was discussed by participants in more than one study, suggesting that they are well evidenced and could be expected to arise if similar research was conducted in other settings. Additionally, the quality of included studies was high as scored by the CASP tool. Despite the wide geographical range of studies, common themes across these indicate generalizability of the research. To our knowledge, this literature review is the first attempt to synthesize the qualitative literature in this area.

Limitations

The dataset presents two main weaknesses, these are; the representativeness of HPs and the recruitment process of LGB individuals. One noticeable characteristic of the body of research is the sex of the HPs who participated. Nine studies included data from HPs, eight of these provided demographic information. The most balanced ratio was that of five female HPs to three male (Rutherford et al., 2012). The other eight studies had ratios of 45:2, 20:4, 17:9, 11:1, 8:1, 7:1 and 7:0 (Bjarnadottir et al., 2019; Haider et al., 2017; Harbin et al., 2012; Heyes et al., 2016; Knight et al., 2014; Neville et al., 2015; Sefolosha et al., 2019). One male HP participant indicated his assumptions that gay men might “hit on [him]” and would therefore only care for them if they did not (Müller, 2017). Despite the lack of male HP involvement in this review, it cannot be assumed that their input would alter results. However, some supplementary research suggests that globally, there is an evident gender gap in acceptance of homosexuality. In Britain, 83% of women said that homosexuality should be accepted compared with only 69% of men, showing there is a clear discrepancy between the sexes. Therefore, men must be represented in research such as this, as it has been indicated their views can differ significantly from those of women (Kohut, 2013).

Many of the studies used sampling techniques such as recruiting at LGB PRIDE events, on websites, forums or through word of mouth and snowballing. These all limit the sample as they recruit only those individuals who are comfortable enough with their sexual identity to tell friends and family or to be part of events and forums. Such strategies also do not incorporate individuals who are questioning their sexual identity or are not yet comfortable with sharing this information. It is possible that this group may have different interactions in healthcare settings.

Conclusion

The evidence base shows strong themes that recur throughout various geographical locations and are highlighted by both HPs and LGB individuals. These themes are; HPs have a lack of knowledge about LGB specific issues, there is some discrepancy regarding the need for identification of LGB identity, there is often a feeling of discomfort from both HPs and LGB individuals, LGB individuals perceive that HPs display heteronormative attitudes, and both HPs and LGB individuals acknowledge that negative attitudes and judgments can be present during interactions. This literature review helps highlight areas that could be improved in order to help the LGB community achieve better health outcomes. The evidence base is strong and of high quality and could help guide policy and influence guidance given to HPs. The research suggests that practices can be improved through routine identification of sexual orientation, education and

administrative change. Identification of sexual orientation has already been recommended in the UK and so this guidance is substantiated by the evidence in this literature review (Humphreys, 2017). Introducing education modules at university or training days for staff could improve the current lack of knowledge about LGB specific issues and also could reduce the levels of heteronormativity, negativity and judgment.

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